The balancing act: key issues in the lives of women general practitioners in Australia

Margaret R Kilmartin, Christopher J Newell and Martin A Line

ABSTRACT

Objective: To identify key issues affecting women general practitioners in their professional and non-professional lives.

Design: A qualitative study using the Delphi technique, with three rounds of data provision circulated to each participant. Coding was used to ensure anonymity.

Setting and participants: The participants were a purposive sample of 40 women GPs drawn from all Australian States and Territories. The study was conducted between October 1996 and January 1997.

Outcome measures: Key issues affecting the professional and non-professional lives of women GPs.

Results: Some of the key professional issues for women GPs were job satisfaction, balancing work and personal life, autonomy, availability of flexible and part-time work and training, affordability of professional expenses, fair remuneration, and having a voice in decision-making. Key non-professional issues included self-care; time for relationships with a partner, children, family and friends; and time management to allow pursuit of non-medical interests.

Conclusions: The conflicting demands made on women GPs diminish their job satisfaction and lead to stress and imbalance in their lives. Recommendations to ameliorate the problems for women GPs include appropriate training, policy formation, financial and other support, and a change in cultural expectations of women GPs by the community, the profession and governments.

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WOMEN GENERAL PRACTITIONERS represented 33% of the Australian medical workforce in 1998,[1] and the average age of women GPs is falling — 30% of women GPs in 1993 were aged under 45, compared with 71% in 1996.[2] In 1999, about 60% of general practice registrars in Australia were women, and this proportion is predicted to rise because of increasing enrolments of women in medical schools.[3] It is estimated that by 2010 42% of all GPs and 37% of rural GPs in Australia will be women.[4]

The medical profession has historically been part of a culture that has expected the provision of 24-hour GP care. This has been traditionally provided by male GPs, often with the assistance of a wife. With increasing numbers of women GPs in the workforce, this situation has changed, but societal expectations have not kept pace with the changes. Women GPs are still expected to carry a greater weight of household chores and family responsibilities than their male counterparts, putting them under enormous pressure in trying to balance their professional and non-professional roles.

Previous Australian studies have identified some of the problems faced by women GPs, but have mainly focused on those in rural and remote locations.[5-8] In our study, we selected women GPs from both metropolitan and rural Australia to canvass the key issues affecting them in their professional and non-professional lives.

METHODS

Reference group and recruitment of participants

A “reference group” was formed, consisting of four urban and two rural women GPs (each from a different State) who were recognised as eminent by their peers in professional, educational or clinical general practice. Teleconferencing, email and facsimile communication were used to coordinate the study. The reference group pretested the research questions and assisted with the selection of study participants.

The participants were 40 women GPs with expert professional knowledge and diverse general practice experience, purposively sampled to represent all Australian States and Territories and drawn from a variety of geographical and demographic backgrounds. The study was conducted between October 1996 and January 1997.

University of Tasmania, Hobart, TAS.
Margaret R Kilmartin, MB BS, FRACGP, Senior Lecturer, School of Medicine;
Christopher J Newell, MA, PhD, Senior Lecturer, School of Medicine;
Martin A Line, MSc, PhD, Senior Lecturer, School of Agricultural Science.
Reprints will not be available from the authors. Correspondence: Dr Margaret R Kilmartin, University of Tasmania, GPO Box 252-33, Hobart, TAS 7001. M.Kilmartin@utas.edu.au

The Delphi technique

We conducted a qualitative study using the Delphi technique, a method of structuring group communication in which study participants discuss complex problems and give their opinions, which are progressively refined in light of the responses of other participants.[9] Several rounds of data collection are required to allow the development and discussion of participants’ responses and to reach a consensus of views on specific issues.[10]

In our study, information was sent and feedback received by post over three rounds. In the first round, participants identified key issues relating to their professional and non-professional lives. In the second round, participants evaluated the importance of the key issues identified from the first round, leading to a preliminary score for each issue raised. In the third round, participants re-evaluated the key issues in the light of feedback from the second,

1: The 10 most important issues in the professional and non-professional lives of women general practitioners (in ranked order, beginning with the most important)

Professional life	Non-professional life
Achieving job satisfaction in general practice through mental stimulation, challenge, and a variety of work	Making time for self-care to avoid stress, guilt, "burnout" and mental ill-health
Balancing professional and non-professional life by drawing boundaries to protect oneself, one's family and other interests	Having time to nurture a quality relationship with a partner
Managing time to allow for successful participation in all aspects of professional and non-professional life	Having time to spend with children to take care of them and to share life experiences
Having a strong sense of self-esteem and self-image, leading to autonomy and control over one's professional life	Managing time to allow for successful participation in all aspects of professional and non-professional life
Having the option of flexible hours and part-time work to allow fulfilment of multiple non-professional roles	Having time and ability to engage in social contacts and foster friendships
Having sufficient income to cover professional expenses and provide for financial security	Finding a balance between one's own career and that of one's partner
Receiving fair remuneration for medical services and work performed	Providing a focus for family life and all the requirements and activities of the family
Juggling the complexities of competing priorities in one's professional life	Having time for non-medical interests that allow for a range of life experiences
Having the ability to train and retrain (after time out of the workforce) in a flexible part-time program in general practice that caters for the individual needs of women GPs	Having sufficient income to pay for private expenses, such as childcare, mortgages and personal requirements
Having a voice and share of power in decision-making about issues affecting women GPs	Balancing professional and non-professional life by drawing boundaries to protect oneself, one's family and other interests

resulting in a consensus ranking of the most important issues in their professional and non-professional lives. Anonymity was maintained by the use of coding throughout the study.

