

Meeting the family support needs of rural GPs via a rural community development approach

Ms Helen Cheney, Senior Research Fellow, Institute for Sustainable Futures (ISF), University of Technology, Sydney, Ms Erin Wilson, Acting Director, Rural Faculty, Royal Australian College of General Practitioners, Melbourne, Ms Sally Campbell, Research Consultant, Institute for Sustainable Futures (ISF), University of Technology, Sydney¹.

INTRODUCTION

The National Rural Faculty of the Royal Australian College of General Practitioners (RACGP) was granted funding² in 2000 to develop a rural medical family support project focused on the family support needs of female General Practitioners (GPs) and GP registrars in rural areas. The project is focussed on piloting innovative responses to the needs of these specific groups and therefore is research oriented and limited in term.

There are three elements to the project. Firstly, offering a non-clinical counselling and communication skills workshop, known as a 'Mentoring' workshop, to rural GP spouses in each State, working through the Rural Medical Family Networks³ (RMFNs). Secondly, working collaboratively with other medical support agencies to develop a resource kit of existing family support strategies as an aid to rural employers and in particular local governments. Thirdly the piloting of a range of strategies, designed to address family support needs in collaboration with rural GPs and their families.

This paper focuses on the last of these three elements. In 2002, the Rural Faculty worked with the Institute for Sustainable Futures at the University of Technology Sydney, to conduct research into strategies used to address family support needs of rural GPs and in particular female GPs who have needs different to many of their male colleagues. Existing research has established that there are significant needs in this area, however, there has been limited study on how these needs may be addressed. The funding of services and programs in response to these needs is relatively recent, the success of which is yet to be evaluated in the longer term. Moreover, there has been limited attention to services and other actions required to meet the specific needs of female GPs in rural areas and with respect to family support.

This project seeks to build further knowledge about the kinds of strategies that might be developed to support GPs and their families in rural areas. It also examines the ways in which these strategies might be implemented with an appreciation of particular local contexts and available resources. The project evaluates these strategies for their effectiveness in relation to recruitment and retention by identifying ingredients of

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success from the perspectives of GPs, their families and other parties where appropriate. By piloting strategies and evaluating them this project aims to:

- Recommend the most appropriate strategies based on the range of needs identified and the ability of particular strategies to address those needs;
- Give qualitative evidence of change in case studies describing the community strategies implemented as a part of the study;
- Draw out the ingredients of change from the case studies; and
- Synthesise findings from this study with reports and literature on other successful community strategies carried out for a similar purpose.

CONTEXT

This project has been developed within the context of government responsibility to provide health services and, more specifically, GP services in rural Australia. In order to reflect the concerns and interests of the profession itself, the involvement of the RACGP has been critical to the project's direction.

A review of relevant literature suggests specific issues and strategies around the family support needs of rural GPs, as well as the differing issues and the resulting strategies designed specifically for rural female GPs. Each of these is discussed in turn.

Research in Australia and internationally identifies that the family support needs of rural GPs are linked to recruitment and retention – key issues in rural Australia. The obstacles are varied and broadly encompass issues relating to professional practice, personal and family life, and the community more generally. Many of these needs are shared by other residents in rural communities.

The key issues affecting rural GPs and their spouses have been clearly articulated in research elsewhere (Nichols, 1997 and WONCA, 1995). The issues are:

- Spouse employment opportunity and educational opportunity in light of their career objectives;
- Spouse isolation where the spouse may be more socially isolated than the GP;
- Family disruption leading to a need for longer than usual periods of recreation leave for rural GPs and their families;
- Childcare services; and
- More flexible practice arrangements.

In various research, spouse satisfaction has been identified as a major issue affecting recruitment and retention.

In 1997 Nichols suggested that strategies for addressing needs in this area could be grouped into two areas: firstly those targeting spouses directly; and secondly, those targeting the rural community. Spouses may be directly targeted in strategies which provide: orientation to assist them to prepare for the type of community they are entering; preparation for practice management, which is often unrecognised as a professional activity and undertaken in an ad hoc manner by rural spouses; and establishment and promotion of various professional, occupational and social networks for rural spouses. This literature suggests that the rural community needs to be involved in strategies which encourage acknowledgement and utilisation of the professional skills brought to the community by the GP's spouse.

