Women General Practitioners in Australia

by Margaret Regal Kilmartin MBBS FRACGP

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Section 3

7.3 Masculine Power and Patriarchy

7.3.1 Introduction

In this Section the views of the interviewees regarding the space WGPs occupy in General Practice and the medical profession is reported. The medical profession is seen as being primarily male, patriarchal, powerful, political and having a masculine culture. A common theme expressed by the WGPs related to the “games that boys play”. The status of WGPs in decision-making, rural General Practice, academia and Divisions of General Practice is also considered.

7.3.2 Patriarchy, Power, Politics and the Dominant Masculine Culture

An urban male GP described the “dominant male syndrome” and how some women fit into this mould:

Probably there are some barriers for medical women. They are conscious or unconscious of a glass ceiling and the dominant males. We don’t want to categorise all men as dominant males
but the dominant male syndrome, the ones who have risen to the top are very highly competitive and prepared to work around the clock. That’s really quite different from the majority of women, although there are some women who would fit into that mould.

In medicine and General Practice there has been a male culture with “systems” and “processes” developed to suit men. An urban WGP acknowledged that it could take generations to change the status quo:

For many years in medicine and in General Practice there was largely only a male culture. It’s only now that we’re becoming a significant group. When I graduated from my university it was a 20% cohort at graduation. Women out there in General Practice when I graduated weren’t that many. That’s a generation ago. Now I think it’s around a third and that will gradually change but that’s why I think we’ve got a lot of systems and processes that suit men. There’s probably a generation or two lag-time for significant change.

An urban male GP who held a senior appointment in the RACGP Training Program acknowledged the existence of a patriarchal society and medicine as a male-dominated profession where change had been slow to occur:

It’s primarily a reflection of our society that we have lived in a patriarchal society. It’s not so terribly long ago where women’s passports in this country were required to have their husband’s name. The fact is women were seen legally as property and those things were certainly reflected in a male dominated
profession. I mean men worked and women cared for homes. Medicine was predominantly like so many of the professions, a male discipline and as the numbers of women came in change lagged somewhat. Medicine is just a reflection of that and General Practice is in some ways the same. The criticism of the College was that it has been dominated by old men in suits. General Practice has made moves faster and more effectively than many, partly because it's had so many more women involved.

Although some women thought of the RACGP and the AMA as “closed shops” or “old boys’ clubs”, one WGP said that these beliefs were false:

There may be some women who are sort of intimidated by the old boys’ club or the male club type atmosphere of the Colleges and the AMA. That's never daunted me. I'm sure that there are women who just feel that it's a bit of a closed shop that everybody knows everybody and it's all organised and that it's very hard to break into. Having had a go and got in there, I've always been very welcome and certainly my opinions have been considered. I've never had any problem on committees, so perhaps some of it is a reluctance based on false impressions.

One semi-structured interview took place with a rural male GP at a conference in a country winter ski resort. During the interview he referred to the way males at the resort behaved toward the women and how this behaviour had not changed since school or undergraduate days. Examples that he gave were of “boys driving motor cars” and “skiing like rockets” while the girls acted like “ski bunnies”: 
During my experience at a workshop on burr holes, the gents knocked the girls out of the way getting to the sheep's skulls. There were all of these sheep's skulls lined up and all these drills and bits and the neurosurgeon came in and told us how to do this and that and then they more or less said go. All of a sudden the gents rushed forward, elbows flying, bumped everyone else out of the way and the girls stood back. The women stood back! I think things haven't changed since university or since grade six at school.

The same male rural GP described how the boys hold on to power and how restructuring should take place to change this:

The boys are sitting in front of their computers getting fatter and paler and pimplier and there's a real problem. The girls are socially interactive and they're now getting into science and they're getting into medicine. But it would be like the white fellas in South Africa, there's going to be a long time before it dawns on the boys that there is a minority running the profession. But the boys aren't going to let go of power easily. So women have come into the profession and we are going to have to restructure things to acknowledge it.

There have been significant barriers to the advancement of women in the medical profession and women have more difficulty in being recognised and acknowledged for their expertise said one male GP:

I think on the professional side there are still enormous barriers
to the advancement of women in the medical profession. In General Practice like in other specialties women tend to have more difficulty being recognised and acknowledged for their expertise, although I think the College of GPs has been much more progressive than other specialties.

An experienced urban WGP feared that if General Practice continued to fall by the wayside fewer males would become GPs and WGP may be complacent about having a diminished career status and income:

At the moment most of the bodies have been male dominated. I think the males are certainly out there fighting for economic improvement and quality of life improvement in General Practice. If General Practice does manage to get ahead then the males will still come into General Practice. If General Practice continues to fall by the wayside, I think fewer and fewer males will go into General Practice. We will have a General Practice largely of females. It’s my concern that with the majority of females in the future they’ll be happy with just less than ideal career status and income.

7.3.3 Violence and Aggression

A rural GP acknowledged that aggression was required in order to succeed. While noting that some female leaders have been very self-assertive, he felt that males set the rules and base them on aggression:
For women to achieve in this situation of leadership is extraordinarily difficult because unless you are prepared to go the pace with bald aggression you will be left out of the race, because they (the boys) will ultimately set the rules. It is like when Britain had the Empire and ruled other countries. They set the rules and provided you adhered to the rules you were right and if you didn't you were chucked into jail. The boys set the rules and it's based on aggression.

Mothers are cuddly, warm and have feminine qualities. It would seem to me so much better if those were the features of leadership that you know and understand; time and a conciliatory approach rather than a grind-them-in approach.

7.3.4 Patriarchy

College State Faculties harbour elements of patriarchy according to a senior male GP member of the RACGP:

It has more to do with the governance of the organisation and when you look at the membership of faculties you see the stronger remnants of the patriarchal arrangements than you do at the Council level (of the RACGP). In the next 20 years or so we will see an almost complete role reversal of the arrangements that we have at the moment.

A female participant in this research gave the following insight on the pervasive patriarchal culture:
I believe that's all about patriarchy. I am old enough at 52 to understand. I came from a culture where when I graduated I couldn't get a bank loan without my father's guaranteeing the loan. However I worked the same number of hours as the man and earned identical amounts of money. There were 20 women in my year, where I suffered minimally but there is still prejudice against women doctors.

My father had hoped that I would do law, but I told him that women didn't get to the top in law so there was no way that I was going to do law. And that's exactly what happened to my women friends who did law. They were not offered partnerships. The prejudices in medicine are quite different because the medical culture until quite recently was masculine. To be accepted in that culture women by and large have had to work in a masculine model.

This woman interviewee also noted that medical males were awkward when conversing with her on formal occasions:

I believe that medicine is still primarily a male dominated culture. The male speakers at conferences and the chairs of the sessions have difficulty in getting their heads around talking to me. Men will get angry with you and they keep on apologising to you.

7.3.5 Politics

A female participant described her experiences in the politics of one of the medical
organisations. Although the men could be rude and aggressive to other men they were unsure about how to treat a woman:

You know the politics is a rough game. Men would be appallingly rude to their male colleagues and slash them to bits. It’s a very ‘boisy’ sort of deal. You have to remind these men that you are not going to burst into tears and you’re not going to fall over. It’s not going to be easy but you won’t crumble if they are unpleasant to you, nor are you (as one of them of rang up and complained to a colleague) weak either. I think that there is this odd business about working with men. Most men in medical politics are my age or older and they’re not used to having women around.

One WGP found that playing the men’s games, including sexual politics, gave a woman a better chance:

One of the problems is that by staying true to your understanding, knowledge and experience it’s a little bit difficult to be taken as seriously by the men still. If you actually play it their way you’ve got a much better chance. Or you play some other sort of games, you know sexual politics or whatever and play it their way you have got a better chance than if you actually stay true.

Politics are often obvious at medical meetings. One interviewee related that at one medical meeting she attended, the men assumed that she was the minutes-secretary rather than a doctor:
I was the Federal Secretary of a College at 31 years. I was going up in the lift to the equivalent of a CPMC [Committee of Presidents of Medical Colleges] meeting and there were all these blokes that were turning to one another in the lift. They eventually asked me who I was. I said I was the secretary of a College. They said, "Oh you’ve come to take the notes". There was an automatic expectation that you were not a doctor. I think that that concept has shifted a great deal.

7.3.6 A Culture of Bullying, Power, Egotism, Subversion and Domination

One woman GP claimed that the RACGP has the potential to support and develop men and women but some male College members had demonstrated bullying behaviour:

With the College I have had a mixed experience of where there has been a certain type of bullying, egotistical males who seem to have pushed their way to positions of power in the College. Yet there are other absolutely wonderful people there who I feel assist men and women, who need to be fostered, supported and developed. I think that until recently the bullying alpha dominant males as I call them have unfortunately bullied other people into positions where they shouldn’t be. I feel that the presence of the women has an effect of the culture and the College has great potential for developing women and men. We have to watch out for a certain type of male who like to exploit position and power and who can subvert those processes.

According to another WGP participant in this research:
The College has been very male dominated. There’s never been any obvious obstruction put in the way of female participation but there is very little support. It’s really been something that you contribute to in your own time, or if you take time off from the practice this has to be refunded either as extra sessions or taken out of annual leave. I particularly resent this because that impacts on the family.

A male GP who held a senior position in the RACGP Training Program doubted that women could significantly modify male domination:

I think there’s a very strong male dominated culture within the College despite the fact that there are individual women who are in prominent positions.

7.3.7 Validation of the Ways of WGPs

One WGP had a clear perspective on why women have difficulty in obtaining a decision-making role in political bodies:

The other big factor which has been obvious all my life is the inability for women to ever have a role in decision making or political bodies, because women’s way of being was just not validated by the medical profession.

However, this WGP also explained that recent change has seen many of the roles of WGP validated and she suggested that men should be adopting these values:
There has been a significant change and the women’s approach and the way they deal with life, is actually a valid way of doing things. It’s got a lot to do with the culture of society and the fact that people are very well informed. There’s a lot of community discussion about gender roles and the way people live their lives but the medical profession has been slow to pick up on that.

I think there is a very widespread recognition that the way you live your life and what you’re doing to your family and how you’re addressing your work, people are saying is the right way and a perfectly reasonable way to live your life and be a woman and a doctor. The men should be adopting more of these values.

7.3.8 Women in the Decision-Making Process and Culture Change

WGPs were able to facilitate a cultural change in the RACGP once they joined the decision-making process on the College Council. A male GP who had held prominent position in Council noted that women were appointed as Council members on their own merits:

Really dynamic, somewhat fairly tough, very independent women were on College Council. They got there on their own merits by making a major contribution. Nothing special had to happen for them to get there. It was a natural evolution, that particular cohort of women getting on with the business of participating in College life and changing it.

College Council and all College activity changed because of the presence of an appropriate gender balance. It really was quite a
different attitude that came to Council for the better. Almost the
cliché stuff, consensus versus confrontation, that sort of thing.
Very positive, and my sense was that nothing much had to be
done.

An urban male GP’s view was that there have been barriers and obstructions in the
past to women becoming involved in the decision-making process of the RACGP but
this was changing:

As women became more involved in the decision-making
process some of those barriers are beginning to break down. To
me it seems like there is a long way to go. It is still very
difficult for women to participate, even if they do it at the high
level. It may be related to time. In the past it’s been difficult to
even have a voice, to have equal opportunity or be members of
College Council or State Faculty Board. College Council
certainly has altered the balance and there’ll be a reflection in
decisions that are made because of it.

The same male GP restated the practical difficulties for WGP’s who join a decision-
making process. Information technology has made communication easier but it has
been a struggle to change the culture:

It really points out the importance of being at the table if you
want to make decisions or want to change the way an
organisation operates. You actually have to be at the table and
make those decisions. In the past it has been difficult, because
women have other priorities in their lives even though they have
wanted to be involved. If you look at the number of meetings, the location of meetings, there’s a whole range of things that make it difficult. Technology is changing and people can communicate better without face-to-face meetings but over time I haven’t seen a willingness to change that culture easily and it’s been quite a struggle to get there.

A rural WGP who was an office bearer in a Division of General Practice confirmed that these difficulties also occurred with Division meetings:

Most of the activities occur into the evenings and that really ate into my personal and family time.

However, a male GP noted that the presence of women at the meeting alters the level and context of the debate:

At Faculty Board levels there’s not many women. I think it reflects in some ways the dry culture of faculty boards. It makes a world of difference to have women at those meetings where the level and context of the debate alters. I think the culture of the College may be in a state of flux currently as this change is beginning to occur.

7.3.9 WGP's in the Club, Working in the Male Model, Wearing the Same Uniform as the Men and Behaving as the Men Behave

In earlier times women on the College Council were perceived to behave as the men
behaved and they did not advocate for issues relating to women. A male GP suggested that this behaviour may have been a tactic used by WGPs to get through the door:

I don’t think they did represent women. I think they may have thought they did. The reason behind that may have been more to do with communication and promotion. If you make it difficult for someone to belong to an organisation they either have to wear the same uniform as you do to get through the door or behave like you do to get through the door. What I saw in my earlier time of involvement was that there was no difference between the women and the men. They didn’t really often stand up for issues where there was an alternative point of view, particularly where it became decisions around women. They were making the same decisions as the men and not confronting them, not in a confrontational way but just debating the issue around what was relevant to an equal opportunity thing across the board.

In contrast a male GP thought that women who are now in medical committees were appropriately representing other women:

I think what’s happening now is that there’s a change in women who feel they represent women. There is a difference in representation in knowing that you do have a constituency who do have expectations of how you perform and what positions you take, rather than someone who’s there, blowing their own trumpet, having their own agenda, and forgetting that they could be doing a lot more for all the other women.
This male GP also said that these champion women have now penetrated the club mentally:

These champions for women have facilitated change in more recent times. I'm talking of the last say four or five years. It is to do with this constituency idea. There is better communication and better discussion amongst women which comes back to support the sort of person who is more likely to speak their language and take up their issues. On the other hand, it's a reflection of how difficult it has been in the past to get through the club environment that culturally still exists.

