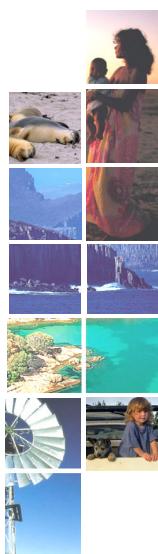


# The agenda for change among female rural general practitioners

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## ABSTRACT

This paper presents the preliminary results of a qualitative study examining the agenda for change being pursued by key influential women in Australia to address male-centred rural general practitioner (GP) workforce policies. Many current recruitment and retention programs do not reflect the needs of female GPs as they are based on the traditional notions of a country GP – that is a full-time, on call doctor with a supporting spouse. As women become the majority in medicine, key women influentials in the rural general practice field are advocating for the restructuring of medicine so that women GPs can be part of the solution to rural health care issues. Previous empirical research and theoretical analyses have suggested that medicine and rural communities are patriarchal. To date data collection for this explorative study consists of 5 in-depth interviews with a purposive sample of key women activists across the spectrum of organised medicine. Preliminary results show how women are pressuring for change but also the sources of resistance they encounter from the dominant medical culture. Key women players use particular collective and individual strategies to advocate for female GP issues. These results reflect some research findings on women leaders and female rural GPs. In conclusion, it is important that women are given equal access to decision-making positions to enable their input into the structure and culture of rural general practice. The recommendation put forward is to build inclusive recruitment and retention rural workforce strategies for female rural GPs.



## INTRODUCTION

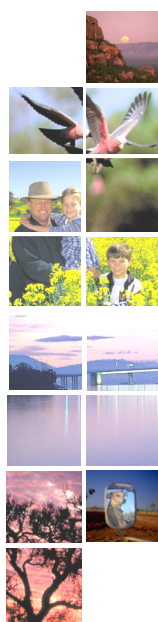
Critical shortages of rural GPs are exacerbated by changing Australian work values and priorities typified by shorter hours and earlier retirement among medical men;<sup>1</sup> and preferences for permanent part-time work and job-sharing among young doctors.<sup>2,3</sup> Women comprise over 50% of medical graduates and 75% of the Royal Australian College of General Practitioners 2002 registrar enrolments into the rural medical course.<sup>5</sup> By 2030 it is anticipated that women will make up 60% of the medical workforce.<sup>6</sup> Women comprise less than one quarter of all rural and remote GPs and are significantly less likely than men to take up full-time practice in these areas.<sup>1</sup> Factors impinging on their willingness to work in rural areas are issues not just for the individual but for the future of rural health care delivery.<sup>6,7</sup> Tolhurst identified that rural female GPs are committed to rural life and work but there is a need for changes to work and training structures based on principles of flexibility and fairness.<sup>8</sup> Underlying this, is evidence that rural women doctors sit uncomfortably in the existing structure and culture of medicine including rural general practice.<sup>9-13</sup> For example:



- government initiatives for rural GPs are based on a dominant image of a full-time, always available, procedurally skilled male doctor with a supporting spouse<sup>4,6,11-13</sup>
- rural communities' conservative values on women's roles<sup>12,13</sup> together with rural doctor expectations causes additional pressures for female doctors including burn-out and role conflict<sup>8, 11,12,15</sup>
- attitudes and organisational structures in rural general practices and medico-organisations that overlook and undervalue female GPs<sup>8,12,16-18</sup>
- the masculine construction and nature of medicine – being competitive, authoritarian and controlling of its members – has high status, high income and community prestige, making rigid professional boundaries; and a positivist paradigm of medical knowledge with cultural ideologies that these are important, right and therefore difficult to change.<sup>13,19-21</sup>

These are key features of the values, ideologies and belief system of a dominant culture in medicine. As a consequence women “work in an environment that suits male GPs and are judged by what they do, not do or against a male model of work”.<sup>6</sup> Women occupy a second class status in the ranks of medicine.<sup>6,20</sup> Tolhurst sees female rural GPs as “change agents”, for restructuring rural general practice.<sup>8</sup> This is beginning.<sup>16-18,21,22</sup> In *Doing Leadership Differently* Sinclair argues that Australian organisations are clinging to an outdated concept of leadership.<sup>23</sup> Furthermore Shannon in *The Hidden Agenda*, discusses drivers of future success and urges the medical profession to adopt new management models. She advocates for changes that require it to “organise itself in new ways, with new types of leaders and managers, who enable, coach, facilitate and empower individual members of the profession”.<sup>19</sup> There is a convergence between the ways women in medicine are working and this new approach to medical practice and training. Pringle regards female doctors as representing a “modern package” of medicine. A fresh feminine approach to modern medicine is welcomed and timely because of the contemporary importance placed on a holistic practice style, enhanced communication, more egalitarian relationships and working in health care teams.<sup>20</sup>