In general, the study concluded that rural communities need to be aware that effective strategies for recruitment and retention of rural GPs involve the whole medical family. By considering both professional and social networks as well as practical issues such as adequate and appropriately located housing, strategies can be developed in rural areas to effectively recruit and retain GPs.

A common strategy to support rural practitioners and their spouses is to establish networks for spouses. A study in Alberta, Canada, documented one such network which facilitated activities like local meetings, telephone networks, e-mail discussion lists, events at conferences and spouse-only retreats. The research found that it was essential to address the three areas of need: professional practice, personal and family issues; and the broader community (Taylor, 2002). The need to provide a flexible and variable program to suit individual needs was highlighted, combined with a need to provide genuine long-term measures rather than ‘quick fixes’. A finding from this study based on the most common message or ‘tips’ from spouses about “how to thrive in a rural setting” was “get involved in the community” (Taylor, 2002, 4).

The needs of rural female GPs differ from those of their male colleagues and given that around 40% of GPs in rural areas are female (Wainer, 2001)⁴, these needs must also be considered. Tolhurst and Lippert (2002) identify that around 86-88% of rural female GPs are married or in long term relationships and a significant proportion of the spouses (37-48%) are also medicos. Approximately three-quarters of those married GPs have children and of the single GPs, about a quarter have children. Despite the diversity of family structures, 95% of female GPs have prime responsibility for care of children and the household whether working full or part time. These demographics result in significant practice differences between rural males and females including the desire for flexible work hours to meet family commitments, part time work and reduced after hours and on call work. In addition, these demographics give rise to specific family support needs around child care and spousal support, education and employment opportunities, among others.

Tolhurst and Lippert’s (2002) report on *The National Female Rural General Practitioners Research Project* identifies the professional and personal support needs of female rural/remote GPs. The main family and support issues facing these practitioners can be grouped into the following categories: personal and professional role conflict, social and intellectual isolation, spouse employment and child care.

A national study in Australia (Tolhurst et al, 2000) identified a number of strategies to overcome problems around female rural GPs, based on focus groups. The recommended strategies relating to family support included more flexible childcare services, including to accompany continuing medical education programs and financial subsidies for childcare. Implementation of some of these initial strategies, including those relating to support groups for female GPs, has commenced⁵. Wainer (2001) builds on this work by suggesting strategies need to:

- Provide work for the partners of female GPs and childcare and schooling for their children;

⁴ It should be noted that the percentage of GPs in rural areas who are female has been estimated to be as low as 25% by varied sources.

⁵ Implemented by groups such as Monash University and University of Newcastle, NSW Rural Doctors Network, RACGP and Australian College of Rural and Remote Medicine

- Encourage a cultural change to value female GPs when their style of practice does not mimic that of men;
- Establish more regionally based, female-friendly post-graduate training opportunities with consideration for cost, travel, childcare and hours;
- Develop more flexible practice structures including flexible hours and on-call rosters, part-time work/job sharing and less after hours work;
- Provide more locums for leave, educational opportunities and after hours cover; and
- Provide maternity leave.

Recommendations resulting from the National Female Rural General Practitioners Research Project (Tolhurst and Lippert, 2002) are consistent with the above and specifically identified: more flexible work practices; childcare; safety protocols for after-hours work; and locums for maternity, study or other leave as important support mechanisms (GPPAC, 2002).

Australian research has established that many of the factors affecting recruitment and retention relate to family, social and lifestyle issues or to location-based issues (McDonald, 2002). The authors argue that these factors are directly or indirectly within the control of the local community who have the capacity to implement strategies seeking to address access to continuing education, employment for spouses and partners' and children's education. Research suggests that successful strategies will be flexible, community based and will work both directly with the GP and more generally with the community.

METHOD

As stated earlier, one core aspect of this project is to identify and trial strategies to address the family support needs of rural female GPs and rural GP registrars. Given the research evidence cited above of the importance of involving community, the project has utilised a community development approach for the identification and implementation of strategies.