7.3.10 Confrontation and Change

A male GP in a senior AMA position described his approach as being “cooperative” rather than “confrontational”:

I am not afraid of confrontation when it exists or when we need to do it as a tactic. You know the right wing is out there all the time and they're all sort of hard, mean and nasty and that does create some problems.

One WGP who had held an AMA leadership position felt that there were people with enthusiasm and vision trying to introduce change into the AMA but the organisation was too inflexible to respond:

In my experiences with the AMA, I look back on it still with
very ambivalent feelings. There is this real dichotomy within the AMA. There are these people with enormous passion and enthusiasm and vision, but you get the feeling that as soon as they take a risk that the guillotine comes down. Then there's this silent majority who don't say anything. People who have been in the organisation a long time and remain in low risk activities. New people who come and try to shake it up a little bit and try to readjust it go away burned out. There is not enough flexibility within the organisation to respond.

What I would say about those organisations is that the people employed within them are products of the organisation. If you want to change the organisation you have to look at the employees as well as the representatives and that is a really important thing.

7.3.11 Industrial Negotiation

A WGP who held office in the AMA had moral problems with negotiating for increased income for doctors and this in turn caused concern for the organisation:

I feel really uncomfortable about the amount of money that they earn. My target income is chicken feed to them. I think my income is very respectable and I'm in the top 10% household earnings. I mean household target income is high, but for them it's insignificant. I had real moral problems with that and that was of concern to them.
7.3.12 Power Structures in Academia

An academic WGP described the informal power structures in organisations and the boys' games that were played in universities and Colleges:

Where are the informal power structures? Another thing which fascinates me immensely is that men set up these beautiful organisational structures, with all these names and people stuck in them. Yet the real power belongs to a little group of people having conversations and things happen only as a result of these. Usually men, having conversations behind closed doors. People in the formal power structure say: "Well how did that get to happen?" I know this, I work for a university and boys' games get played there. It's the same in the Colleges.

This academic WGP also claimed that the people that form organisations are not considered when structures are designed. The priority is designing policy, guidelines and management:

I think it's realising that there's issues for women and the people in the organisations. I strike this daily in the university where I'm working. We set up all these lovely flow charts about how things are going to be done, but we leave out the ingredient which is the people that make the flow charts happen and get the things to be done. We have to actually consider the people.

I've read a lot of organisational literature including Scott Peck the Psychiatrist who wrote a book on it and he calls it "The Hole
The fact is that organisations don’t think, conceptualise or work out what to do about their people. All the modern American management literature is talking about how to think about your people.

The medical profession as a whole just doesn’t think about its people as people and how they should be behaving. They spend a lot of time telling you what you should do with your patients and at the same time, punishing the behaviour in the people that belong to the profession. These are very big issues about people in the profession that we need to start addressing.

Power structures in organisations should be transparent, democratic and benefit the people, said this WGP. Yet, hierachal bureaucratic organisations can block individuals from access to power or money:

Any formal power structure can be very easily made transparent, open, democratic and people-friendly if the intent of the people in the organisation is correct. I don’t think there’re any barriers. I’m in a hierarchal bureaucratic structure at the university and the power structures are there to either block people, keep them out of the power structure and the money, or to facilitate people, depending on who the people are in the decision making and power structures. It depends entirely on your state of mind as to whether you use it to help people or to block them.

A female participant suggested that organisations hold the power to determine what

3 The Hole in the Mind refers to a chapter in Scott Peck’s text A World Waiting to be Born.
happens. Women had to join these hierarchies as caring-and-sharing was of little use:

Women don’t tend to be organisational people. Political power and the power to move and shake and determine what happens comes from being involved in organisations. There’s no way that organisations don’t have hierarchies. That’s the only way that they work effectively. You’ve got to get in there. You’ve got to understand how their hierarchies operate. Caring and sharing doesn’t work terribly well. There are a lot of women who can manage it well but a lot of women don’t like it and they fall off the edge.

7.3.13 Bias in Attitudes Towards Women

The experiences of an urban WGP lead her to believe that attitudes and core beliefs of professional bodies must be examined and changed:

I think the whole thing essentially is attitudinal. We’ve got to always research our attitudes. It’s their core belief about things. In the bodies that I belong to (the AMA, Division and the RACGP) the attitudes are being looked at and addressed. I believe that’s the change that’s necessary.

This same WGP referred to the attitude that training WGPs was a waste of the government’s money, because women married, had babies and ceased working:

I had an old surgeon come up to me and say, you’ve just got
married, and you’re expecting to do all this stuff and then you’ll just stop and have babies. I can remember being absolutely incensed because I had never had that from anybody. He came from an old school where women didn’t work after they were married and when they had the babies you didn’t work anyway. He made the comment that we were wasting the Government’s money to train women. I’m very thankful that that attitude is changing.

Another WGP thought that society approved of males in positions of power but they disapproved of females holding these positions:

I think it just reflected the attitude of the rest of society. People are still very surprised at times to find a female as a leader. I think it seems all right in a relationship, that the male can be the one doing power type things but that he sees it as somewhat an imbalance of power if the opposite is happening.

7.3.14 Hearing The Voice of WGP

A rural male GP said that women’s voices are creating change that benefits medical women:

It’s just amazing how this accumulation of little roars and yells can make a definitive yell. So in the end little bits of energy here and there are I think improving the lot for women in medicine.
It takes time for WGPs’ voices to be heard but when a man voices an opinion it is acted upon said a WGP:

When I first went on AMA Council years ago you felt that when you say something, there’s just a blank look, you don’t get any reaction to what you’ve said. It’s only after quite a while that you find an acceptance of what you’re saying, and that happens too in the College or in the (Royal Australian College General Practitioners) Training Program at a national level. When women say something it can just get ignored but if a guy says the same thing it’s acted on.

7.3.15 The Ethos of Rural General Practice

The culture of rural GP organisations and the perceived position and needs of WGPs working or training in rural General Practice presented major difficulties for those who did not identify with the existing rural male ethos, the macho procedural male GP or “big R-rural”. As one male rural doctor described:

The rural debate has been overwhelmed by hairy-chested people. Most women are not hairy-chested and this presents an image that is a big turn off to women.

Understanding rural culture and rural General Practice assisted one rural WGP when she had to decide if she would join ACRRM:
I may have a philosophical difference in the sort of thing where their emphasis seems to be on the big R-rural. I don't see that is how I see the whole spectrum of rural health. Their emphasis is very much on the procedural stuff.

Another rural WGP who had expertise in General Practice education related her impressions of the newly formed ACRRM board:

What I hadn't appreciated at the time was that ACRRM was a splinter group. The dissatisfied rural doctor group and I didn't sit terribly comfortably in that position although I understood what they were trying to achieve. I felt that there was a lot of unnecessary disunity.

An academic rural WGP who had conducted research regarding WGs in rural practice concluded that some of the issues that rural WGs struggled with were also difficulties for rural male GPs. The males initially showed hostility rather than acknowledge these problems:

I think there's actually been a change in attitude amongst the medical profession in recent times. When I first presented the research from this rural report there was a lot of hostility especially from the men about some of the issues. Then 12 months later I felt that there had been a real softening of attitudes. When I first presented this report, there were people saying, "Well the women aren't there when we're doing the hard yards at 4.00 a.m. in the morning". I said well they are because 60% of these women did on-call work.
But the next time the blokes were starting to say, "Yes well we're finding these issues hard ourselves". I do think that a lot of people found it hard to cope. I really do think that there is more openness to say "We're all finding it hard. How can we look at it?" I think some of the issues relate to men as well.

A rural WGP (who was not a member of ACCRM) felt that although the voice of women was nominally present in policy setting, male domination and the belief that the procedural component of General Practice distinguished rural from urban was paramount:

There is a strong female voice in policy setting. I don’t see that actually colouring the attitudes of the male dominated leaders of ACCRM who I think tend to regard that part of rural practice which distinguishes it from urban practice, that is the procedural component as largely dominated by males.

The negative attitudes and stinging comments made by some male rural GPs towards rural WGPs were related by a rural WGP:

There were some interesting comments I have had from women about the attitude of their male colleagues. One woman told me that because she wanted to leave work at 5.30 p.m. the partners in her practice said, “Well if it’s too hot in the kitchen you can get out”.

Another woman I know said (both of these women are very competent people involved in a lot of professional
organisations), that one of her partners said to her, “You will have to make a choice whether you want to be a doctor or a mother”. That sort of thing is absolutely appalling when you consider no one would say to a man “You’ve got to make a choice whether you want to be a doctor or a father”. That whole issue of where women fit into the professional scene, especially as rural doctors, I think is a very big issue for women.

7.3.16 Education and Training for Rural General Practice

According to a rural male GP, rural practice was not presented to GP registrars in training in a positive manner:

The majority of our trainee registrars are women who are going to practice medicine. They are not going to practice what I see as a pre-World War II version of operative practice. It doesn’t exist any more.

This male GP also related his view of the reality of dealing with the rural emergency procedures:

We are now in the age of helicopters and retrieval units. The real emergency in rural medicine is more likely to be handled by a retrieval unit coming in, maybe an anaesthetic registrar, who is probably a woman, who will resuscitate, rather than some male doctor who does two appendix operations a year and he’s completely stuffed up the second one because it wasn’t an appendix anyway.
He also lamented that rural doctors have given the “wrong image”:

A woman doctor in our practice said she would never go into rural practice if they had this image of [her] doing an amazing number of procedures, 24 hour a day because it’s a complete turn off to a non-competitive, non-ego-bound people.

Rural training for WGPs is recognised as a complex and difficult issue that needed to be addressed, said an urban male participant:

The issue of rural training is a complex one. If we say to women with young children that you’re going to have to go to the country and that’s going to wreck your lives that doesn’t solve either the rural shortage of women or give an equality of sexes in training...I don’t have an easy solution to the rural training problems around part-time training and allowances for women in training. I think that’s a challenge that we need to address rather than just accept that it’s too hard and can’t be done.

7.3.17 Hairy-chested Attitudes in Rural Divisions of General Practice

WGPs have also felt the male domination, “hairy-chested attitudes” and lack of concern regarding the issues affecting women in rural Division of General Practice. Describing her experience one rural WGP said that in her local Division of General Practice:
I was the only woman on the Division's board and it was quite difficult chairing a board of male rural doctors who tend to have very hairy-chested attitudes. The women doctors in the rural Division would only be about 15 to 20% and I don't think those blokes consider the needs of women as an issue at all.

This WGP told how a Division employee had threatened her and how he had "hassled" a female member of staff:

You know he can't work with women. One of the female staff felt very hassled by this bloke but the Board seemed not to see that as something that they really ought to be doing something about. This may be reflected in other rural doctor organisations because rural doctors tend to be very male dominated and the voice of women is not seen as particularly important.

7.3.18 Changing the Public Perception of Rural Medicine

A rural WGP shared her perception regarding the future for rural doctors:

In the future rural doctors will gradually sort of come round on the national level because they are going to have to. There are so many women. At the moment the women they take notice of are really atypical because they wear the pants in the family and might be out in some isolated area.

At the time of undertaking this research the next president of ACRRM was to its first woman president. A rural women interviewee related how that
would change the public perception of the rural movement:

This will be wonderful because I think it will change the perspective, the thrust and direction of that organisation. I am actually delighted about it. It will change the public perception of rural medical movement that you don't have to be ten foot tall and bullet proof.

7.3.19 A New Free Flowing Culture in Divisions of General Practice

In contrast to the experience of rural WGPs, urban WGPs who joined the evolving Divisions of General Practice experienced support, flexibility and inclusiveness within the organisations. An urban woman GP stated that Divisions started with a “clean slate”:

Divisions didn't come in with any pre-established hierarchy or power structures or have these complicated games the men play. Men love to have their structures and their positions and their titles which make everything very rigid. Divisions have been much more free-flowing.

Divisions developed a culture of employing the talent of GPs and cutting through the red tape that is still present in other medical organisations. An urban WGP thought that Divisions had “the liberty” of developing as the members wished:

Divisions seem to have attracted all the people that couldn't fit
into the AMA and the College and everywhere else. They all fled to the Division. Despite what people say about the Divisions having government money, they have actually developed and openness of culture and an acceptance that we need to get a job done. We won’t be worried about position power and hierarchy or degrees. It’s whoever is on the ground in our community we will use that person to do the job. I think that approach has meant that women’s abilities have been considerably tapped.

A WGP working in a Division felt that Divisions had created space for the non-bullying males. She also said that the increasing numbers of WGs had made a difference:

I think Divisions have given some of the non-bullying males a role. They are the sort of men who can work with women and foster women’s roles. I feel that they have had a significant impact on the ability of women to make a difference.

The formation of Divisions introduced new models of General Practice to replace the existing “male model” which is, according to a male GP:

Male, 50 plus, trained 20 [to] 30 years ago, works in solo or small practice, on call seven nights a week, family life is second, and the rest of the world is third.

This GP described the woman-friendly new model of General Practice and suggested that it also catered for a new wave of doctors:
Divisions brought a new model of General Practice that presented women’s inclusiveness, flexibility, part-time nature, lack of gender-bias and not constrained by the male model of General Practice. This new model is able to cater for the part-time model of practice that is required by women and the newer wave of doctors including males who seem to put medicine third, family and relationships one or two. They are less inclined to stick to the view of General Practice and medicine that this 50 plus male group speak of.

According to an urban male GP, Divisions defined a role for WGPs that recognised their merits and needs:

Divisions do have a part-time structure which allows women to define a role. They appear to be treated on their merits, not on their gender when they want positions on committees.
Section 4

7.4 The Difference between Men and Women and Generational Change

7.4.1 Introduction

This Section highlights the differences between men and women and also includes the socialisation, brain patterning and culture of women. Generational differences and issues for future undergraduate medical students and postgraduate WGPs are also documented. It also reviews how the "bean-counters" and "number-crunchers" view the value of WGPs.