This paper is part of an overall project that has been funded by the Australian Research Council with the overarching aim to contribute to the recruitment and retention of female general practitioners (GPs) in rural areas of Australia. Data collection consists of three types: in-depth interviews, document and event analysis; and a chronology of key events and milestones in mainstreaming issues for women GPs in rural areas. In the context of a dominant culture of medicine this research highlights the way women are challenging the existing structures and notions of medicine at a practice and wider organisational level. This paper presents some preliminary results of 5 face-to-face interviews with key women activists who work at the organisational (ie political, bureaucratic and educational) level of medicine and within the field of rural general practice. Although the issues pertaining to female rural GPs may be relevant to the wider medical culture, the focus of the research is on the medical culture related to rural general practice including the spheres female rural GPs will interact with along their career path. The spheres include broad medical education, specialist training, rural experiences and continuing medical education (CME), it also includes medical associations and organisations and other more specific rural general practice groups, agencies and events.



## AIMS

The two key aims of this part of the research project are:

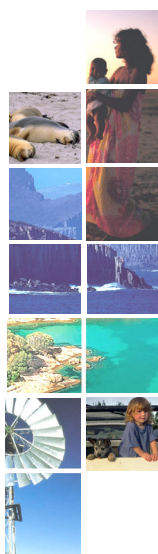
- To identify the obstacles that key women players are confronting as they attempt to create changes at the organisational level.
- To describe key women activist's strategies for challenging and negotiating changes in the structures and ideologies of medicine related to rural general practice.

## METHODS

Key women in medicine were purposively sampled across the spectrum of organised medicine. The strategy to identify key informants involved surveying research reports, conference proceedings, professional journals, project reports, scanning rural health and medical organisation websites and correspondence with in-the-know health professionals to produce a pool of potential key players in medicine. The selection criteria was based on their demonstrated and active participation in working groups, research, conferences, policy developments and other initiatives to promote the interests of rural female general practitioners. These initiatives in the "agenda for change" movement were defined and detailed on the chronology. To date, of the seventeen key players that were individually contacted to be interviewed twelve in total accepted the invitation and three did not respond. Five interviews have been conducted to date and it is intended to follow-up with non-respondents.

Interviews were conducted and recorded on tape by the author at a place that the women suggested such as at their workplace, at their home, or when distances involved in meeting were problematic, an intermediate point such as a friend's or relative's home. Interviews were 40 minutes to 2 hours in length, in a semi-structured manner, opening up with a broad statement asking to tell of their story in the agenda for change in terms of their role and involvement. This style of interviewing gave women an opportunity to give voice to their strategies and struggles in creating change and of gendered experiences in a dominant medical culture. Ethics approval was granted prior to the interviews and informed consent was obtained from all the participants.

The author conducted transcriptions of the interviews and subsequent data analysis. Nvivo, a computer-assisted qualitative data analysis program, was used to manage the large amount of information rich data. Grounded theory underpinned the analytical method to thematise results by creating codes grounded in the data. The author attempted to draw out various dimensions of strategies and obstacles using *in vivo* descriptors. To maintain the ethical consideration that key players are not identifiable, no organisational or personal names are revealed, nor pseudonyms used.



## RESULTS

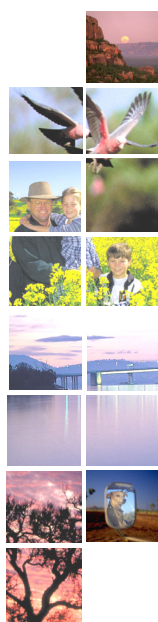
These findings about research on women as change agents reveal how women and medicine are constructed in a traditional male-dominated culture. Built into the organisational structure are norms about what medicine is and looks like, how one should behave, but these social mores have been constructed in the absence of women. Therefore how women organise themselves and their efforts is very much a result of their peculiar position, and the need for women as rural GPs and key players to be attentive to the boundaries. Those key players who were not GPs were conscious of their outsider position and the need to respectfully manage their relationships with medical organisations, medical professionals and medical women. But also, “because I am not a doctor”, as one key player says, meant that as “an agent of change” she could “speak the language of the [female] doctors that they are too afraid to speak themselves” and not be “knocked off” by the profession. Their present positions included rural general practice, rural workforce planning and research, and rural medical curriculum. It is important to understand the traditionally male culture in which women often operate, and the influence this has, whether conscious or unconscious, on the strategies they exhibit and prefer.