Community development approaches tend to be more flexible and directed at providing long-term solutions. This social change strategy depends on community owned change, meaning that both the definition and solutions of the problem come from the group most affected by the issue. The approach deliberately seeks to be inclusive of those members of the community to be served by the programs. Further, the longer-term nature of the program is secured through the community being actively involved in choosing, organising and implementing the strategy. With these principles in mind this project has attempted to balance the particular needs of individuals in their local situation with other initiatives in the community.

The specific process of community development used by this project is described in detail elsewhere (Wilson, 2002) but can be summarised as a series of cycles. Key aspects of this method include: developing a relationship with those most affected by the issue; agreeing on goals; exchanging of skills and information that enables all stakeholders to participate in bringing about the desired result. The action group is then

expanded outwards, particularly toward politicians and bureaucrats in order to influence policy and decision-making.

The research approach taken complements this community development approach and can broadly be described as one of action research and more specifically collaborative evaluation. Wadsworth argues that such an approach is valuable because it involves parties who might be expected to change their practice as opposed to a non-participatory and non-democratic evaluation process, which cannot ensure an appropriate outcome for those who will be affected (Wadsworth, 1997). To instigate successful change the affected parties need to experience both directly and personally the evidence for the value or significance of, and the consequent arguments for change.

In this project the researchers have negotiated directly with GPs and their families - in Wadsworth's terms, the critical reference group - to act on the needs that they have volunteered rather than assumed or predetermined needs (Wadsworth, 1997). The research team worked collaboratively with GPs, their families and other community members or service providers to respond to these needs with innovative strategies. These are then evaluated directly by these same parties from whom the change was initiated.

For this approach to work it is essential to be flexible and open to a range of possibilities. The research method encouraged GPs and spouses to identify the issues most likely to affect their retention and did not try to avoid or exclude areas that could be seen as the responsibility of other sectors of government such as education or childcare. This is a broad and inclusive approach which does not limit the range of strategies to pre-determined areas. From this starting point the researchers are able to be responsive yet negotiate courses of action that are compatible with the time and resource constraints of the project.

The project focused on two specific cohorts, a registrar cohort and a group of rural female GPs in a region of South Australia. The project team consulted with both GPs and their spouses about their family support needs. This was achieved through individually contacting GPs, registrars and their spouses and engaging them in dialogue about the project. The dialogue sought to identify the particular family support needs and willingness to participate in the study. In one cohort spouses were asked "What would make a difference to how long you stay in a rural community, in terms of your family support needs?" This encouraged people to select their own priorities and did not constrain them by definitions of family, needs or support.

ISSUES AND STRATEGIES

Through the approach discussed above, a range of issues and related strategies were identified. These fall into two broad categories: individualised strategies, being those specifically related to an individual's needs; and broader based strategies, which are those which address broader community issues in addition to the needs of rural medical families.

The individualised strategies are the smallest group of strategies to be trialled. In part, this may be due to the emphasis of the Rural Medical Family Network which already offers a range of very targeted supports to rural medical families, including individual

support to spouses around issues such as re-training. In many cases, members of the cohort of this project were directly linked to these activities. Strategies trialled by this project in this area were largely focused on the issue of employment for spouses and included:

- Linkages to practice management training, addressing the specific context of geographic isolation, travel and childcare; and
- Linkages to accounting training and specific business technology, addressing a specific context of geographically distant GP and spouse/family.

The largest set of strategies trialled were broader-based strategies. In the main, a key motivation of participants was to benefit their wider communities whilst simultaneously addressing their own family support priorities. In general, these strategies both offered broad scale benefits to rural communities as well as involving rural communities in aspects of strategy delivery and ownership. The strategies range across a number of issues which will be discussed in turn.

As with the individualised strategies listed above, one focus of the broader strategy group was around the issue of spouse employment. Strategies in this area included:

- Extending childcare services for before/after hours care including a local needs analysis across a range of resident and professional groups towards establishing a viable local model; and
- Research into work-from-home opportunities and mechanisms and a trial of the technology needed to effect these. This investigation sits within the context of no local employment opportunities to match spouse professional skills and no local childcare to support such employment.