7.4.2 WGPs in the Medical Profession

The General Practice Strategy Review (1998) was designed to bring about change in General Practice. According to a male GP who took part, the review presented an opportunity for General Practice issues to be addressed:

Probably in the General Practice Strategy Review there was an intention of tackling some of these issues from a finance sector point of view, a workforce point of view and a training point of view.
The Review highlighted the need to recognise the increasing number of WGs and the changes that would be necessary if these women doctors were to be retained in the profession, explained a male GP:

There’s a lot of work in the review which highlighted an urgency for the profession to recognise that the numbers are changing in terms of the distribution, gender and the age of general practitioners. There’s an increasing number of women in the workplace which is altering the balance. With that comes a recognition that the environment is going to change, not because there are more women, but because a lot are going to walk away from the profession if it doesn’t fit in with the opportunity to be part of it. We’re dealing with a group of very intelligent people who could be successful at anything they choose. It’s a terrible loss both to the profession and the country to spend not only the money but the time on an individual for six plus four years and to take away their opportunity to be part of what they decided to do for the rest of their lives.

Acknowledging the issues and gaining some understanding of them through self-examination is a necessary process for an organisation to undertake, according to an urban WGP:

The very first thing is to acknowledge these issues exist and try to get some understanding of them. If you’re going to look at issues like this, it requires self-examination by anyone who belongs to an organisation. You’ve got to be able to look at yourself and your own values and where you are in life and what
you’ve done with your life. That’s so threatening, and you have to acknowledge that there are issues and start thinking about them and who in the organisations is going to think about them.

This WGP explained that women were equal to men in their medical skills. However, WGP’s were intuitive and found that the biomedical model of patient treatment in General Practice was not necessarily best:

We can match the blokes in the street by our medical skills. If you’re being intuitive, being true to yourself and your values and really behaving like a networking, communicating human being you actually look at the biomedical model of trying to treat a patient in General Practice and it simply doesn’t work. Those people who are just rigidly applying the socialisation and the models that they’ve been given, find it’s dreadfully uncomfortable to look past them.

Medical women were generally comfortable with their intuitive behaviour, but men were not commented one WGP:

A lot of women I speak to are intuitive. The medical women like talking about their intuition and their intuitive behaviour. The men they’re terrified when you bring that up in conversation or try to talk about intuitive behaviour.

Women are agents for change and must shoulder the responsibility to change the profession said a WGP:
We’re in a state of transition and I think there are great opportunities to change the profession. The women are the change agents, and it’s a very serious responsibility.

7.4.3 The Differences between Men and Women

Some women interviewees perceived that being both a woman and a doctor confuses people:

One of the significant things is that being a woman and being a doctor really caused a lot of confusion for people. People were trying to be something that they weren’t because of the type of training and socialisation that occurs in medicine. Women automatically felt that they were at the bottom of the rung. They weren’t good enough and they didn’t match up. They didn’t have the values and behaviour of the male role models.

WGP research participants suggested that women have a different perspective but society devalues the female perspective. According to one male GP:

I think these differences re-emerge in that women will look a little bit differently on things, although there’s enormous area of overlap. These differences and perspectives are complementary. There’s been a slight devaluing of the female perspective. Women are a little bit more qualitative, a little bit more person centred, and have a different emphasis and a different understanding.
The opinion of a WGP was that:

Men have a more organisational, structural or functional type of approach. Women have a bit more of a personal approach, although, there's an enormous overlap and variation within the genders.

Women GPs need to make difficult choices in their career more frequently than men, said one male GP:

There is an availability of choices along your career path and I think those issues are more so for women perhaps than for men. A lot of men's lives are becoming more complex and therefore their choice is more complex.

One male GP noted that the approach to problems differs for males and females, saying:

We know about the differences in women's approach to dealing with problems. They tend to have more of a person-focus rather than a problem-focus which is more typically a male attribute. Women tend to be in the thinking, judging category. I read that in the navy, if a boat was torpedoed the male type attributes would say "We've got to fix up the ship", whereas the female type attributes would say "We have to look after the welfare of the crew". Both are dealing with the same problem, but coming at it from slightly different perspectives. Women in a group are more interested in the inter-personal aspects of their
lives. Men are more interested in object things, successes and activities. This creates tensions in the way that the genders relate to one another in organisations.

One WGP described how WGPs network and how these skills can complement the strength of males to achieve the best results:

There’s a lot of work to suggest that females are networkers. They spend their whole lives networking. They’re excellent networkers and communicators whereas males are very, very focussed. I think that the best way for skills to be used is to acknowledge that some women do have social and networking skills in areas that men don’t have, and use the strengths of both groups.

7.4.4 Socialisation

One urban WGP explained socialisation and expressed her belief that both socialisation and brain patterning played a part in roles that women take on as mothers:

Socialisation is complex and very wide ranging. It’s to do with what’s considered attractive in women, what’s considered feminine, what’s considered acceptable. I think it is all of those things as well as the pattern of socialisation, the brain patterning and the social roles that you take on as mothers with children.
Socialisation, biological difference and the masculine medical culture are important factors in the life of a WGP, said a WGP:

I've read how women are socialised differently from men and the fact that the hormones influence on the brain pre-natally means that you're programmed in a slightly different way. I think there's a lot of validity in the feminist attitude to the patriarchal masculine view of the world. Reducing it, chopping it up into little bits and only paying lip service to the broader view in the holistic sense. It comes down to women being trapped into that sort of cultural socialisation.

I do believe there are biological differences and that the socialisation is different and when you get to the medical culture itself it's a highly masculine, hierarchical, biomedical orientation which some women learn to adapt to. Women adapt to it while we're in there and as soon as we get out we spring back to our different view of the world.

According to a WGP educator in General Practice, women stayed at home until the second wave of feminism began to change society's attitudes:

I think it's just a whole societal thing of post-war, emphasis on families and the women's roles was to stay home and look after the kids. Then we started to get feminism to change all of that in the late '60s early '70s. That started to change attitudes. The profession's conservative of course and it takes a while for that to filter through.
Consideration of gender issues by academic staff and medical educators is necessary in the medical curriculum and in their interaction with their female students, said a male GP educator. He recommended a review of the culture of the hospital environment which had tended to negatively influence female self-perception:

During undergraduate years gender issues should be in the minds of academic staff and medical educators when thinking about how they deliver the curriculum and how they interact with their female students in comparison with their male students. There should be a program of thinking about what happens in the culture of the hospital environment in undergraduate years which might currently have a negative influence of female self-perception. That means there should be studies of the academic staff's attitude to women and the influence of the curriculum in the way that it's taught. Maybe there are differences in how staff react to the vocal male compared with a quiet female and whether that's harmful or beneficial to the female medical student.

The same male GP drew on his experience in postgraduate education to detail the different effects of the hospital environment on women and men:

Women are more severely affected in an adverse way than men when they're faced with the traumas of intern and RMO (Resident Medical Officer) years. Particularly the fairly callous environment of a hospital causes male interns and RMOs to
react differently. They tend to be seen to be successful and get on with the job and carry their feelings internally. Female doctors tend to be seen to be not quite so strong and resilient and probably verbalise their fears and anguish in the hospital environment. Maybe there's a perception that it's weakness and less capability. The men might then have breakdowns with their marriages outside the their hospital environment, women react differently in the hospital environment than men and then in turn are seen to be less suitable for the super-specialties.

The men's way of dealing with it is up front but their morbidities are outside the hospital environment and are more hidden. Women tend to carry the scars and traumas of their intern and RMO years in the way that they are less supported by their male counterparts in the hospital and they carry more fear and uncertainty and more anxiety. They have higher anxiety levels when they leave the hospital environment and go into General Practice training than their male counterparts.

This male GP reported on the anxiety of WGPs when training for General Practice and made suggestions for dealing with these:

Males are perceived to be better copers. I just wonder whether female GPs have higher levels of anxiety in dealing with the uncertainties of General Practice, the unpredictability, the threats of litigation and the environment of General Practice. There's something to do with the intern and RMO years that's sort of conditioning and maybe there's some very severely harmful effects on women which are not being recognised now. The consequence of this is probably coming into the RACGP
Training Program.

There are higher anxiety levels in female doctors and registrars in doing on-call and after-hours on-call. That’s not just personal safety it’s something to do with the anxiety of meetings and emergency medical problems where they’ve been relatively unsupported during their intern and RMO years. I think maybe it is that women are less well supported than men.

Professional bodies should communicate, collaborate and interact with the universities and the interns and RMO employing bodies. The College of GPs shouldn’t look within its own boundaries, but should have an active stance of looking beyond what has happened to our GPs prior to entry into General Practice. Research could go into the interactions of the College with other bodies such as the universities and hospital-employing authorities with regards to women.

Registrars need to be exposed to the organisational cultures, otherwise they do not know the details of organisations when they enter General Practice, reflected one woman GP:

If you are not exposed to it, you never know it. I think it must be part of the educational process. When a registrar comes you can see they don’t know anything. All they know is the College is running the Training Program. They struggle to even understand what the College is. They inevitably have a distaste for the way it’s run simply because as adults they are often people with families being dictated to. In the past they haven’t
been given choices. I know that has changed and things are better.

They know nothing about Divisions. They’re told that you haven’t got time to do anything with Divisions, which is ludicrous and the AMA is sort of a foreign language. The AMA is something that some guy on television is talking about. They wonder “What relevance has that to me today and in the future?” It is beyond comprehension. It’s understanding how the organisations fit in, what they do and what they deliver.

7.4.6 Generational Change

An academic rural WGP considered that in her generation WGP's competed with men without admitting to difficulties:

Women of my generation were ground-breakers. With the younger women I think there’s going to be generational difference. When I talk to registrars, younger doctors and students there is a difference. It’s not a gender difference, it’s a generational difference. Women of my generation considered ourselves lucky to be there without saying “Look, this is a bit tough, you know we’ve been feeling that we have to be competing on the same level as the blokes”. We’ve got to be doing all the things they are doing and if we dare admit that it was a bit difficult then you would just be considered a wimp. The blokes would say you can’t do it because you’re female, (laughing). That no longer exists. I think the men have changed as well as the women.
One of the male GPs thought that younger men were comfortable with their wives working and occupying leadership roles:

I’m the oldest of the younger group and following me is a whole stack of men who are perfectly comfortable with their working wives. Their wives are very active, intelligent and often better than them. These men are quite comfortable with the idea of working with women in leadership roles or in other organisations. I think my GP wife works harder and she is more focussed on work and better at it. I think she is less judgemental than I am. She’s a class act and so I don’t have any trouble bowing to her superior capacity in that area.

Younger doctors were more assertive about their work practises, said one WGP:

The under 40’s groups are much more assertive of their own rights and how many hours they’re prepared to work. I possibly detect less willingness by those groups to be involved in organisations. You see a lot of women making the decision that “I am going to work part-time because it’s all I want to do”.

An urban male GP thought that the problem was that registrars were not cultured or educated about General Practice but rather disenfranchised:

We don’t culture registrars who are the future GPs or educate them enough into what General Practice is about. We’re very good at teaching them the clinical aspects of General Practice but by disregarding General Practice as a culture, as a way of
life, we're actually disenfranchising and disempowering them. This is because we don't understand their willingness to become involved until they're burnt or hurt or damaged.

Another male GP supported the concept of having both male and female GPs registrars training in rural locations. However when it involved removing the social supports of their children, this became a problem:

There's also the issue of the requirements in the training program for people who are married to move into other areas. I'm thinking about geographical re-location for components of their training. I would argue that for people who may have a spouse but who don't have children, there really shouldn't be any preferential arrangements for males versus females or vice versa. Where you're dealing with someone who has children and who might be working part-time then removing that person and their children from their social supports is I think extremely problematic.

One male GP who held a senior position in the RACGP was concerned that registrars were less willing to make sacrifices. This hindered them from delivering patient care in rural areas:

Our registrars today are far less accepting of the self-sacrificing and family-sacrificing professional past in their own lives. Rural practice in particular still requires us to be available to our patients.
The new generation of male GP registrars want to share the care of the children, said a WGP:

Attitudes are changing a lot. A lot of our registrars, the men, feel it's their responsibility to job share with their wives and share the care of the kids. That's happening a lot so I think those changes are going to make a difference.

7.4.7 The Bean-Counters and the Number-Crunchers who Determine the Future for WGP

A concern of a woman interviewee was that the number-crunchers and bean-counters will attempt to limit the number of women in medicine:

One of the real anxieties I have now is the number-crunching that is going on about the number of hours that women work in the medical workforce and the amount of money it takes to train them. The economic rationalists and the bean-counters will say we're going to limit the number of women, we take into medicine because we don't actually get our money's worth.

The first study that was done about this was Ione Fett's study\(^4\) out of Monash and she clearly demonstrated that the lifetime hours of work for women were identical if not longer than men.

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\(^4\) Ione Fett's study showed that men have high hours of medical work and low hours of domestic activity. Women's time is more evenly allocated to each, except for the quarter of all women who spend 90 or more hours each week in domestic activity "...in effect most of their waking hours".

If you did those studies now you wouldn’t get those sorts of results and the real risk is that the bean-counters have ruled to do something about that. It may be against the law to discriminate against women but I’ve seen people rule lines.

This woman participant also spoke of the possibility that the value of the style of medicine that WGPs practice may not be considered valuable:

The value of women and the different sort of medicine that they practise will not be seen by bean-counters as worthwhile. Medicine is becoming increasingly technocratic. I think the bean-counters are in there and the economic rationalists are in there. Medicine is expensive, there is the possibility that there will be a negative outcome for women.

On the other hand this doctor thought that the feminisation of medicine has promoted professionalism and inter-personal skills:

There is also the possibility that medicine will rise up and say that’s enough. There will be something really worthwhile that comes out of feminisation of the medical workforce. There will be an eventual view that medicine is not simply a technical exercise. The real skills are in the thinking and the involvement of the patient. There has to be some value placed on professionalism and inter-personal skills.
Section 5

7.5 WGPs in Medical Organisations and Colleges

7.5.1 Introduction

Section 5 reports the deliberations of the interview participants regarding medical organisations and Colleges and the position and leadership roles of WGPs in these bodies.