Ethics approval

The Ethics Committee of the Royal Australian College of General Practitioners approved the study. Participants were assured of their anonymity and told that they could withdraw from the study at any time.

RESULTS

The three rounds of the study were completed by 39 of the 40 participants.

Demographic characteristics

The median age of participants was 38.5 years (range, 25–65 years), and the median time spent in general practice was eight years (range, 1–40 years). Twenty-six participants were born in Australia, 28 were living with partners, and 30 were vocationally registered. Twenty-two practised in a capital city, eight in a remote area, five in non-capital cities, and one in a small rural centre, while four were not practising at the time of the study.

Key issues identified

The 10 most important issues identified in the professional and non-professional lives of Australian women GPs are shown in Box 1.

Job satisfaction was the top professional priority. Most women GPs wanted work that embraced a broad range of problems and patients, claiming that this provided mental stimulation, challenge, enjoyment and variety.

Some participants admitted they had been driven to breaking point in their professional lives, yet they did not identify stressors or did not deal with them sufficiently early as part of self-care. The only solution for many women GPs had been partial or total withdrawal from the workplace.

Making priorities and setting limits and boundaries were seen as essential to the wellbeing of women GPs, yet boundaries were frequently breached by emergencies, paperwork, or the needs of sick children. Women GPs were expected to fulfil their professional roles unsupported and without recognition of the difficulty of providing home visits or after-hours consultations while at the same time being responsible for child care.

Participants were concerned about rapidly increasing costs for items such as medical indemnity insurance, registration, professional fees, quality assurance and continuing professional development. Women GPs who were single parents or approaching retirement felt the financial impost most acutely.

Many participants felt they were not receiving fair remuneration for their services. They observed that women GPs provide more long consultations, deal with more problems per consultation, and manage more problems of a psychosocial or gender-oriented nature than male GPs.

The lack of voice and power for women GPs in decision-making processes and leadership positions featured strongly in participants' responses. They noted that decisions made by male GPs working full-time and owning general practices could be detrimental to women GPs, especially those working part-time.

DISCUSSION

Job satisfaction and time for self-care were rated by the study participants as the most important issues in their pro-

2: Recommendations

To redress the imbalance in the demands made on women general practitioners compared with their male counterparts, we make the following recommendations to governments, professional and collegial bodies, and the broader community:

- Provide courses for women GPs in time management, stress management, conflict resolution and boundary setting.
- Provide work, training and educational options at all levels on a part-time basis, geared to the realities of women GPs' lives.
- Design employment contracts to recognise the realities of employment for women GPs — incorporating flexibility and fairness in pay and conditions, and specifically addressing superannuation, long service leave, holiday and sick leave, parenting leave, and professional development leave.
- Incorporate part-time practice into funding models and recognise the difficulties that women GPs who work part-time face in meeting professional costs (eg, medical indemnity insurance, registration, quality assurance, professional development and professional memberships).
- Incorporate a "whole of life" approach to the realities of practice as a woman GP, recognising in funding models the financial disadvantages incurred by fulfilling parenting and familial roles.
- Provide courses in business and practice management that give women GPs the knowledge and skills to own and manage a general practice.
- Provide child-care policies and programs that include on-call and after-hours services.
- Provide policies that address the employment of a spouse when the family moves to rural areas to facilitate women GPs taking up rural positions.
- Institute policies of affirmative action that require representation of women GPs on committees, boards, working groups and other bodies that make policy decisions about general practice.
- Develop leadership programs and finance mentoring for women GPs to encourage their participation in policy-making and governance.

fessional and non-professional lives, respectively. Lack of job satisfaction, resulting from conflicting and excessive demands on the time and availability of women GPs, leads to stress, guilt, "burnout" and ill-health.[11]

The perception of women GPs that they provide longer and more in-depth consultations than male GPs (found in our study and elsewhere[12]) accords with previous research findings[7,8] that many women GPs believe they do not receive fair remuneration for their services — especially those who work part-time or receive only a percentage of the Medicare rebate from their employer.

Increasing professional costs may eventually outstrip the financial viability of working part-time as a GP. Furthermore, financial dependence and loss of income during time out of the workforce for maternity leave and child-raising impose significant lifetime financial disadvantages for women GPs. Those employed by others, commonly without a work contract, may have an additional financial disadvantage in not receiving superannuation or paid leave for sickness, holiday, study or long service. Moreover, employed women GPs do not enjoy the financial capital benefits of practice ownership.

Our findings highlight the extent of the problems faced by women GPs in Australia and the adverse outcomes that can result when no action is taken. Women GPs need a stronger voice in decision-making in the profession.

While women GPs are a diverse group, the problems consistently identified in this and other studies have many similarities and should be heeded by policymakers. The lives of women GPs have been ill-considered or poorly understood by patients, the medical profession and governments. A cultural shift by the community, the profession and policymakers is needed for the development of alternative, more flexible models of general practice (see Box 2).

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COMPETING INTERESTS

None identified.

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