A core issue that was identified as part of the broader based strategies was the area of social and recreational support for rural GPs and their families, and in particular their children. Participants documented their frustration with lack of facilities and the added workload of driving children (or themselves) significant distances in order to access neighbouring facilities. For many, local recreational activities were key social supports for themselves, their families and other allied health workers as well as community members. In response to this context, the following strategies were identified:

- Support of a local pony club to extend their facilities and activities;
- Research and development to extend the season of the local swimming pool (possibly via alternative heating options); and
- Trialling of swimming coaching in order to offer locally accessible activities and skills development for children.

Participants frequently noted their concern for their children's opportunities for academic and creative development. In response to this need, a visiting arts (dance) program was developed as a holiday program for children of the local community.

Finally, two more policy related strategies were identified:

- To increase the awareness of local governments (as employers) of the needs of rural female GPs. This is to be actioned through work with the State's Local Government Association; and

- To research the viability of larger project funding to analyse the ways family support considerations would be included in GP packages and contracts (for example, levels of locum provision, extended family access etc).

It is important to understand the impact of such issues on considerations of retention. Despite being otherwise content with living in a rural area, these issues have led families to consider moving to enable increased access to social, recreational and educational opportunities for themselves and, in particular, their children.

EVALUATION

The evaluation strategy has been designed to enable maximum learning from the research undertaken and to guide future implementation of family support strategies for rural GPs. Evaluation is conducted three to six months after implementation, with strategies being documented in case study format in order to provide a specific context of factors leading to the development of the strategy.

The pilot strategies are evaluated through stories from the people involved concerning the impact of the strategies on the need first identified. Evidence of the change is sought within the attitude and situation of the rural GP families rather than changes in the rural community at large.

The key evaluation questions include:

- What are the characteristics of successful strategies to address rural GP family support need?
- What is the impact of the strategies on retention of GPs and their families in rural general practice?
- What is the impact of strategies on quality of life of GPs and their families in rural general practice?
- To what extent was the strategy able to be linked into the broader community?
- To what extent was the strategy relevant to other members of the community?
- To what extent did the strategy increase community and/or employer awareness and commitment to the family support needs of rural GPs?

PRELIMINARY FINDINGS

Preliminary findings indicate that the family support needs of rural female GPs and rural GP registrars are also the needs of other sectors of rural communities. Issues such as access to childcare, employment for spouses and quality education for children are not those usually addressed by health funding, especially funds relating to rural GP retention. Where retention funds are used to meet such needs they are exclusively targeted at the GPs and their families, with no flow-on funding to the rural communities in which they live.

In the instances recounted in this paper, rural GPs and their families required interventions that were of a broader nature and that would equally benefit and involve other community members. The community development method used provided an

effective way to link concerns of rural GPs to the community more generally and to demonstrate the possibilities for collaboration in addressing these.

To secure longevity of programs it is essential that: needs are shared by a wider community; strategies are generated locally; local people share in the range of tasks to be undertaken; and the activity is linked with other funding mechanisms and decision makers at a policy level. Nevertheless, the importance of support personnel, specifically in a community development role, is critical to facilitating such social change actions especially where rural community resources may already be thinly stretched.

CONCLUSIONS

This paper calls for a cross-sectoral approach to funding rural needs and an understanding of these needs as interlinked. It is suggested that focusing on rural communities as holistic entities, rather than targeting discrete professional needs within them, will yield greater results and contribute to the long-term sustainability of rural communities. Many of the needs and consequently the strategies explored in this research, cannot be addressed by employers of GPs and government health departments alone. The thinking and approach to issues such as childcare, educational opportunities and employment needs to be much broader in scope.

There are at least two gaps that need to be bridged. Firstly, the issue of diversity between particular localities and the way in which government funding is administered from a central source. Secondly, the gap between the particular responsibilities of health service providers and the full range of service providers working in the area of sustainable rural communities.

A policy recommendation from this research is that the relevant agencies which are already involved in this area explore opportunities for collaborating with parties who have an interest and mandate for addressing issues that face other professional groups and the general community. Moreover, it is essential that the administration of resources be flexible. Policy makers and service providers need to remain open to the range of alternatives available to address the specific issue of recruitment and retention of GPs in rural areas and at the same time the more general issues associated with disadvantage and rural communities which bear a critical relationship to the success of rural retention strategies.

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