7.5.2 Factors that Determine WGPs Organisational Subscriptions

The availability of time was a significant criterion upon which young GPs decide if they can contribute to organisations. According to one male GP:

In your professional life there are times when you're busier than others. Child rearing in particular comes into this as far as females are concerned. When I say more time, I mean more malleable time. That is why you get people on councils and faculties who tend to be a bit older, because they have got that capacity to give more time. You've got to have process where you get the younger voices in some other way. Time is as much a problem for female doctors as it is for male doctors but in different ways.
The view of another male GP was that women may be less experienced because they have taken time out to raise a family. Older men were regarded as being experienced but older women are seen as outmoded:

They’re fighting the fact that their experience is less. Women seem to suffer as they get older they’re perceived as being past it more than men are. Men are seen as having experience as they age but women are seen as having their time passed. They are a few years behind with career progression because of time out compared to their male colleagues.

The same male GP noted that personal life impedes the professional life of WGs but some women have been notable exceptions:

Personal life to some extent holds back a woman’s potential in the professional life let alone any gender or cultural perceptions about the role of women. There seems to have been in the last 50 years some notable exceptions.

Joint subscriptions between organisations would help link these organisations together, said one male GP:

You have to look at the reasons why they don’t belong and what you can do to correct that. I’ve already mentioned subscriptions. I believe that those bodies that are closely aligned should look at joint subscriptions but individuals believe that their organisation is all things to all people.
A rational basis for setting subscriptions especially for GPs working part-time had not been achieved alleged one male GP:

There are clearly some issues for practitioners who work part-time in terms of subscriptions and fees. I don't believe as an organisation that we [the RACGP] have a rational basis for setting a subscription.

This GP also noted that professional and personal services provided by the organisation were important:

We all look at the various services that can be given to members, whether they be professional services or personal services. It's very important for the perceptions of the organisations that we look at the public relations side.

This male interviewee mentioned the importance of publicising the benefits and advantages of an organisation and researching the opinions of GPs:

The other thing is always looking at the relevance of your association. How your organisation appears to the people you want to join. You've got to have runs on the board. You've got to say this is what we have done and can do for you. Exit polls are useful in finding out why people leave. Surveys show why people joined, whether they're happy and why they're not happy.
Medical organisations must be appealing, have an inexpensive memberships fee and not be in competition with each other said a male GP:

It's very expensive to belong to an organisation. It's important that the organisations look to keeping those costs down and having a structure that is appealing to people and a local structure that supports people. I don't believe it's in the interests of medical organisations to be seen to be in competition with each other.

7.5.3 WGPs in Medical Organisations and Colleges

A male GP suggested that organisations could address obstacles for WGPs by introducing a sliding scale of membership fees, support groups, and assistance with career choices:

You've got to have membership fees that truly reflect part-time work and a support group of networking women. It's helping them define what career opportunities might exist.

Changes that have taken place outside organisations have created networks that have enabled WGPs to drive change within organisations, reported a WGP:

There have been some really impressive changes that have happened and a lot of them have actually happened from outside of the organisations. The women's e-mail group that has provided this really strong political discussion and energy that
you can tap into if you want to or you can just observe. You can see that it has driven change within organisations and is getting women involved. They have to actually sit back and look at why. Why is the AMA representative of older men? Why are the women choosing not to join?

The same WGP gave an account of the difficulty of creating internal change based on surveys that an organisation had conducted:

They did a survey, I can remember looking at it and it was absolutely staggering to me that the women wanted the AMA to be value for money. When I saw it and said, “Oh my goodness, you know this is pretty staggering” but you’re one voice and they’ve got proof from however many hundreds they surveyed and that makes you wrong. Creating change within those environments is very difficult.

The problem of getting individuals to dedicate time and passion to organisations was recognised as a problem by one WGP:

There’s a real problem in getting people to be involved and it doesn’t matter what organisation you’re in. Getting people to be passionate enough to dedicate themselves and some of their precious time is a problem. I hoped that there would be some incentive to get people involved.

A male GP recommended that organisations tolerate rather than control the chaos and complexity in WGPs’ lives:
Women’s lives tend to be a bit more complex and often a bit more chaotic. You’re not able to control and order their lives as much as you can order the lives of males, because there’s more unpredictable forces around women’s lives to respond to. I think we need to be moving into organisations that can actually tolerate that degree of chaos and complexity. The hierarchal nicely-organised little structures that we have now are not going to serve women well. The structure just often reflects a culture.

Organisations should suggest options to members regarding the way they participate remarked a WGP:

I'm not sure that just changing our structures to flatter structures is necessarily the only answer. It’s around being prepared to offer range of choices in the way people participate. Currently there’s a very hierarchical structure, with hierarchical career paths. Both of those will probably change as we accept that people can’t just move along pre-determined pathways. That’s a fair bit to ask of an organisation because it means loss of a lot of control.

It is important for men and women to work together said a WGP:

The blokes criticise your performance far more than they criticise any of the men. We can role model and mentor other women in a way that doesn’t put people off. We can’t put the men off. We have to work with the men. We have to get the good characteristics of the men and work with them. They have to accept that we’ve got a lot to offer in our way and they need
to work with us.

An urban WGP thought that women should feel comfortable in organisations rather than acting as honorary males:

Women have to be there and do it on their own terms. That is on the terms that they as women collectively feel comfortable with, rather than being honorary males.

However, a male GP thought that organisations will only work to improve issues for women when they appreciate the "bigger picture":

In terms of how the organisations might work together to improve issues for women, that won't occur until you have got a generation of people at levels that make decisions and understand how they all work and what is happening. Why are we fighting against one another? Often you have got people in different paradigms thinking that their culture is the only culture and not respecting or recognising what others have to offer.

7.5.4 Organisational Structure and Cultures

According to a male GP, Divisions have a local structure, together with a State Based Organisation and at the national level, the ADGP. At the time of this research the ADGP was starting to emerge and the Australian Rural Divisions were "fledgling organisations". A male GP who had extensive involvement in the Divisional movement, suggested that there was balance provided by a combination of the AMA,
RACGP and Divisions of General Practice:

Let's just call the AMA a political organisation. You have to understand the difference between what the Colleges are trying to do, which essentially is about standards, training and education, and what the AMA as a political body is trying to do, which is represent industrial and political issues. What Divisions are trying to do is to improve service delivery across the different areas that General Practice interacts with. I think the balance in General Practice is a combination of those three.

The same GP questioned why the organisations that claim to represent General Practice have diverse views and cultures:

It's been very useful to understand the culture of those organisations, how they inter-relate and the personalities involved. The difficult thing to understand was why organisations that were all representing General Practice had such diverse views on different issues.

It's not until you actually visit them and participate in the debates they have that you can start to understand why they might be different. You can begin to bring them together by pointing out that they haven't considered the other point of view or they haven't tried to understand the culture of the other organisations. There's a wide difference in the culture of the organisations and the puzzling thing to me was why the organisations themselves weren't prepared to accept the change. It was sort of staring them in the face that the populations of the
members were altering and yet they weren’t keen to recognise the needs of the members in many ways.

7.5.5 The Mandate and Structure of the RACGP

Although the RACGP is concerned with standards, education, training, and research, politics is also involved according to one WGP:

The College of GPs really does have a mandate to be concerned about standards, education, training and research. That doesn’t mean it can’t change over time. I’m not sure that the membership has fully embraced the larger political role that the College tended to take on. I think the directions of Vocational Registration and Practice Accreditation and QA and CME are all about standards and all about the business of the College. They have taken a fair bit of political clout to actually get up and running as part of annual practice. There will always be political elements to standards.

In the opinion of one WGP the RACGP had been absent in political negotiation with government regarding remuneration for GPs:

The RACGP failed fairly dismally politically and that really came home to me at the HIC when I saw first hand how the other Colleges and associations negotiate with government. They’re negotiating there all the time through the AMA for improved remuneration. Doing deals left right and centre, and it’s constant, absolutely constant. There was a lack of presence
of the College of GPs and any affiliated association.

A male GP who held a senior position in the RACGP described the complex structure of the RACGP and its contribution to the progress of General Practice:

The RACGP is complex because of its organisation and the relationship between employed often extremely technically highly qualified people and elected and voluntary extremely well qualified people. I think that can introduce stresses and strains.

There's also the extraordinary diversity in General Practice reflected in the organisation and the problems that occur because its a highly distributed organisation with sometimes ineffectual communication lines. Sometimes there are quite different points of view about things that people can't reconcile or don't understand.

The College is a bit like the Church of England, its diversity is its great strength and I think it is increasingly being seen as a body that has achieved enormous things that were quite unachievable in other countries. The things that have happened in this country in relation to General Practice are quite unique.

One of the senior male GP employees in the RACGP also took a positive view of the College's progress:

This College is significantly ahead of many of the other Colleges. Probably this is partly because of the nature of this
College in that it has got a much higher female representation than any other and probably because the people who are attracted to General Practice are those who are attracted to caring and the less technological side of medicine. I suppose that facilitates some of what you might think of as the more feminine aspects of us as people and of the profession. The College has made very real gains in the last 10 to 15 years. Your accession to President is in a sense the final representation of that.

Another senior male RACGP member thought that the College had made particular progress with gender and age balance:

What the College does have particularly over the last couple of years is a significant shift at the decision-making levels of the organisation in the gender balance and age balance which inevitably will reflect in the way the College does its business.

7.5.6 WGPs in the RACGP

The RACGP had difficulty in taking account of the concerns of WGPs and instituting change regarding gender issues. An Equal Opportunity Task Force was established to research the issue and report to Council but no action followed. According to a WGP interviewee:

I don't think that the RACGP has taken equal opportunity on board in any serious way, although they are trying to. I am not
sure that they have done it in a very reflective way though, or in a very systematic or organised way. With a President who's a woman, who got elected on those issues, it's obviously a strong feeling and before that particular President came on board it was certainly there as an issue. They had this working party but no one knew what to do. Well let's send it to the State faculties they said. I think we actually gave it to some other portfolio and it got locked away.

One of the WGs who had experience in the Equal Opportunity Task Force thought that the College did not see it as a significantly important issue:

The RACGP had a national working party on Equal Opportunity and Status of Women. Since the report nothing really has happened. It hasn't been taken up by our State Faculties and it doesn't seem to have been an issue that's thought important. I think that has been largely a part of the culture of the College, that it's not seen as really important. It's very hard to push things if people aren't wanting to go there. I've found you can't force the issue until a Faculty is ready or there is something that comes from the College as a whole and there's enthusiasm for it.

As another WGP put it:

Like a lot of changes, it's very difficult for one individual to really impact on a structure. You need a group or a little cohort that actually is able to begin operating in a different way to influence the larger group.
The RACGP was trying to address the issue of Equal Opportunity, said one WGP:

I think the College more than any other organisation tries to contribute to this issue. They now have a greater proportion of trainees that are women than men. In the hierarchy of the College there is more feminisation than a lot of other organisations.

A rural WGP noted that:

In a lot of the workshops that the female rural director of training runs, issues relating to gender are discussed. RUSC [Rural Undergraduate Steering Committee] is bringing up a lot of those issues relating to gender which previously weren't discussed at all.

With the increasing number of WGPs one rural WGP considered that the College should concentrate its efforts on issues for WGPs:

The College is the organisation where most is being done and can be done, because there is a much larger proportion of women becoming general practitioners. I graduated in '72 and a third of the year were women. I was on the crest of the wave in terms of the number of women coming into Medicine. Once you get half the students who are female, obviously it is going to change things. As those people get older and get themselves into senior positions things will change.
7.5.7 Membership of WGP’s in the AMA

A male GP who was a senior member in the AMA explained the aim of the Association:

We should be looking at how as an organisation we can get women involved, because that’s what we’re all about. The AMA is all about influence, influencing people, influencing governments and influencing the community. If we don’t have women GPs providing that face then we won’t be able to influence as many people as we would like to.

With the increasing number of women in Medicine, the AMA has realised that it needed to address issues that concerned women. This GP continued:

I don’t think the AMA has spent much time addressing the problems of women. It is not surprising that there is a poor uptake in the membership by women.

Nevertheless, a woman who was an AMA member thought that the AMA membership structure was a deterrent to younger women:

The AMA has a membership structure that isn’t particularly conducive for young women to join and the AMA has become aware that it needs to start addressing some of those issues.

Other WGP’s who were interviewed expressed significant negativity about the AMA
and felt a degree of hopelessness with the situation. Their comments included:

The AMA, I don’t think I’d even attempt to make any comment, I haven’t seen any hope there.

I’ve always been disappointed at the AMA and what it does for General Practice. I’ve come in and out of the AMA over time. I’m not a loyal member of the AMA.

The AMA; in the end if you are a woman you have to give up on it because it is hopeless and that’s what I’ve done.

I am a bit sick of the way they treat you. You have specialists and others and like most organisations the power brokers have been men. They’re on about specialists and they very happily defend people who earn $1 million a year. Now of those people who earn $1 million year or even $5 million, to my knowledge there are no women among them.

Another WGP felt that the AMA’s Women in Medicine Committee was about side-lining women and that the men saw equal opportunity as a threat:

The AMA makes things absolutely worse for women. In all my dealings with them, they don’t want to know, they haven’t got a clue. My opinion of the AMA Women in Medicine Committee is about side-lining women. “Oh gee, these women are making a bit of a noise, let’s invent this committee, give them a few dollars and then we can ignore them”.
I said to them what about an EEO [Executive Equal Opportunity] person? EEO we couldn't do that! It's too threatening. All my dealings with the AMA have been so utterly negative. If you're going to look at issues about women, it means you've actually got to examine yourself. I find that the men who are attracted to certain organisations just couldn't possibly look at themselves, their behaviour, their attitudes and their values. The AMA seems to attract those men and the women who are in there are very brave. I couldn't put up with that, I just can't go near them because of the degree of negativity.

A major barrier for women's participation in the AMA was that meetings were held in the evening and did not finish until late. Meetings in both the RACGP and the AMA were also held on weekends which made it difficult for women to attend because of their domestic and family responsibilities. One WGP observed:

I know one woman is absolutely, totally and completely committed to General Practice and health issues. I know very often at the meetings she is on a mobile phone, in and out trying to arrange her kids and the cat. It's the women who you see on their mobile phones, because we meet in the evenings. They're never talking about business things with people there but they are organising something around their family lives and it's obviously intruding.

