

# Women and Rural Medical Practice

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## Abstract

The shortage of rural doctors affects many countries, including South Africa. Medical workforce planners have introduced various strategies to encourage or compel doctors to practise in underserved areas. One of the strategies is to respond to the increasing presence of women as doctors by seeking to understand how women practise medicine, and how rural practice has to change to attract women.

## Introduction

The maldistribution of doctors has been identified as an important equity and workforce issue in both South Africa<sup>1</sup> and Australia.<sup>2</sup> Doctors are underrepresented in rural and impoverished areas, and female doctors are currently even less likely to go into rural practice than their male colleagues.

This paper explores the relationship between women, medicine and rural medical practice. In South Africa and Australia there has been a radical change in the sex ratio of the students studying medicine. Until recently women were a small and largely silent minority of students. In the year 2000 fifty six percent (56%) of first year medical students in South Africa are women, and in Australia there is an equal number

of females enrolled as first year students for the first time. We need to understand how these young women relate to their profession if we are to attract them into rural practice.

## Culture of Medicine

An established culture operates with the assumption that what it knows and experiences are important and right. The suggestion that there are equally valid ways to know and experience can feel like a challenge. Many cultural rules apply to both men and women, but there are some that are gender-specific. (It may be helpful to note that the word 'sex' refers to the biological fact of being female or male, while 'gender' refers to behaviours and norms considered appropriate for each sex and is a social construct.)

Dr Catherine Shannon<sup>3</sup> noted in a paper on *Culture of the Medical Profession*: "The culture of the medical profession, the culture of medical organisations and the politics of medicine form the matrix in which we live and work. These cultural influences pervade all our activities, the way we think about and practise medicine, the way we speak and deal with each other, the way we deal with patients, governments and other professions and the way in which we organise ourselves."

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## Women not Present

Up until now, the culture of Western medicine has been developed without women's input. Women were not there when the art and science of medicine was being developed. Women were deliberately excluded from colleges where medicine was taught and from hospitals where it was practised. At the time when the foundations of medicine

were being laid, women were excluded from and punished for practising 'the healing arts'.

Yet the earliest doctors among the common people of Christian Europe were women who cultivated and prepared herbs, who tended births and deaths and who were the original

anatomists, scientists and healers. During the Inquisition conducted in the 16<sup>th</sup> to 18<sup>th</sup> Centuries, these healing women were named as witches and eliminated, with the encouragement of the developing professions of medicine and law.

Women were particularly attacked as witches if they were healers. The

handbook on witch-hunting, Malleus Maleficarum, said: "If a woman dare to cure without having studied, she is a witch and must die." However, women were excluded from study at that time.<sup>4</sup>

As a result of the witch burnings, the culture of medicine reflects the masculine experience and does not include or value the feminine and the impact of the witch burnings continues today. Many women who work in the health professions, particularly medicine, are reluctant to draw attention to their femaleness and instead adopt a variety of masks and behaviours that protect them

from being seen as intruders in their own profession.

Attacks on mature and experienced women who are not under the control of a man are not just part of European history. It is current practice in some parts of rural South Africa for women to be 'necklaced' and burnt as witches. Women who control the affairs of villages when the men leave to find work may be demonised and burnt when the men return home and seek to regain control. In the United States in 1997 a woman was fired from her teaching job and hunted out of town after being

accused by Christian fundamentalists of being a witch. At the Beijing +5 Conference at the United Nations in June 2000 Non-Government Organisations drew attention to the current practice of inflicting a social or actual death on widows in Africa and Asia, who are killed for reasons similar to that behind the witch-burnings.

It is dangerous even today to draw attention to one's femaleness in a male-controlled culture such as medicine in which leadership is embodied in the heroic male, and in which many of the structures and values are derived from the military.

## Medicine and the Military

Medicine was developed to win the war. Florence Nightingale (Crimean War) and Dorothea Dix (American Civil War) were tolerated in their drives to reform nursing because they were making a contribution to the war. The first English speaking woman doctor was Dr James Miranda Barry, medical officer and inspector-general of the British Army hospitals between 1813 and 1865. In order to survive, like Joan of Arc she dressed, behaved and lived as a man. She disguised her

gender, concealed her identity, and obscured her real self in order to obtain, in her words "the privileges of manhood, the greatest of which was a doctor of medicine degree".<sup>5</sup>

Along with the exclusion of the feminine, this has had radical consequences for the way in which medicine is conceptualised and taught. The military influence on medicine is evident today. The medical profession is authoritarian and controlling of its members in a

way that no other profession would tolerate and medical education includes hazing and harassment of students similar to that found in military academies. Even the language of medicine is militaristic. It is at war with disease; it fights battles to survive; it conducts campaigns and it is unable to conceptualise death as anything but defeat. It is no wonder that many young women (and some young men) struggle to feel comfortable in this culture.