### Obstacles to creating change

Obstacles refer to the dominant belief systems, power structures and entrenched interests within the medical profession that the female activists are confronting. These women typically describe the current phase of the agenda of change as “scraping the surface.” A common reason was aptly summarised by one of the women: “At this point medicine is a masculine construct and despite the increasing presence of women as doctors very little of the women are having a major input either into the knowledge base of the profession or the professional structures.”

**Table 1 Obstacles to creating change**

<b>The dominant culture's point of view</b>
<ul style="list-style-type: none"> <li>• Entrenched attitudes and ideologies</li> <li>• Devaluing of women as doctors and unsupportive of them</li> <li>• Traditionally male focused work ethic and approach</li> <li>• Male defined knowledge base/and professional structures</li> </ul>
<b>The creation of an amorphous, genderless person</b>
<ul style="list-style-type: none"> <li>• “Gender is an invisible question” to the dominant culture</li> <li>• “Doctors first, women second” – identify with medical culture not gender</li> <li>• Gender issues a confronting term</li> </ul>
<b>The medical hierarchy</b>
<ul style="list-style-type: none"> <li>• Women feel vulnerable to marginalisation/lack autonomy</li> <li>• Male controlled medical organisations/senior faculties of medicine</li> <li>• Lack of women in decision making, and leadership positions</li> <li>• The need to “getting people [men] on side” to create changes</li> </ul>
<b>Resource intensive</b>
<ul style="list-style-type: none"> <li>• Finding time and energy</li> <li>• Gaining adequate resources</li> </ul>



### *The dominant culture's point of view*

The women I interviewed who were attempting to promote research or action on female rural GP issues met entrenched opposition from some of the men on medical organisational boards. These attitudes reflected dominant medical ideologies. One retold how some male doctors on the board responded to her suggested project:

Well I don't know if you really need to do any of that because in fact you are not a real doctor unless you work full time. And so there was that real traditional notion, which is obviously breaking down, but is still very prevalent I think. It seemed actually important to counter that attitude... which was very much the dominant culture, and still is very much the dominant culture.

Another explained how the attitudes of male board members were obstacles to the need for restructuring rural general practice:

There have been times when that approach has been quite hard to work with. I have felt humiliated on one occasion, ...patronised sometimes, and irrelevant...Those doctors are wonderful people but there are some issues about their attitudes and expectations of rural general practice. The fact that the majority of students coming through medicine are female, worries them greatly — they don't believe women are going to do procedural medicine and they may not understand why women doctors spend more time with patients and do less after hours work.

Women in key positions were often the minority on organisational boards, except where specific working groups had been formalised by women. As well as negative attitudes, some of the approaches the women experienced in training, practice and organised medicine were clearly unsupportive of women and are distinctively male defined:

And the more I thought about it...not just me, other people, there was a ground swell sort of opinion thinking, you know We have been running these grants and so on, we've been running these initiatives but they are pretty well all designed for male doctors, because of the kind of traditional notions of a country GP as a male doctor.

Really nothing much has changed, the structures are still very much the structures that work for men. And there is currently [a significantly funded study into rural practices]...and to my understanding at this point they have had almost no input from women for designing the study... So they are continuing to build the future in the absence of women's experience.

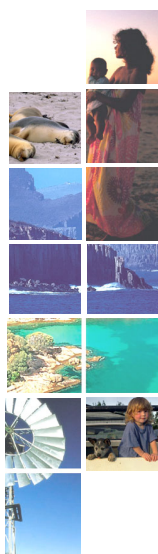
[One rural medical organisation] has predominantly supported existing middle aged male GP proceduralists.

One of the women practised in a rural town, was the only female doctor in her practice and was marketed as the women's health person even though she attempted to gain recognition for her skills in obstetrics and anaesthesia:

Whereas a male GP came along who was an anaesthetist, um, and he was immediately marketed in the practice as, you know, "This is X, and he does anaesthetics as well." ...And so I kept analysing — Was that just a chip on the shoulder? No I don't think so. It was a different approach to my work, compared to other people in the practice. And I think that partly contributed to the fact that I left, cause I didn't feel valued.