The content and operation of the meetings can also act as a barrier to women's participation said a male GP:
Women want to belong to an organisation that has a broader understanding of health, General Practice and welfare. The Australian Medical Association Council of General Practice meets in the evenings and the issues are not necessarily issues that women want to be involved with. They're usually reactive to something that's occurring in medical politics. You've got to make a stand compared to, “Let’s develop or review a policy of what we’re doing and try to make it better” [the women’s perspective] compared to... “Let’s fight the government and break down the system”. I don’t think that appeals to women.

This male GP perceived that women appeared to act differently to men regarding politics:

Somehow the women there were different political animals in the sense that they weren’t necessarily like the boys. They were probably stronger willed and were accepted better. The problem is that there were never enough of them. They were prepared to be outspoken on women’s issues not because the opportunity was there but I think because of their personalities.

One WGP thought that teleconferencing and refining meeting structures would assist women to attend meetings:

Many of the meetings are very unwieldy and meet far too often and discuss far too much and go far too late into the night. I think there should be refining of meeting structures and teleconferencing for a lot more meetings in some of these organisations, so that women can be involved and help make
decisions.

7.5.8 Encouraging Women to Join the AMA

A male GP who was an AMA office holder examined the positive contribution that women bring to an organisation:

I have been in a position of being able to influence and encourage females to join the association. That means delving into why they don’t belong. I’m not sexist, and I think that undoubtedly women bring a totally different perspective and slant to the associations in General Practice. They not only broaden the approach taken by the organisations but its thinking and also its appeal, but women are staying away from most organisations.

A male GP who held a senior position in the AMA considered the importance of having young women in the AMA:

It really has got to be one of the AMA’s prime aims to make sure that they present a face that covers the breadth of the profession. If we’re not seen to be having more women actively involved we won’t identify with our market and we’ll lose them. If we’re not addressing the concerns of women, then we won’t get them.
An urban woman GP detailed her dislike of an organisation that appoints token women:

The problem that I have with any organisation, whether it's interested in the future of women or is political or professional or educational, is the concept of token women, which I think is a dreadful one. I think any organisation that decides they'll put women in just because they need a certain percentage of women, is really doing the wrong thing by women. I think that's very patronising.

A male GP was troubled by WGPs who had no knowledge of the current issues in General Practice:

What all these organisations need to be doing is finding the women who are prepared to take a stand, and become central to the power structures of the organisation and mentor them and get women to lift their game politically and educationally. Women should be encouraged to take a more active role and to become more conversant with the issues. There's many women in General Practice who have no idea what the Government's latest plans for General Practice are, or what the GP Strategy addressed or whatever the current issues are. They're not interested and as long as they rush in and do their session, get paid at the end of the week, that's all they care for.

A WGP reiterated the importance of involving women after they leave their hospital posts:
It's a mentality that changes from the time women leave the hospital situation, where I am sure they're just as aggressive about hospital conditions and hours as what the males are. When they start to worry about families the professional assertiveness sort of dies a little. We have to keep the women involved right from the time they leave the hospitals.

A male GP who was in a senior position in the AMA noted:

We don't have enough women involved, we don't have enough Asian doctors involved, and we don't have enough young doctors involved. Now, those three groups tend to be the under 40 age-group.

7.5.9 The Women in Medicine Committee

The AMA's national Women in Medicine Committee had been set up to address issues relating to women's health and women doctors. A female AMA member reported that that the purpose and function of this committee was questionable, viewing it as a feminist organisation. She found it difficult to accept the activities of the committee even though she admitted being a feminist:

There are a number of people who feel that the issues that the Women in Medicine Committee address (and it's important to note that there are plenty of men on that committee) could well be addressed under a different heading. The Women in Medicine Committee had its tenth anniversary a few weeks back
and has looked at a number of gender specific issues. I personally have grave difficulties with something called the Women in Medicine Committee and I have grave difficulty with most feminist type organisations, although I would see myself as being a very committed feminist. There are problems about gender specific issues and many of the things that the Women in Medicine Committee addresses under the umbrella of women could be well addressed without that.

A male GP who had a senior position in the AMA believed that the role of the Women in Medicine Committee was originally to foster the involvement of women in medical politics. However, he thought that the committee should change its direction:

That committee has had a few problems getting its message across and functioning. What I particularly wanted was to try and get in our publication more pictures of women doing things. The perception we can generate is that women are actively involved and it's not a women-unfriendly organisation to join.

This same senior male GP admitted that women in medicine had been discriminated against:

I've always seen women as being equal in my job as a doctor. I sometimes am surprised that I find that they don't see themselves as equal. I've never felt that I've had a problem about working with or for women. You'd be an idiot not to think that they haven't been discriminated against in particular
areas. I think it’s changed a lot particularly in the last ten years.

7.5.10 Structure, Operation and Function of the Australian Federation of Medical Women

According to an urban WGP, women doctors supported one another in the hospital setting but this support was not generally available in the established organisations:

It’s very much to do with actually getting a voice and that has always been part of the reason why we formulated the Medical Women’s Society. To establish the organisation there was a group of women who met together to discuss what was going on and to act as an information exchange. A lot of us at the time had come out of the hospital and suddenly gone into this absolute vacuum of where there were no women. There weren’t any women who went to meetings. It was so difficult to meet women and actually exchange information on how to survive because this had always been the protective mechanism that we’d established within the hospital scenario. When we’d meet, we’d say “Watch out for this person”. We’d always looked after each other and this is the real difference. I haven’t ever felt that from the more established organisations.

When you get a group of women together as we do within the Medical Women’s Society it’s just the energy and the enthusiasm and the fact that you actually feel totally relaxed. You can say whatever you want to, people will listen. They will respect you and will actually try to hear what it is that you’re saying and provide perspectives to that experience.
Although AMFW is an organisation for Australian women doctors, one WGP expressed concern regarding its structure and way of operating. She described her experiences as a State President of the Medical Women’s Society:

I have real concerns about the AFMW as an organisation. They don’t have hierarchy. How they go about nominating representatives is a concern. I don’t want it to be an in-club situation. It needs to be inclusive, open, transparent and democratic. My initial involvement in the AFMW was as a State President of the Medical Women’s Society. They were unincorporated and had one annual meeting when they actually all got together. They were concerned about money and were charging people $20 for membership, which is just pathetic. They had no policy documents and didn’t make any statements. I really felt very negative about it. I remember in that meeting saying, look you either incorporate or we don’t come. I’ve got 120 women sitting over here and they were listening. They incorporated as a result of that. The State women were a really important catalyst to drive the AFMW.

This WGP also spoke of lack of communication in the AFMW:

We don’t receive any newsletters and the information that we receive is so indigestible and unpalatable that nobody reads it. The State newsletters that we have tried really hard to generate at least three a year and to make them very inclusive. It all comes down to individual people’s energy.

A large structural problem for the AFMW is that the national body is required to
move from State to State. As one WGP said:

The AFMW unfortunately has these real structural problems in that their constitution requires that the national executive has to move from one State to another. The States have this enormous feeling of anxiety, “Oh my God it’s our turn next, forget about us, we’re not mature enough, we’re not developed”. Whilst it was based on sound principles it’s actually a real problem.

Another urban WGP spoke of how she participated in the social events of the Medical Women’s Society:

The Medical Women’s Society, I haven’t been all that active. They hold nice social events, nice networking things, but I haven’t had an active role in that. There are a number of active medical women in the State so women’s issues are talked about more up front perhaps than in other sectors.

A female GP maintained that the society was a forum to advocate for women when issues arose that would affect their professional lives:

The Medical Women’s Society represents what we’re all about. It certainly is very helpful in giving a forum for us to raise issues that are of concern over the years. If there have been any issues that affect General Practice such as Vocational Registration and the recent Provider Number issue, Medical Women’s Society always takes that up and talks to other bodies and tries to get something done for the sake of women.
7.5.11 The Academic Association of Australian General Practice

Only one WGP interviewee referred to the AAAGP organisation:

I belong to them just because I was interested in getting any information around what's happening in the education and research area. They haven't been a very active group and haven't provided much for anyone.

7.5.12 Genesis, Membership and Function of AAGP

A male GP explained that this organisation was established to consider the politics of General Practice:

Its genesis was in disaffected AMA members in fairly senior positions who wanted to form a new organisation although there were females as founding members. Positions on its Federal Council were very much the males over 50 years, former AMA group, and that's continued more or less since.

They've had no success in retaining women into positions on the Federal Council. It's really an organisation of a small group of people who meet to discuss General Practice politics without having a power structure or career structure that people have to go through to get into it.

An urban WGP explained why she was still a member of the AAGP:
I joined initially because when it first formed, its original role was around being a political arm for General Practice. I've kept my membership because I'm still not sure whether we need that.

7.5.13 GP Perception of the AAGP

A male GP deliberated on the lack of appeal of the AAGP to WGPs.

The AAGP saw that it may have a fairly overt political role. The issue is the way they had gone about it in the early days. It was probably distasteful to women as there are no women on the Council and that would be repugnant to the women in the sense of how can we belong to an organisation where we are not represented.

The Council would say not so, we encourage women. I think when you come to the table and hear the debate then you make a decision. “Do I want to participate with the way these people carry on or am I going to make a difference or is it going to be like this every night?” The problem is that they misunderstand the issues for women. I think the culture within the AAGP it is a difficult environment for women the way it currently stands. It could change if it had new life, a new direction and purpose and if all the members currently there withdrew when you have a new election.

7.5.14 Academic WGPs

According to a male urban GP interviewee, universities do not encourage part-time
Universities don’t warmly embrace part-time work for academics at a senior level. I remember a senior female GP academic perhaps implicitly rather than explicitly talking about having maternity leave and having to go back to work. I always got the impression that she wouldn’t necessarily have gone back to work as urgently as she did other than for her career’s sake.

One WGP found the General Practice department in which she was employed was short of teaching staff and going through a period of change. She described this experience as follows:

My job here is as a senior lecturer in rural General Practice. We are very short staffed in General Practice. My job is meant to be like all the other rural academics, basically taking forward the rural initiatives under the RUSC program. Our professor retired 12 months ago. They haven’t as yet been able to replace him.

The Discipline previously consisted of a professor, a lecturer and me half-time. The lecturer resigned at the beginning of the year. I have been the only academic member of staff in General Practice. We have got three people [GPs] working a day a week each but they can’t do any of the administrative stuff. Their role is doing some teaching and marking. Dreadful!

Another WGP who had worked in an academic organisation spoke of how difficult it was for a woman to be selected for a job in a senior position:
Look at me, I mean look at someone who hasn't really succeeded in the sense that I've had to keep moving sideways. There is a sense that it's very hard to really crack it because when the chips are down and the people are selecting for important jobs, generally they select someone like themselves.

The [David's] of this world, as much as they were oh so supportive of me, would always select someone who has got a little hair on their face and just talk more of the same language. That's unconscious maybe and you challenge people on it. I did challenge David on that and you know he said, "Oh no, no!" But actually I think so. Yes, it has been written about in a number of publications about women getting top jobs. It's the unconscious disadvantage of the selection committee going for their own kind. I think having an equal opportunity officer present must have some impact but whether that is when you have got that [gender] balance and depending on how powerful the person is who balances. It's the gender balance you know. I'm sort of doggedly sticking to my principles for better or for worse. Worse more like it!

The same WGP said that women were respected and acknowledged, but not appointed as a professor:

I think that's going to change, but it hasn't quite changed yet. You are respected, you are acknowledged but if they're really going to make a choice of Professor of General Practice, they will give it to the male. Just look at the distribution around. You either give in or you stick with it, knowing that eventually
There will be enough strong women out there that that will be given equal value.

An academic WGP from overseas was told to get a doctorate and a number of peer reviewed papers:

Because of various life circumstances we came from overseas and I was trained in a special interest area of Medicine, but there's no jobs as there's no specialty here in Australia. So I was told I needed a doctorate, which was about the last thing I would have needed overseas. Overseas they would have said, “Okay, go out there and do it”. In Australia they said “Oh God no! You better publish papers”. “How many papers?” “Oh your papers!” Papers no one was even going to read. The peer review process is so rotten you know that people select the males. Overseas I think they had a better process where you had to show results. You had to achieve things. You had to demonstrate that your research work was actually making some positive outcomes rather than producing some poxy paper in some journal. Peer reviewed by your friends or your enemies, if you’re in the club you get published and if you’re not it’s harder.

This academic WGP was told to bring in money. Despite her feeling of rejection she was determined to achieve the requirements that had been set:

I had to really work with my babies and my work and I had to bring in money, bring in money, bring in money! I did want to use all my training and experience and there wasn’t anywhere to slot into. I had to try and earn using that experience but really
there was no position that was offering much pay. That really made it a big struggle! My children have been very easy to look after and been very untroublesome, so it's not them. Then I just got the bit between my teeth, because my experience and background wasn't recognised and said. I'm just going to do this!

Now I have done it, I don't care any more. It's been a long hard struggle and I'm not sure it's worth it. You only have the personality that you've got and you only see the things that you see. Now I'm through it, I think I could have looked at that differently. But anyway I saw it this way. Big challenge and I was going to win at all costs.

7.5.15 Leadership by WGPs in the Medical Organisations and Colleges

A number of the research participants talked of the glass ceiling that exists for WGPs in medical organisations, but this may be changing according to a male GP:

There would appear to be a glass ceiling within General Practice for women to achieve senior positions, or positions with power attached to them in the general practitioner bodies. Probably in the last two to three years there has been a marked change in that there has been a number of women breaking through what a lot of women felt was a ceiling, whether it was academic General Practice or the College or the AMA or even within the Division's program.
A WGP said the socialisation of women has to change so WGPs

...are comfortable, attractive as women, loved as women, strong and intellectual. There must be room for women to be women in these organisations.

To answer the question of how to involve women without being unfair to men, this WGP suggested a change in the socialisation of women at all levels:

What do you do, how do you involve women without being unfair to men? Of course women have to be motivated. Part of their socialisation has to change. You’ve got to start working on other ways of socialising women so they can be strong. They can be intellectual and that’s a good thing. I think this must happen at all levels, from socialising through schools to having room for women to be women in these organisations.