## A Difficult Issue

It is difficult for women in medicine to talk about gender issues. Critiquing the system is like biting the hand that feeds you. Women may feel they run the risk of being stigmatised as 'not one of us'. Women have established that they are as competent as medical practitioners as men are and having done that, may find it difficult to say, 'yes, we can do what you do, and we may want to do it differently.'

Psychiatrist Carolyn Quadrio has noted that women in medicine have more conservative attitudes than those in the arts and humanities; are less likely to perceive discrimination;

and when they do, they are more prone to attribute it to personal inadequacy.<sup>6</sup> Medical men have been identified as even more conservative than their female colleagues on issues of female professional work and are less sensitive to the problems of female doctors.<sup>7</sup>

Some leaders in the profession are encouraging women to challenge existing systems so that medicine can gain the full value of its female members. Recent research by Moodley, Barnes and de Villiers highlighted the scarcity of women in practice partnerships and the lack of

provision of maternity leave for female family physicians in South Africa and hopes to make family practice more accommodating to the female doctor in South Africa.<sup>8</sup> The President of the Association of American Medical Colleges, Dr Jordan Cohen, commented: "We must cease relegating (an increase in leadership by women in medicine) to the category of 'women's issues'. Too many men have chosen not to involve themselves. It is essential that men as well as women regard the shattering of barriers to gender balance as our issue — our joint societal obligation."<sup>9</sup>

## Women in the Rural Medical Workforce

The shortage of rural doctors is focusing the attention of governments in countries such as South Africa, Canada and Australia on the need to better match the infrastructure of rural practice with the professional and personal needs of the younger generation of doctors, half of whom are female. Research suggests that women are less attracted to rural practice as it is currently structured than men.

Australian data shows that rural practice continues to attract a lower percentage of females than metropolitan or provincial practice. Strasser<sup>10</sup> found that there are significantly fewer female general practitioners in rural practice (19%) than in suburban general practice (32%) in the Australian state of Victoria, although a higher proportion of younger rural doctors are women (43% of those aged less than 35).<sup>11</sup>

Rural practice will have to become better at attracting female doctors if it is to address the issue of under-supply of rural practitioners. Models for recruiting and retaining rural practitioners which have been developed from the perspective of a predominantly male workforce will need to be recreated to allow for sex differences and increased female participation.

## Hours

Rural doctors work longer hours than urban doctors. Australian data shows that remote area doctors work an average 52-hour week. In addition, rural doctors are called more often when on call<sup>12</sup> and this has substantial implications for doctors who are also 'on call' for their families. Most rural doctors work 35 to 49 hours a week, with three times as many male rural doctors (38.6%)

working around 50 hours than female rural doctors (15.5%).<sup>13</sup>

The National Rural General Practice Study conducted in Australia<sup>14</sup> found that the number of hours worked per week is a more important issue for women than for men. This is consistent with the dual role most women doctors play, that of parent and doctor. Female rural doctors report that fulfilling the

requirements of both roles results in considerable stress.<sup>15</sup> One of the ways to deal with this is to work 'part-time', defined by the Australian Medical Workforce Advisory Committee (AMWAC) as less than 40 hours per week,<sup>16</sup> although thirty-eight hours is a standard full-time work week in most disciplines. In the UK 26 hours is considered part-time.

## Variety of Practice

The National Rural General Practice Study also demonstrates that women place less importance on the ability to utilise a range of medical skills as an attractor to rural practice. They rate access to inpatient care and hospital facilities as less important than men do. Campbell's study, which was conducted in Victoria, found that women doctors

were over-represented in the workforce of rural towns without hospitals and under-represented in towns with hospitals.<sup>17</sup>

If Campbell's findings can be generalised, they would indicate that fewer women general practitioners are involved in in-hospital care than men and, as a

consequence, they may value this less. This may be particularly likely if women are squeezed out of hospital medicine by the hierarchical and structured nature of hospital culture and inflexible rostering and lack of childcare. Their exclusion may be an unintended consequence of the dominance of the masculine culture in medicine and in rural practice.

## Continuing Professional Development (CPD)

South Africa has recently introduced a requirement for continuing professional development among family physicians.<sup>18</sup> Access to CPD is commonly identified as a problem in rural areas, accentuated for women because of childcare commitments and the lack of attention paid to this by course organisers.

Tolhurst and colleagues have found that women, who may work fewer hours in medicine than their male counterparts,

are still required to obtain the same number of CPD points, regardless of other work they may be doing.<sup>19</sup> This means they invest a higher proportion of their professional time in continuing education than their male colleagues who may be more heavily invested in a single professional role (doctor) rather than the dual role of doctor and parent.