### *The creation of an amorphous genderless person*

The culture of medicine socialises women into seeing themselves as "doctors first, women second." This creates resistance to the pressures mounted by the key women players. For medical students this is a particular issue when they are focused on



developing their identification with the medical culture, and will not want to question that culture.<sup>24</sup> As the women reported:

Yes, I think what I am seeing is, the students, even for students through to the final year of the course, they don't see what the gender issues are. Or they like to think there are no gender issues. Because they haven't had any direct impact themselves. I mean they're in a course with equally as many females as male students; they don't see many senior female academics or role models; but they don't consider that yet, I don't think....But most of them are just looking at their career as a sort of amorphous genderless person. And I guess that's a naive position.

I mean I see some students...who elude to issues that relate to gender. Firstly they may not recognise it themselves, and secondly they don't feel they've got the autonomy or the power to take it further, cause they feel it will effect their career. Or effect their marks, or effect the way other students perceive them. And because it's such a competitive atmosphere, they're really being socialised into being almost isolated. So it's not a very feminine way of doing things, where you might expect the community feel to the course, more of a supportive atmosphere.

But in those days [in 1996] to mention the word women or feminine threw them all into a panic.

But even when women are present in the college structures they are doctors first and women second. That's how they learn to be doctors and they carry that and they don't want to know about issues for women. Because they say we're a generic doctor.

Well there is a momentum and the people which make the decisions around these issues is the guys and to them it is an invisible question.

### *The medical hierarchy*

The hierarchical structures of medicine, with men controlling the higher echelons, create settings where women see themselves being easily marginalised. The process requires that projects must be approved by these boards, most of which have few women representatives. The need for "getting people [men] on side" may be vital however during this process the strength or potency of a project may be lost. As one woman says, "...in the way I have worded things is to be very careful..." She explained that if results were presented in a fashion that really "tell it as it is" there are difficulties in receiving acceptance. To be effective one must present the results as "an issue of medical workforce planning." She discusses whether in doing so, this means results are "watered down." She remarks that without this approach "...it's too easy to be marginalised...[as at any opportunity they can say], 'Oh she's just, she's just going off.' "

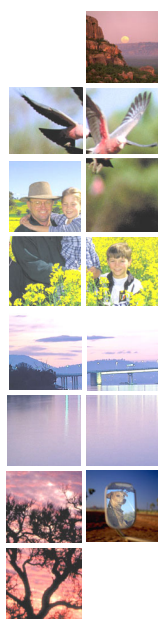
One described the evidence of a dominant hierarchy and acquiring the status of men's support:

And I think one of the challenges of this committee is to find enough men, cause there are plenty of women who are interested in this, but I'm wanting some fairly senior male academics to be on it as well, because there are gender issues that cross men, of course. But also to create a bit more weight on the committee.

I think — very traditional university and the senior faculty here, the majority of them are still male...which I can see as a big issue when we're trying to address unusual aspects of the curriculum. There is quite a resistance to that. And the hierarchy is such that you have to pass it through the curriculum — 90 per cent of who are male too — to achieve change.

### *Resource intensive*

All of the women alluded to the link between creating change and the exhaustive amount of time and effort that this takes. This is at least in part due to the other



obstacles. Difficulties in finding adequate funding, female doctors and medical students operating in a culture that is consuming, and the lack of support and legitimacy offered by the dominant culture all makes change resource intensive.

These things take longer than recognition to correct it... I mean they do take a huge amount of effort. And I mean female rural GPs don't have the support of [rural medical organisation] yet, although they claim to support female GPs.

Medicine's a culture that doesn't allow a lot of time for self-examination and self-reflection. You have to on an individual level learn to survive, but looking on a broader picture, actually hey, I'm part of a group of women suffering this, yeah that's right, the penny takes a long time to drop.

## The ways women work to create change

The strategies of change used by the women are listed in Table 2. They should not be regarded as an exhaustive list nor exclusively gendered – but rather examples of how women work within a medical context.

### *Facilitating projects that makes women visible/present*

Advocating for research reports and presentations that focused on women's experiences in medicine, and also gender analysis in generic rural medical workforce research was "one of the things that might shift the balance. If we've got more evidence to suggest there's some inequity or some need to look at gender issues specifically." The language the women used to describe these initiatives spelt out their objective to increase the presence of women's voices, making it more gender inclusive including:

It was the first female generated survey...