The view that WGPs are still seen as the care-givers for their family rather than as part of a leadership group was frequently reported:

Some of it relates culturally to where we are as women in our society. That does vary amongst women general practitioners depending on what their particular culture is. In Australia the Anglo-Saxon culture still prevails. Women are still the basic care-givers for children and older people. They may have some leadership roles but never or very rarely are they the majority leadership group.
A male GP explained that the slow pace of change in the organisations was related to individuals who considered that their view of life was the only view:

This problem with changing organisations has been that change takes a long time. Some GPs feel that they have a place in the sun. Organisations seem to be dominated by strong-willed personalities who feel that their view of life is the only view of life. It's either a case of waiting for them to move on, which is a very difficult thing to do because they tend to have a whole lot of clones who think and feel the same way. They are surrounded by them.

There are limited times in the lives of WGPs when they can take leadership roles, said a male GP:

There are specific times for people to take active leadership roles, when they’re available, capable, they’re looking for something to do and have enough experience to do it with. The kids are a bit older, families are settled, they’re competent at their practices, they’re travelling okay. That is the time they want to make a contribution.

However, a WGP thought that criticism of women in senior positions deters some WGPs from taking leadership roles:

Because of society’s attitude to a woman who makes it to a high position, they have to work harder, make sure that they are dealing with people fairly and they can get quite a bit of
criticism. It's not an easy role, and that's why I think that we get a lot of women GPs who really aren't prepared to have to put up with some of the attitudes that they get.

WGPs who have taken up positions of leadership gave courage to other WGPs to take part, said a WGP:

When people started to see that women could take positions of responsibility in those bodies on an equal footing with the men, that was a big step for me. Your election and people in the AMA being elected as chairs of committees on their own merit, that to me has been a big thing. I think it's given a lot of women courage to continue if they believe they have a role to play.

One female interviewee related her thoughts on the role of Past Presidents of medical organisations:

If I get to be elected to the Presidency, I imagine my time in medical politics will be over in three and a half years. Then one becomes a feather duster. Some organisations have the Past Presidents still sitting on their executive and they are culture carriers. The AMA does not. In the RACGP the Past President goes to the archives committee.

In contrast, a male GP who had had Presidential experience considered it would be unlikely for a person caring for a young family to become a President:
The commitment to get to the top in the organisation is such that you've really got to put your heart and soul into it for a long period of time. It took me eight years to get to where I got. I had to really sacrifice my family and my practice very significantly to get there. You tend not to drop into it out of the blue to get where you are. I think the timing commitment is such that you've really got to balance it up between family and work to get to the top at an age when you're not feeling like you're getting a bit past it.

To get to the top you have got to be pretty focussed on it all. It does mean that you have got to make sacrifices and that means that it is a very difficult thing to do while you have still got a young family that you're caring for and rearing. They really need to be off your hands before you can do it.

Another male GP said that he felt that a woman could follow him but he did not want one to defeat him:

We're currently looking at the structure of the AMA. I haven't specifically thought about how we might do things differently or let more women get to be President. Maybe I haven't because a woman is following on behind me. It's going to happen, I actually had wanted a woman to follow me. A woman stood against me a couple of years ago, I didn't want her to beat me, she can follow me.

Women needed support and promotion to attain leadership positions said one WGP:
There needs to be some head-hunting of women who are forthright and opinionated and who need a little support, or a little promotion. It’s finding key women who are prepared to be involved.

7.5.16 The Experiences of WGP in Leadership

A male GP interviewee when questioned why women don’t get appointed to leadership positions acknowledged the paucity of women in senior academic positions:

There are organisational approaches that need to change around part-time work. If we could get that as the first step that would help the culture of legitimising parenting. That would allow both men and women to share that task and have careers within organisations.

The universities have not made it easy for women to take senior positions. They still define a full-time professorial positions as requiring some overseas training and work. We have this clumping of women at junior levels, and then a clumping of men at senior levels which obviously is common in other industries.

A female WGP who had held a State leadership position in the AMA felt that she was without guidance or feedback:

I can remember expressing very strongly this feeling of leading from a vacuum. You tread your path, you herald what you’re
doing and nobody will tell you whether you're going the right way or not, until you do something that they don't agree with. Then they come down on you like a ton of bricks and they say, "why didn't you do this, why didn't you do that?"

The same WGP wanted to institute change but after considerable effort she realised that she

...had to put these ideas out there and sit back and wait for them to actually consider and absorb them and then for them to come up with the idea and say, "Hey this is a really good idea". This was preferable than to lead from the front. She described it as a bit like feeding the chooks. You had to sort of spray it out and wait for them to come and think that they had actually found it all on their own.

WGPs know that they can experience emotional harm when holding a leadership position. As a WGP said:

I decided that I would nominate and I decided that this was a high danger activity. I contacted a psychiatrist friend and I said I've nominated for a senior position in the AMA. I don't think I'll survive if I don't have regular de-briefing.

This WGP wondered if her previous workplace performance had influenced her present leadership position:
When I had been their resident doctor in the hospital system I had questioned their management. They didn’t like that. I had a bit of a reputation of being a bit of an upstart. I think I was pretty lightweight really. It’s more to do with the fact that I wasn’t representing any gender issues.

The same WGP also spoke of being different to other members. However she had support from male GPs who had similar experiences:

I’m young, I’m a fairly ‘in your face’ sort of person and I take a very different path to a lot of them. I choose to work part-time and I don’t own my practice. I’m not representative of the membership. I still feel uncomfortable about it.

I did it with quite a lot of support from men who had been through the same system. A young fellow wanted to nominate but because he had actually been vocal and had already actively rubbed a lot of people up the wrong way, they all came out and said no. They said “we think you’re too young”. I would have been 34 then. I was young but he was a bit younger. I think it was partly to do with the fact that they wanted to return to the old traditionalism.

A senior WGP had wondered if those who denied the presence of discrimination had ever personally encountered it:

Within the AMA sometimes you get a couple of women who feel that there isn’t any discrimination and that there’s really no need for the AMA to be pushing those lines. Likewise, in the
Medical Women's Society, there are often remarks from other women or men saying “Why is there a need?” They don’t think there is a need. I think that that’s because they have been fortunate enough not to have been in the position where they have experienced any discrimination.

A senior male GP member of the AMA thought that positive discrimination was not necessary:

We’ve still got a large number although not as many women on our Council as we did have. That’s just a natural occurrence, it’s not a gender-based thing. It’s who’s available and who’s willing at the time. I don’t believe in positive discrimination, that’s not my way of thinking and I don’t think it works.

Another male GP highlighted what he considered to be the view the men in the right wing of the AMA:

It is not that they’re women but it is a matter of opportunity and time. There are some barriers in that women are seen as soft, give in too easily and are too cooperative. I think that that’s not sat well with the hard right wing that tend to some extent to run the AMA. We’ve certainly tried to change it.

One male GP AMA member reported that politics was aggressive but that women who were tough coped:
Politics are a pretty aggressive business at times and you’ve got to be a bit of a tough nut. We’ve plenty of women who are tough nuts. What’s happening now is that capable women who put their hands up in the AMA are just getting worked to death. They just get so overwhelmed that it’s a bit hard for them. They need to share the load around a bit.

A WGP found that being in a position of leadership in the AMA had left her drained by constant argument:

It sapped me because I was idealistic. I had high ideals that we could join with the government and come out and say positive things and we could encourage women and GPs to participate.

I became quite bitter and twisted because negotiation with the government was negative and nasty. You might come up with these high ideals but we know that in the back room you’re going to come up with a bad media release. You know it was all so adversarial. I’ve come from a feminist background and being involved with feminist organisations where there’s a lot of consensus thinking, and that was very much my modus operandi.

If somebody comes to me with something I’ll listen to them and if they’ve got a valid point, I’ll take it on board. If I go along with something really positive they just sit there and argue. This arguing, this constant feeling that I was always giving and responding and being flexible and nurturing and nobody was responding in return.
A male GP who was a leader in the Divisional movement thought that WGP's fitted well into local Divisions:

The Divisions are regionally based and this lends itself to women joining in the leadership roles, as women are particularly comfortable with locally based activity.

Women participating in leadership activity can juggle their other responsibilities quite comfortably. We actually perceive them as an asset. Women GPs are well represented as office bearers and in terms of total numbers in Divisions. So the decisions being made in terms of involvement, participation, and issues were always going to be more relevant.

Another male GP from the State Based Organisation gave an example of how WGP's fit into committee structure:

In this State for example half the members of the State Based Organisation management committee are women. It's something that comes naturally and fits into their lifestyle. It's not political but I think they can have a pretty powerful political influence. They can certainly affect and alter the decisions that are made.

### 7.6 Conclusion

This Chapter highlights the analysis of the themes that emerged in the semi-structured
interviews. These themes demonstrate how the professional and non-professional life of a WGP forms a composite, indeed a mosaic. The themes also show the nature of the socio-political space WGPs occupy in professional organisations and Colleges. It is apparent that there are a myriad of subtle and overt expressions of masculine power and patriarchy that affect WGPs who strive to achieve equity with their male counterparts, especially in professional organisations and Colleges. The inseparable components of the mosaic of the professional and private lives of WGPs are further examined in Chapter 8.
Chapter 8

Masculine Power and the Games that Boys Play

A woman in a masculine institution is always an outsider: as long as women remain small minorities in such institutions they can be subject to extreme pressure, as the men close ranks. What is beyond doubt...is the hostility felt by the men who are intent on making women feel threatened and unwanted. These are not cases of chivalry misinterpreted or sexual high jinks but of deliberate victimisation using sexual aggression...Self-defining male elites always gang up on outsiders, especially if they feel the outsiders have been forced upon them (Greer 1999, p. 180).

8.0 Introduction

In this chapter the themes from the Delphi Study (Chapter 6) and the semi-structured interviews (Chapter 7) are combined to form the components of the final framework of this research tabulated in Appendix 1. These linked themes (referred to as the research) are critically evaluated in tandem with supporting evidence from literature, theory, and the words of the research participants (denoted by quotation marks). In addition a historical component continues to provide an international context to the professional and non-professional lives of the WGP participants. By employing a multi-strategy in this thesis new knowledge is generated regarding the key issues in the professional and
on non-professional lives of WGP's in Australia and the socio-political space these WGP's occupy in the medical profession, Colleges and organisations concerned with General Practice.

8.1 The Status Quo for WGP's

We are looking for someone at professorial level with an international reputation [and] with say 100 publications and evidence of ability to bring in research grants and knowledge of both the university and health sector (Anon 2004).

This was the response given by a Dean of a Medical School to a WGP who recently applied for a senior academic position in an Australian university. Although it was not actually stated in the Dean's reply or in the selection criteria of the job description, the implication was that a WGP whose life experience was vested in raising a family and practising as a GP need not apply. As was the case for an academic WGP participant in this research, producing a large number of publications and attracting research grants were clearly the criteria for selection. This normative barrier (referred to in Chapter 4), largely explains the existing status of WGP's in contemporary Australian universities.

As Chapter 1 shows, women have been carers and healers since the Egyptian and Greek civilisations and throughout the era of the witches. The roles of caring and healing still remain very significant for WGP's. Wainer (2004) showed that the concept of being a healer "contributed significantly to satisfaction of female doctors"
and had a “positive but non-significant effect for men” (Wainer 2004, p. 18). It appears from the outcomes of the present research that the eminence of women as healers and doctors has changed little from the 13th Century, when licensure laws and the guilds in England and France prohibited women from the practice of medicine. Indeed, there has been slow progress for women in medicine in Australia:

Medicine is the same as ever isn’t it? The same hierarchical structure, with men dominating at senior levels; the same culture of heroic individualism; the same male-female inequalities with selection promotion, retention procedures; the same difficulties for women to reach their professional potential (Sewell 2001, p. 376).

Existing legislation requires that there be no discrimination against women (including WGs) and equal opportunity theoretically exists for all doctors in the medical profession. Women may study medicine and train to become GPs, but their progression into the most senior ranks of General Practice is slow and the profession appears to continue to be governed by masculine power and “the games boys play”. In this research some males and WGs claimed that either discrimination against women no longer exists or had never existed. If GPs do not have the experience of discrimination they tend not to believe it exists and have

...little reason or incentive to seek change...Not only do most men not experience a problem, they are apathetic or actively resistant to changing a state of affairs which...reflects and advances their interests (Sinclair 1998, p. 134).
Most women participants in this research suggested that WGPs who deny the existence of discrimination either have not experienced discrimination themselves or found that the existing "regime was to their advantage". Sinclair suggests that disbelief in discrimination is an individual response to personal circumstances and it confers further benefits on those who already have power and privilege. It "reduces the number of competitors and keeps the rules of the game insulated from challenge and protective of the majority" (Sinclair 1998, p. 136).

Significant critical literature indicates continuing practices conferring disadvantage on women in general and women professionals. This suggests women doctors continue to practice their profession under disadvantaged circumstances and there are existing barriers to the progression of women as health care providers, academics and scientists. These barriers continue to arise from

...entrenched social attitudes, outdated institutional systems, financial constraints, family responsibilities...discrimination continues to hinder women in their efforts to achieve and contribute according to their potential as health care professionals, academicians, and biomedical scientists (Pinn 2001, p. 81).

There has been little progress in removing these obstacles and both individual discrimination and subtle forms of institutional discrimination continue to persist in "gentlemen's agreements about the desirability of accepting women into certain specialties, departments and programs", and in the "differential promotion of men
and women physicians and discrimination in salary levels” (Shye 1991, p. 1169).

Brooks (1998) argues that even though the numbers of women in General Practice had increased, they had become “marginalised and ghettoized”. This was apparent in the present research where WGPs found themselves working for male GPs to provide patient care in the domains of women’s health and psychological or social health instead of providing a more diverse role of patient management within the practice. Thus WGPs provide patient care “which is largely located within feminised segregated niches” (Brooks 1998, p. 184). The phrase “ghettoism” has been coined for women doctors who see: “...specific categories of patients in a group practice for specifically women’s problems, psychiatric cares and paediatric care” (Miles 1993, p. 148).