Campbell's study found that doctors in towns without hospitals (33% are

women) were significantly less confident about their ability to carry out an identified emergency procedure than their colleagues in towns with hospitals (7% are women). This indicates an even greater need for CPD to be delivered in a way that is accessible to women's work and life patterns. There is also an identified need for education in areas otherwise not well covered, but which communities expect female doctors to

deliver. These areas include office gynaecology, counselling, family violence and sexual assault.

### Partners

The National Rural General Practice Study confirmed that

female rural doctors were more concerned about opportunities for their partners than male doctors were, and satisfaction with opportunities for partners was strongly linked to the likelihood of remaining in rural practice.

Evidence suggests that a male doctor will undertake practice in an area regardless of whether there are good opportunities for their partner. Female doctors will avoid those areas that lack opportunities for partners.

## Women have their own Work Culture

Several studies have found women practise medicine differently from men.<sup>20 21 22</sup> Women practitioners value psychosocial aspects of medical care, in particular social and psychological factors, more than men do. Women are therefore more likely to utilise the biopsychosocial rather than the biomedical paradigm in health care.

An Australian study indicated that women doctors were more influenced than men in their choice of speciality by the need for "the opportunity for holistic care" (86% of women and 58% of men). Another study found that "...clinician gender has an effect through

the clinician-patient relationship and its outcomes; patients perceive male and female doctors differently; and women patients believe women doctors have the good qualities of both male and female clinicians, such as assertiveness and initiative, but also tenderness and nurturing."<sup>23</sup>

Female doctors see more women patients than men do. They see fewer patients, have longer consultations (particularly with female patients) and deal with more clinical problems per consultation.<sup>24</sup> Britt<sup>25</sup> and Tolhurst<sup>26</sup> confirmed this. They also found that women doctors do more counselling

and work with violence and sexual assault cases. They do the mental health work of the community.

According to Strasser,<sup>27</sup> it is strength of rural practice that the doctor knows his/ her patients, their families and their contexts. This strength may intersect with notions of 'holistic care' in a way that attracts women to rural practice. Work by Canadians Rourke, Rourke & Brown<sup>28</sup> suggests that women and men might practise medicine differently because women are more involved with the art of medicine, while men are more captured by the politics, economics and technology.

## Attracting the Next Generation to Rural Practice

The Australian government has responded to the shortage of rural doctors in part by funding programmes to encourage rural origin students to consider medicine as a career, and universities to support the entry of rural origin students to medicine. In 1995 only 7.9% of medical students were of rural origin and the proportion of women among these students dropped compared with 1989. Monash University is an exception to this trend. Approximately 20% of its medical student intake in 1997 was of rural origin and 22 out of the 27 first-year rural students are women. A majority of members of rural student clubs are women.

In the United States medical schools committed to training doctors for rural practice provide an increasing amount of medical education in a rural setting, and this example is being followed in Australia. In 2000

-2003 it is anticipated that all medical faculties will establish rural clinical schools.

The Australian government has also responded to the increased presence of women in the student body by funding the development of an undergraduate curriculum unit that explores issues for women in rural medicine. This project has been developed at Monash University as part of the rural curriculum and has been taken up by Newcastle University and the University of Melbourne. In South Africa the University of Stellenbosch has introduced a discussion of gender issues in medicine.

The development of a curriculum unit, which expands existing norms, needs to take into account the values of the decision-makers on medical curriculum in the different universities and to be able to be

presented in a form, which can be advocated and supported in a compelling way. Rourke and Strasser<sup>29</sup> were talking about the introduction of a rural curriculum when they determined: "At all stages this process should be needs-driven, evidence-based, learner-centred, and outcome-measured." Their comments apply equally to the introduction of curriculum on gender issues in medical practice.

At Monash University consideration of gender issues in medicine is now a part of the rural curriculum in the second- and sixth-year of study. One of the outcomes of this curriculum is to provide students with tools to help them understand what they are seeing and experiencing as men and women in medicine, and to explore how women and men can combine their personal lives with the challenges of rural practice.

## Summary

Women and men practice medicine differently, have different preferences and attractions to rural medicine, and have different points of intersection between their personal and professional lives. Rural medical practice must be

restructured to attract women if rural workforce needs are to be met. The alternative is to continue to attempt to restructure women to fit rural practice. This approach is ethically dubious, and unlikely to succeed.

It seems timely to address these issues in a deliberate and systematic manner, rather than continue to work on the assumption that if women would only be a bit more like men, there would be no problem.

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