It was about women's issues in women's language.

...women-defined national data set

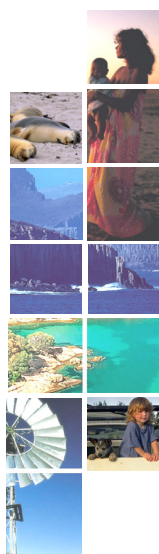
Women should be on the platform – because they were invisible...They should be plenary speakers, they should be visible.

Medical curriculum was another important pathway for facilitating the "translation of gender knowledge into medical culture." One of the objectives of the gender sensitive training was to assist female rural medical students to "develop a conceptual framework in which to think about their femaleness instead of it just having to be a problem".

### *Creating legitimacy*

#### *Discourse*

Learning the language of the culture of medicine both in terms of "how to speak the language and communicate" with the medical women and "how to present the results," to the medical profession was an important way of creating legitimacy, and opening opportunities for change. The key players understood that to gain acceptance from the dominant culture you had to learn the rules. As one woman says: "Ah...the wording is always so fundamentally important..." And another says:



That was really important, was just how to present the results and the conversation that went around the results which was always, "This is a medical workforce problem that we need to address, just in terms of our future workforce."

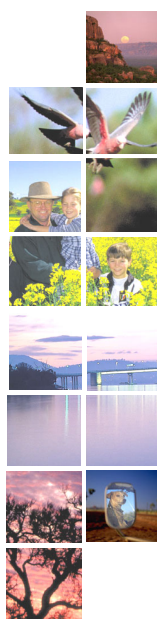
The key women players were "deeply respectful of the skills and knowledge base" of the female rural doctors, and regarded learning as an exchange of perspectives. One woman said of her role in the agenda for change

My agenda is to ...create the language and to take it places that the medical women themselves can't take it. ...to position myself as not a moral in my own right but as somebody, someone to articulate the skills that belong to somebody else and to take them where my strategic skills take them.

"And it worked and I got heard," commenting on how she was using the right language in order to create legitimacy.

**Table 2 The ways women work to create change**

<b>Facilitating projects that makes women visible/present</b>
<ul style="list-style-type: none"> <li>• Advocate for gender sensitive and inclusive research, curriculum and policy</li> <li>• Gender Analysis</li> <li>• Transfer gender knowledge into medical culture</li> </ul>
<b>Creating legitimacy</b>
<ul style="list-style-type: none"> <li>• Discourse               <ul style="list-style-type: none"> <li>"How to speak the language and communicate"</li> <li>"How to present the results"</li> </ul> </li> <li>• Building momentum</li> </ul>
<b>Enabling "female friendly" structures</b>
<ul style="list-style-type: none"> <li>• Understanding the "ways women work"</li> <li>• Female friendly training, committee structures (For females by females)</li> <li>• Building policy for rural female GPs to be integrated in mainstream medicine</li> </ul>
<b>Having clout</b>
<ul style="list-style-type: none"> <li>• Persistence, Initiative</li> <li>• Hard work and Commitment</li> </ul>
<b>Creating networks/ Building a team</b>
<ul style="list-style-type: none"> <li>• "Get togethers" with women</li> <li>• Wide representation on committees</li> <li>• Outcomes focused</li> <li>• Often created by word of mouth</li> <li>• When "all in one place" key players will get women together for input into work in process</li> <li>• Short term teams, but building future relationships</li> <li>• Teams for supporting, collaborating skills knowledge and experience.</li> </ul>
<b>Making contributions</b>
<ul style="list-style-type: none"> <li>• Being involved with women's boards/committees</li> <li>• Presenting at conferences, workshops</li> <li>• Developing policy</li> <li>• Planning and co-ordinating awareness raising activities on female rural GP issues.</li> </ul>
<b>Empowering women</b>
<ul style="list-style-type: none"> <li>• Mentoring and encouraging between women</li> <li>• Coaching new and potential leaders</li> <li>• Strategic appointments of women to influential boards/committees</li> <li>• Training women to bring out their best.</li> </ul>



## Building momentum

Women were conscious that their own work was part of a wider strategy occurring in research, programs and initiatives of other key women players to “building momentum,” and “creating legitimacy for the topic.” The flow on effect of having a growing body of evidence was being able to “draw on” these to maintain the movement through various awareness raising, policy, research and practice initiatives and rural female practitioner committees with the desired outcome “to change rural practice for women”.