Studies conducted on the organisation of work within medicine or primary care indicates that work is defined by a sexual division of labour (McPherson and Small 1980; Elston 1993). For women in medicine, the division of labour results in occupational segregation and women are under-represented in the top posts and proportionately over-represented within the lower ranks (Allen 1988; Riska 1988). Women have been directed to the softer caring aspects of medical work (Miles 1993), this work being thought to be suitable work for women and consisting of working with women and in child health:

Women’s careers in medicine appear to be limited by vertical
segregation, being concentrated in lower status jobs within occupations...and also by gheottoisation in that such jobs are differentiated by gender (Brooks 1998, pp. 181-184).

Reports from WGPs (employed by male GPs) in the research undertaken for this thesis indicated that they not only were presented with the gynaecological, social, emotional or psychological problems of women patients, but also with long and emotionally draining consultations. In the meantime their male counterparts engaged in the heroics of procedural medicine or clocked up numerous short consultations that are the “bread, butter and money for jam” of General Practice.

8.2 Relationships

In this thesis use of the term “partner” refers to the person with whom the WGPs cohabits, even though the WGPs participants in this research usually referred to their partner as a husband. These WGPs identified that the relationships in their non-professional lives that were most important to them involved their partners, children, extended family and friends. This echoes the claim by Gilligan (cited in Chapter 4) that it is relationships with others that are seen as central to life. As these WGPs attempted to coordinate the triple challenge (some times called the double day) “of combining career, family needs and the [often] conflicting demands of their partner’s career” (Turner et al. 1994, p. 130), their relationships sometimes floundered or failed. This naturally had dire consequences for their own health, well-being and
professional careers.

Individual WGPs need to be part of a community and have family, friends and colleagues with whom they can communicate and develop personal relationships that define who they are and what their worth is. They must be able to explore and clarify their own individual values, purpose and sense of identity. As MacKay (1993) argues, relationships determined the

...critical aspect of feeling in control of our lives [in] the knowledge that our lives are not lived in isolation, but involve sharing in a common experience with other people...the social context is essential for most of us to feel confident about who we are and what we are doing (MacKay 1993, p. 301).

WGPs participants in this research (especially in the Delphi study) lamented that their relationships were limited by a lack of time. They attempted to compensate by constantly juggling, trying to balance their professional and non-professional lives and avoiding the perils of role strain. Juggling, finding balance and role-strain have been previously documented in the literature as separate concepts important in the lives of women doctors. Since all these factors were seem as important to participating WGPs in this research, juggling, balance and role strain need to be considered together in evaluating their effects on the relationships and lives of WGPs.

8.2.1 Time Constraints
Richardson and Burke (1991) identified that lack of time was a key factor in the life of a physician, resulting in occupational stress and job dissatisfaction by both men and women. For women, the three stressors that rated most important were

...total hours worked, time on call and not finding enough time to keep up their own professional knowledge. The same concerns regarding time were reflected in what women rated least satisfying about medical practice, including lack of time for family and personal life (Richardson and Burke 1991, p. 1185).

Time pressures and overwork, such as "too little personal free time, continuous on-call responsibilities, and heavy work loads" have also previously been documented as sources of dissatisfaction (Mawardi 1979, pp. 1483-1484). Although time pressures and the threat of malpractice litigation were sources of stress, Richardson and Burke considered that over-all satisfaction was related to satisfaction with both professional and social aspects of the job (Richardson and Burke 1993, p. 811).

Australian studies also show that the fear of litigation and lack of time feature as key stressors in the lives of GPs:

The threat of litigation, work overload issues, such as time pressure to see patients, phone interruptions and too much work to do in a limited time, were the most common stressors for GPs (Schattner and Coman 1998, p. 136).
Time management strategies used by WGPs may be helpful to them, but the crux of the problem is that their professional and non-professional lives are over-full. Each additional activity or event that they try to squeeze into their lives, risks precipitating failure to cope. WGPs in this research found that one answer to the shortage of time was to reorganise their professional work, family and personal activities, so that their relationships and self-care became priorities.

Becoming workaholics, being influenced by the taunts of males GPs who criticised the WGPs for working part-time and not being “real doctors”, or conducting “boutique practices” brought WGPs misery. The prevailing attitude in this research regarding WGPs who worked part-time was that they were not “proper doctors”. The structural barriers to work that having children caused, followed the post World War II emphasis on families and the belief that a woman’s role was to stay home and look after the “kids”. As one WGP participant said “…women tend to take the lion’s share of the load of caring for kids”. The feminist movement of the ’60s and early ’70s started to change society’s attitudes to this belief, but it seems that the conservative medical profession take much longer for attitudinal change to filter through.

It would appear from this research and the literature that most male GPs have wives to care for their domestic needs, including looking after their children and sometimes looking after the accounts. This leaves time for the male GPs to do unlimited work, build successful businesses, and engage in the networks and organisations that boost their position and prestige in the profession and community. This issue is primarily related to power; as Hochschild and Machung (1989) noted, if men lose power over
women in one way they make up for it by e.g. avoiding the "triple shift" (Chapter 2).

In this way

...they can maintain dominance over women... How much responsibility these men assume at home is related to the deeper issue of power (Hochschild and Machung 1989, p. 221).

One rural WGP participant described how "all the blokes had a wife at home putting the dinner on the table, no matter what hour of night they got home". WGPs do not have the "luxury of a wife" to attend to the domestic duties and family since their husbands have careers. While the males often have someone at home to fill the role of mother and housekeeper, WGs struggle to fill both of these roles simultaneously. "Everybody needs a wife" and men have always known this:

No proper male physician lacks a wife to enable him to fulfill his multiple roles as doctor, pater familias and gracious host... Women physicians, no less aware of how useful it would be to have a wife, are at some difficulty in obtaining an unpaid domestic worker cheerfully willing to stoke the furnace, prepare gourmet meals on short notice, keep the children from underfoot, draw the bath and lay out the morning clothes (Eisenberg 1981, p. 84).

Until the community and the profession adopt the concept that child-bearing and fulfilling family relationships are valid and essential contributions to society, the tired and unproductive arguments and resentment of males to the way WGs conduct their
lives will continue. As Perry says:

The main challenge has to do with childbearing and child rearing issues that have not historically been of concern to male physicians because it has long been accepted that a man can easily be physician, husband and father (Perry 2001, p. 15).

8.2.2 Role Strain

The concept of "role strain" is frequently used to explain the problems women doctors endure in combining their professional and non-professional lives. Goode (1960) defined role strain as "the felt difficulty in fulfilling role demands" (Goode 1960, p. 483). Epstein (1970) cited by Ducker (1980) expanded the concept to describe

...the feelings of women professionals which result from the problems they encounter in their various roles...that from culturally based disapproval of the combination of the female status and certain professional statuses and that from the conflicting demands of the statuses of wife-mother and professional (Ducker 1980, p. 550).

The WGPs participating in this research experienced problems of role strain when male colleagues disapproved of their caring for a family and at the same time practicing as a GP. The WGPs, especially those working in rural locations, were expected to work at the same level of activity as the male GPs. This work included
sharing the duties of being on call, after-hours services and earning significant money to boost the practice income while not "dropping" their "share of the practice expenses". WGPs found that performing these professional requirements as well as their non-professional roles lead to exhaustion, ill-health, burnout and guilt. One WGP was told by a rural male GP that "...you will have to choose between being a doctor and a mother". This comment not only caused the WGPs enormous "role strain" but confirmed that WGPs were expected to fit into a masculine profession when in a rural environment. The WGP thought it would be very unlikely that anyone would tell a man "you've got to make a choice whether you want to be a doctor or a father".

One WGP in the research was told by a rural male GP that "... If you want to be a doctor sweetheart this is the deal". If WGPs choose to be a doctor and a mother they generally endure "the deal" so that they do not place an extra burden upon other GPs in the practice or seek concessions from male GPs. A rural WGP participant in this research who practised obstetrics found that when she was pregnant with her second child, enduring "the deal" was intolerable. The outcome was that her family left the town. Leaving the geographical area is sometimes the only alternative to resolve the situation. Unfortunately the patients in that location also lose their GP. Smithers-Hammond (1993) confirmed that role strain was the result of societal expectations, leading some women to push themselves to become "super-docs, super-wives and super-moms". Role strain is

...the conflict that results from having to choose among the
multiple demands of a career, the obligations that arise from being a mother and wife, and one's own needs. Society still expects women to be primarily responsible for the home and for children whether or not they have full-time careers. A woman physician must be a doctor, teacher, writer, mother and lover; each of her roles seems essential to her well-being (Smithers-Hammond 1993, p. 1591).

The conflict of role strain can occur between couples even though both parties make an effort. In such cases the women feel “overburdened” while the men feel “unappreciated” (Myers 1984, p. 1138). Some WGPs participating in the present research found that their combined roles as GPs, care-givers and nurturers equated to exhaustion for them, but to equality as seen by their male colleagues. Myers (1984) provided the following comment relating to three WGPs who suffered from role strain related to exhaustion as a result of combining their work with caring for their families:

Their husbands were not very empathetic and found it difficult to comprehend and respect the exhaustion associated with medical work. These women were expected to be always and immediately available to their families (Myers 1984, p. 1388).

In the course of this research one rural male GP explained that “unequal relationships” between a couple resulted in the WGP not having security, not being supported by her husband and not being able to share the domestic chores. These women suffered considerable role strain and “at the end of the day they go home and
to do the washing and cook tea, while their husband comes home and puts his feet up and drinks beer.”

8.2.3 Achieving Balance

In an Australian study of rural women Rourke (1996) noted that balancing marriage and medicine has a direct influence on the well-being of the women and their ability to manage work. In many cases, women did not to delegate these home affairs while pursuing their medical practice. However “among female physicians the presence or absence of role strain is associated with level of self-esteem and work satisfaction” (Rourke et al. 1996, p. 1064).

A number of the WGP's participating in the research felt that caring for a family and providing child-care should be a “more equal responsibility” with “both partners (not always women) making adaptations”. They also thought that “…women need to be taught that they have these rights” and men should cooperate with the women who are pursuing a profession and caring for a home and family. Firestone (referred to in Chapter 4) reinforces the notion that men must share with women the experience of child-bearing but unfortunately it seems that men and women rarely share domestic duties and child-care. To ease the stress and role strain that resulted from multiple demands South-Paul and Grumbach (2001) recommended adopting

…role cycling, adjusting expectations, developing support
networks, and selecting creative practice styles (South-Paul and Grumbach 2001, p. 282).

Life is a “balancing act” as the WGPs in this research discovered when they attempted to maintain equilibrium between time for themselves, for their children, for their partner, for their extended family, for friends and for their patients. Achieving the correct balance was important to the WGPs to protect themselves from burn out. Balancing their professional and non-professional life becomes especially pertinent as more WGPs are opting to have a family while continuing to work. Perry (2001) observed that:

As medical education and delivery methods change, expectations on the part of the public, the profession, and women themselves keep this issue [of balance] relevant (Perry 2001, p. 15).

Having balance in life is equally important for both female specialists and WGPs. Fye (2002) reported that although cardiologists may appear to have a “macho image” and the maxims “Service above self” and “Medicine is a jealous mistress” are intended to affirm altruism, the desire for balance between career and family life continues to grow as “...most male and female medical graduates are seeking better balance between their professional and personal lives” (Fye 2002, pp. 384-385).

Bruce (2003) confirmed that female consultants in Australia “face undue pressure in balancing their medical and domestic roles compared with male consultants” (Bruce et al. 2003, p. 174).
It was noted in the present research that one strategy employed by WGPs to achieve balance was to erect boundaries to protect themselves, their family and their other interests. In the Delphi study, WGPs said that they aspired to achieve and maintain a balance between their career and the demand of their partner (Kilmartin et al. 2002, p. 88). Male GPs are also attempting to introduce balance into their lives. In considering professional life and life in general, one male participant of this research commented that, "women appear...to be more effective [in achieving balance] than men but men are catching up". Both men and women are seeking "...a bit of balance in their professional and private lives, some sort of mixed role rather than being dominated by their professional roles".

As previously referred to in Chapters 1 and 3, Tolhurst and Stewart (2004) found that most Australian medical students in their study identified that balance in their work, family and lifestyle was an important factor when making decisions about their career and health. Some male students preferred to work part-time while the female students maintained that they would achieve balance by selecting areas of medicine where "limited-hours" of work were available. They also intended to seek help with child-care from their partners and parents (Tolhurst and Stewart 2004, p. 361).

The WGPs participating in this research found that it was often their partner who dictated where they travelled and lived so that he could train and work. The outcome was often isolation, lost qualifications, loss of identity and sometimes the cessation of the WGPs' careers. Young (2004) deals with the ultimate balancing act by dividing
the WGP's career into "acts" of professional life, each of approximately ten years in length. These acts take place in tandem with the WGP's private life and WGPs are encouraged to maintain flexibility in their professional and non-professional lives during each of these periods:

Balance is the key to life...The proportion of the involvement of the acts depends on our personal, family and professional commitments (Young 2004, p. 102).

Dickinson (1994) also noted that women who are the partners of medical men find difficulty in reversing the classic pattern of the (male) specialist going to train and work overseas "towing a wife who raises small children in the confines of the hospital residents' quarters while he studies and works on call" (Dickinson 1994, p. 636). With respect to the issue of balance for registrars, Shanley et al. (2002) in a study to evaluate factors in career choice of GP registrars noted that

...males placed more emphasis on autonomy and financial prospects whereas females rated family/domestic circumstances as more important...Different balances [were] struck by male and female former registrars in response to the demands of professional and family life (Shanley et al. 2002, p. 53).

The professional and non-professional lives of the WGPs taking part in this investigation were so tightly linked together as to be inseparable. One rural WGP noted that this was a major difficulty for women as their professional and private lives are "totally interlinked and the big issue is actually not being able to separate the two". Providing a balance between their professional and non-professional lives is a
key issue for WGP s. These WGP s know that they are bringing a balance to the medical profession and that in the future some general practices and medical organisations may have more WGP s than men GPs. This possibility concerns some male GPs who feel that this would create a lack of balance. These men choose not to reflect upon the inequities of the past when most practices and medical organisations were dominated by male GPs.