And when I say building the argument I mean we just keep it on the agenda, we keep discussing it, we keep bringing people in to discuss it, we keep generating material about it.

So I had to ...this international work, policy work that I was doing was in part building up the body of evidence for the need for change. You’ve got to establish your credibility.

And with that research, we were then able to draw up some policies to take to the board.

### *Enabling female-friendly structures*

Many of the key players are determined to create structures in medicine that enable women to have equitable access to the medical profession and eliminate discrimination in all its forms. Women mentioned setting up female-friendly structures for continuing medical education courses; training weekends; medico-organisational boards; and medical curriculum. Building policy for rural female GPs is another way to enable female-friendly structures to develop. Integral to this strategy is understanding “the ways women work” and also how they have experienced medicine. Understanding is achieved through one’s own experiences of the medical system, and by listening to women and recognising their needs.

One of the ways women work is because we are so multi-tasking, we can’t just say, “Yes we will do that”, we have to be able to do other things. So you have to be able to move women in and out as their life demands change. So that’s why job sharing and backing each other up and having some flexibility is critical... A lot of the reasons why women won’t take on representational roles is because they know they don’t live a life that’s as clearly defined as that, but if you set up structures which allows women to move in and out then they will. It has to be a guilt-free option to pull back when they can’t. So if you set those structures up then you get women coming forward.

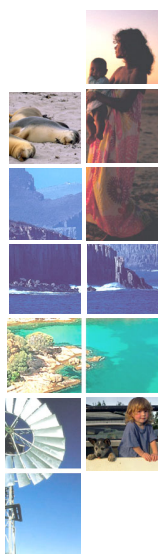
### *Having clout*

Persistence, initiative, hard work, commitment and assertiveness, and a track record are the elements of this kind of strategy. In the stories some women described some of the qualities they admired in other women, such as, “these people who are really working so hard and are so committed,” or in how they felt they could have done it better. The women did not say they possessed these traits however it was reflected in how they worked.

There was a bit of a feeling that there should be some males represented. I just didn’t think it was an issue for them. So I felt strongly about that, that was one thing where I stuck my ground.

The whole thing about really asserting what you need...I wouldn’t do that again, yeah, I would definitely, definitely say I will do this and it’s an important workforce planning issue and therefore I am going to argue for resources to do it.

The other thing we did, was we gate crashed [the working party] because there were no women on it.



And I offered to join that [board] ...So with a double agenda, one was to assist with the writing...But the other agenda was to make sure that the agenda, the recommendations around women were included in that foundation document. Because [from experience] if you are not there keeping an eye on those things, they fall off the agenda. So they are now part of the [policy document].

### *Creating networks/ Building a team*

“Get together and reinforcements are very necessary”. Important elements in creating most networks were all female representation; a broad range of membership across organisations including academic, rural practice and workforce planning positions; with common goals to achieve. Networks are often created by word of mouth when work needs to be completed and takes the form of committees, working groups and conference groups with interests in rural or just female GP issues. Developing policy, research and recommendations or curriculum were mentioned as objectives of the networks that work “very co-operatively” and some met by teleconferences. A key player may build a team by inviting women to get together at a function or conference or whilst women “are all in one place” to get them together ad hoc, for a purpose of creating action. For example:

So then from the workshops I got a group of women, 4 or 5 of us, who actually developed the recommendations to put to the recommendations committee, then worked with [X] to carry those through on the recommendations committee. And then they became part of [key policy document] and then the recommendations were adopted by the working party.

Within networks, women will plan the approach, support and advise others, share their knowledge, skills and experiences. Collaboration between women was very common in terms of sharing information and expertise and building relationships. For example, “[At the annual conference] we invited some key female rural GPs to come and present and they did a really good job...so that, pushed the discussion along.”

Networks provide effective ways to drive issues forward with encouragement, support and debriefing from the women within the team.

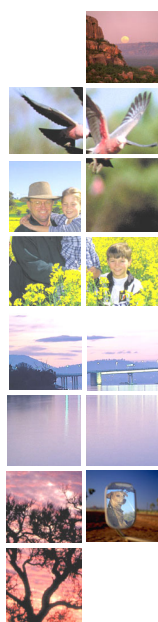
### *Making contributions*

Key players were committed to making a contribution including being involved with women’s boards/committees; presenting at conferences, workshops and training on research, education and practice related issues; developing policy; publishing papers and workshops (to resource others); and planning and co-ordinating awareness raising activities on female rural GP issues. It was not uncommon for women to be involved with work among other key players.

### *Empowering women*

All of the women were either active mentors or received mentoring from other key women. This included coaching women to get actions passed and identifying and training potential leaders such as:

...and I had a long conversation about what it was all about and she said yes she wanted to be involved. “Right well, I’ll train you in leadership skills. I’ll train you how to do it, I’ll work with you”, and we’re still doing that.



Empowering women was important to, “encouraging her to believe in her own skills”. One woman described the success of this strategy:

...and helped [a potential key woman activist] and a couple of other women identify what was going on and when they got mad, angry where to go with that. And [that woman] has been a major player ever since. Now I am only one of the many people contributing to that.

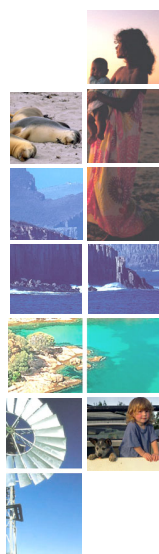
Mentoring enabled women to move into strategic positions on boards and committees. Key players recognised the need to “provide leadership training to these women, including some of the non-academic who I know would be influential in the future.” And also the need “to encourage more women to do it – to teach, to learn, to come in and do this.”

## CONCLUSION

The results show there are clear obstacles to creating change and consistent strategies the women use. There is a distinct linkage between the obstacles and the ways women work as change agents. The obstacles highlight the way medicine has been constructed in the absence of women. It consists of a culture that has a male-defined hierarchy and point of view and one that controls medical time and resources and disregards gender. Key women players’ response is to put women back into the equation. They do this through collective action such as networking, resourcing and mentoring among themselves, through their own personal contributions, and understanding how women do medicine, and how medicine traditionally operates. Sinclair argues that women leaders use influence strategies that are bi-gendered. That is they become attuned to the norms and strategies of the dominant culture but also remain in tune with their preferred interactions.<sup>21</sup>

One obstacle to change is that medical women do not want to be women or are not allowed to be women. As Margaret Kilmartin remarks in her address at the Royal Australian College of General Practitioners “Women in general practice conference”, “Some GPs have concerns about a changing profession and generally changes in society, culture and women’s roles”. In the year 2000 we still hear comments such as “do women want to be women or do they want to be GPs”.<sup>16</sup> These results showed that on medical-political board meetings some members described that, “women were the problem”.<sup>16</sup> Other studies support this finding.<sup>9</sup> In Sinclair’s research on gender and leadership she found that women leaders build colleagues up, listen and take others opinions on boards rather than boost their own ego’s. Women leaders were highly visible and thus easily criticised. Obstacles to women acquiring power had to do with their gender rather than their style of leading.<sup>23</sup> Furthermore women leaders were careful about mentoring and coaching other potential women as this was perceived as taking sides and thought to threaten their leader positions. The same problems persist in the medical culture.

Gender is invisible in medicine. Whilst male approaches continue to control the status quo, medicine will remain “genderless”. Whilst women’s contributions, distinctive practice approaches and styles are recognised, this professional environment makes it difficult for these differences to be valued or rewarded. Women are working among themselves to achieve change where their opinions are valued and welcomed. But women can only be women in secret. A report by the Women in Rural Practice Working Group (WIRP) established that the “The absence or under-representation of



women in decision making in medicine has substantial consequences for women and for medicine.”<sup>22</sup> This makes it necessary to promote women to decision-making positions. Fairness and flexibility will only fully take place when women’s perspectives are given voice.

## RECOMMENDATION

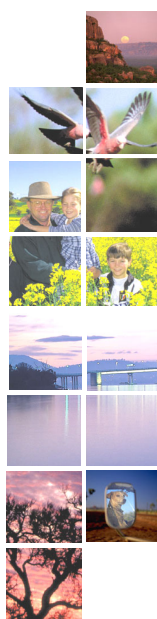
Ensure that all research, policy, programs and initiatives for rural general practitioners take into account the interests of women and women must be represented on all decision-making bodies. Furthermore, ensure that female friendly structures are available in organised medicine to enable women’s equal participation in leadership.

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## PRESENTER

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