8.2.4 Equality and Equity

The male GPs interviewed in this research argued that WGP s wanted “equal opportunity” in the practice. The WGP s did not expect “any privileges” regarding taking a share of the work but it was understood that they did require “special needs” in order to care for their family. Some of these males did not identify what these “special needs” were but they alleged that time had delivered the “recognition of professional equality” to both sexes as WGP s made “special contributions” to female patient care which men “counterbalanced” with their service to male patients.

A common male GPs vision of equality for WGP s was to share the practice workload, take care of the delivery of health care to women patients, and at the same time care for their own family. These male GPs were exhibiting “false consciousness” regarding the state of equality for WGP s. The Marxist concept of false consciousness argues that the proletariat is misguided as to its place in the class structure (Science Daily 2004, p. 1). When this concept is extended to the position of WGP s in the class structure of General Practice and the medical profession, there is
clearly a disjunction between the real state of affairs and the way that equality for
WGPs appears to male GPs.

De Angelis (2000) maintains that achieving equity is the challenge for WGPs rather
than achieving equality. Sharing equality with men has not significantly advanced
the professional position for WGPs, but through justice and fairness WGPs can
achieve equity with male GPs:

I do not believe equal opportunity for women will ever be
possible. I would settle for equity that is, freedom from bias or
favoritism (De Angelis 2000, p. 426).

Reichenback and Brown (2004) claim that healthcare providers are not a
homogeneous group, but rather individuals who choose where and how they provide
healthcare. However, gender has an important role in this decision process and the
goal is

...not just ensuring equal numbers of men and women (gender
equality) but also guaranteeing fairness and justice in
professional opportunity structure (gender equity) (Reichenback
and Brown 2004, p. 792).

In the future, academic medicine (which includes education and training, research
and clinical care) must address the gender dimension of enrolment, curriculum and
promotion, just as in the past academic medicine addressed gender through
recruitment and policies for enrolment in medical education. This had the outcome of an increased number of women in medicine, but according to Reichenback and Brown (2004) these women do not occupy the senior and specialised positions of their male counterparts. Gender equity can address underlying injustices in the professional opportunity structure and presents a challenge and critical questions for decision-makers at all levels of academic medicine. However

...as a conservative, male dominated institution, medicine may not easily examine the gender dimension of its operation (Reichenback and Brown 2004, p. 794).

8.2.5 Juggling

The image of a juggler appropriately describes how WGP s deal with the complexities of “competing priorities” in their professional and non-professional lives. Juggling work and family life was one of the key issues identified by WGP s who took part in the Delphi study. Freyd (1990) deliberated upon juggling and concluded that the implications drawn reflected pervasive and destructive values about children’s needs, parents’ roles and what it means to be committed to work:

Saying that a working parent need only “juggle” his or her schedule and that “others manage it”... implies that parental responsibilities are comparable to activities that are inherently flexible, less important than work, or even dispensable as an athletic hobby, say, or a trip to Bermuda. It also implies that if the faculty member only had his or her priorities straight (like
the “others” who manage to juggle their schedules), parental responsibilities would not get in the way of professional commitments (Freyd 1990, p. B2).

A worrying issue for WGPs taking part in the present research was that children's sickness or family crises could not be scheduled in advance. Sometimes the WGP herself became ill or the employed child-carer unexpectedly cancelled. These situations left the WGP no option but to juggle her day as her parental responsibilities became paramount. A WGP who is faced with this dilemma requires flexibility in her workplace and help from her spouse. However, male partners are generally also employed (often in a professional occupation) and rarely consider themselves as being available, so the WGPs are left to cancel their patient appointments and other professional engagements:

Women physicians with young children must constantly juggle home and work responsibilities, and disruptions such as a child’s illness, can throw even the best planned schedule into chaos (Stewart et al. 2000, p. 188).

Women’s lives were described by one male GP research participant as “complex” and “chaotic” due to the “unpredictable forces” they have to respond to in their life. He claimed that “you’re not able to order [their] life as much as a male” and that there is a need for “moving into organisations that can tolerate that degree of...chaos and complexity”. Men are perceived (by men) to be able to operate an ordered life, whereas women’s lives are thrown into disarray as a result of the multiple and
compounding roles and issues that they have to contend with. Patriarchy prevents such men from understanding or assisting these women in their plight. Rather, they tolerate what they view as the chaos and complexity of a woman's life.

8.2.6 Having a Partner, Children and a Home

As previously identified in Chapter 4 of this thesis, the majority of WCPs participants in this research were responsible for “the lion’s share” of caring for their children as well as the domestic issues in their home. In New Zealand Heslop et al. (1973) found that motherhood was the main reason for reducing medical work, while marriage without children was associated with a relatively small work reduction (Heslop et al. 1973, p. 219).

Both Fett (Chapter 2) and Dennerstein et al. (1983) reported that “medical women performed almost as much domestic work as did the non-medical wives of their male colleagues” (Dennerstein et al. 1983, p. 41). Some WCPs participating in this research alleged that care of the children and home duties should be a shared with their partner, and a few women managed to achieve this through having a “house husband” or a supportive partner. This gives credibility to Symonds' (1983) contention that some women doctors validate their femininity by taking full care of children and a household and by being a "super-mom, super-wife and super-doc":

Most often she [the woman doctor] continues to function as the primary parent in taking care of [children]. She is the one who
stays home with a sick child, [and] interrupts her work for nursery school...The husband's professional activities or business life is rarely altered (Symonds 1983, p. 33).

In the present investigation it was evident that much energy was spent by the WGPs to ensure that sufficient and high quality child-care was provided for their children, regardless of the financial cost. They nominated this as a priority, asserting that a system needed to be in place to enable them to attend work, educational, professional and non-professional events. As Gautam (2001) said, "having children and raising them is one of the pivotal issues that separate women’s and men’s career experiences" (Gautam 2001, p. 39).

An academic WGP who took part in this research reported that in order “to be taken seriously” she had to recommence work in her university position on a full-time basis when her child was 12 months old. A component of the glass ceiling (described by Lorber in Chapter 4) for academic WGPs is that women are “held back in a chronological sense by their time out for child-rearing” and these WGPs are thought to be up to ten years behind males of the same age in terms of career development. Carr et al. (1998) confirmed that not only did academic women have particular difficulties in initiating and maintaining suitable child-care, but that female faculty staff with children face major obstacles in academic careers (Carr et al. 1998, p. 532).

The effect of having a child at the commencement of a professional phase in the life of women has been aptly described by Schwartz:
The one immutable, enduring difference between men and women is maternity. Maternity is not simply childbirth but a continuum that begins with an awareness of the ticking of the biological clock, proceeds to the anticipation of motherhood, includes pregnancy, childbirth, physical recuperation, psychological adjustment, and continues on to nursing, bonding, and child rearing (Schwartz 1989, p. 66).

Some organisations investigated in this research did not provide child-care for WGPs to attend organised work or educational events, even though this was “vitally important” for WGPs with young family. Catering for parental responsibility was seen by one male GP to be “giving people advantages” that they did not already have.

An example that arose in this research was that information provided to delegates at medical conferences sometimes states that provision is made for child-minding so that the wives of GPs could partner their husbands to social events. Alas, any consideration that many of the delegates were WGPs was overlooked.

A number of options were outlined by the WGPs participating in this research for accessing child-care. One method described (and referred to in Chapter 3) was to employ a nanny who lived in the WGP’s home. Some WGPs also employed a housekeeper to assist with the domestic duties. Employing a nanny is a popular method of child-care for WGPs in the UK, but in Australia the WGPs frequently carried the load of housework and child-care tending to “cling to the traditional housewife role”. A nanny sometimes helped to perform some domestic work as
well as caring for the children and a “live-in” nanny is generally able to child-care when a WGP is on call or is required to perform unscheduled clinical or professional work. As the scattering of WGPs in geographical areas distant from their extended family increases, the availability of family members to assist with child-care become markedly reduced. A major disadvantage of the nanny system is the financial cost. There is no financial relief in taxation concessions for WGPs for any method of child-care, and there is little, if any financial assistance to help pay for child-care, especially when the WGP works outside office hours.

According to Perry (2001) many employers in the USA provide child-care on site. This includes health care facilities, which have been at the forefront of this move. Because health facilities often have 24-hour staffing, child-care is needed around-the-clock for all employees. thus male physicians benefit as well (Perry 2001, p. 16).

If a WGP’s partner’s work is flexible, as it is for some men who run their own business, then these men may be able to take time off work to accompany their children to some event or place when a parent is needed to attend. Some of the partners of WGPs in this research had inflexible work schedules involving shift work or travel away from home leaving them unable to contribute to child-care.

To provide more options for child-care for the growing number of WGPs, the practical and philosophical suggestions outlined in the Harvard Business Review for business-women might be recommended to Australian governments, communities
and the medical profession:

The decision to become involved in the personal lives of employees is no longer a philosophical question but a practical one...the quality of child care has almost no relation to technology, inventiveness, or profitability but is more or less a pure function of the quality of child care personnel and the ratio of adults to children. These costs are irreducible. Only by joining hands with government and the public sector can corporations hope to create the vast quantity and variety of childcare that their employees need (Schwartz 1989, p. 74).

Some of the participants in this research said that WGPs were responding to their biological instincts by having children, and perhaps as a result tended to underestimate the "massive impact this has on their lives and professional careers". Firestone (cited in Chapter 4) saw biology as a cause of women's oppression and this was socially institutionalised in the interests of men. According to Lefford, the establishment has also used this instinct to explain the under-achievement of WGPs since "women do not aspire to prestigious posts in medicine" (Lefford 1987, p. 1255). As was seen in Chapter 4, this statement is a reiteration of Parsons and McClellend's (1960) belief that women were limited by their "natural inclination towards domesticity" and their role as wife and mother was dictated by biologically based psychology. These sentiments were certainly not those of the WGPs interviewed.

The sex/gender distinction was used by feminists in the late 1960's and 70's to dismiss the notion that biology was linked to destiny, by arguing that gender was
linked to socialisation and hence open to radical restructuring. This is seen in Chodrow’s developmental model (discussed in Chapter 4) which argues that females develop a greater sense of connectedness to others whereas males emphasise separation, autonomy, and ego boundaries. This sex/gender distinction allowed women to achieve separation between nature and culture and between their biology and their socialisation.

Despite this Eisenberg (1981) considered there was a link between biology and destiny for women:

> There is no denying that biology does affect destiny. Because it is women who become pregnant and give birth, a biological fact, and because it is women who continue to assume the major responsibility for child rearing, a social fact, it is they who are far more concerned with the impact of parenthood on career directions (Eisenberg 1981, p. 48).

For some of the WGP's participating in this research traditional opinions prevailed regarding their position in the profession, but the mindset of many of them was changing toward a less confined and a more flexible lifestyle. No longer do WGP's think that remaining single is a requirement for training for, and practising medicine. One or the research participants related that past generations of medical women accepted that “nobody got married during their undergraduate years” and marriage and parenthood was delayed until “they had finished their postgraduate years”.

Indeed women who wanted to become specialists expected that they would “not have
children for the rest of their lives”. Unlike past generations of medical women and women in science, the younger WGPs in this research investigation married in their undergraduate years or during their postgraduate training. Marriage was definitely not on the agenda for pioneering scientists such as McClintock who was “threatened with firing” by a misinformed departmental chair who thought that she had become engaged (McGrayne 2002, pp. 47).

As reported in Chapter 1 Cole and Zuckerman (1987) examined the consequences of marital aspirations for women in science and medicine in past generations. As they argue, in the early 20th Century marriage for women in science or medicine was seen as “treason”. They had to “go into a shroud”, not “wear normal clothes” not “get married” and not “have children” (Cole and Zuckerman 1987, p. 85). This community mindset regarding the role of the professional woman has changed, however some current elders of the medical profession have been slower to comprehend this change or come to grips with it. The concern is that many of these elders of the profession are those with most power and they can and do make adverse decisions regarding WGPs in their employment:

The elders of the profession seem unaware that society is changing: the working wife or mother had become an economic necessity in many homes; family life is more changeable, with a high divorce rate and second families a frequent occurrence; single parents of either sex bringing up children alone are common. Men are now more willing to share household duties and child-care. This change may arise out of respect for the
professional training and aspirations of the female partner (and her potential earning power) or simply out of the desire to share the pains and pleasures of a close relationship with one's own children (Lefford 1987, p. 1255).

The effect of marriage on work and mental health is different for women and men. Apparently marriage brings many benefits for men but fewer for women. According to Eisenberg (1981) when married women are employed outside the home, they report fewer depressive symptoms than housebound wives, but still considerably more than single women:

Being married is a powerful protective factor for men against many sources of morbidity, including psychiatric disorder; married men experience lower rates of depression than single, separated or divorced men. For women marriage acts more like a stressor than a support. Married women not only have higher rates of depression than married men, but also than never-married women; the status of divorce and separated women relative to married ones is more uncertain (Eisenberg 1981, pp. 84-85).

The relationships of WGP registrars participating in this research were often placed under stress by the combination of their work and study for exams. Other WGP participants reported that their social and domestic relationships were jeopardised to such an extent that their relationship with their partner was severely threatened. One WGP who was working extended hours and also studying found that she was being "left off the list" when her partner was invited to social gatherings. Confronted with
this, her partner told her to “pull herself together” otherwise he was “leaving the relationship”.

WGPs risk damaging their relationships and personal lives in the same way that some men have done, either by undertaking excessive work or major roles in political and professional activities. Their children grow up without knowing their mother and their relationship with their partners is strained unless there is support and understanding. Barrand (1987) writes:

Worst of all, he has a mistress already, *Medicine*. She is an impeccably discreet mistress whose courtship brings approbation, acclamation and the slow, insidious destruction of relationships at home...The only things that matter to him are his patients (Barrand 1979, p. 667).

Setting priorities regarding the family, work and relationships is an essential part of maintaining a marriage or partnership. Taking time to nourish a relationship or “sharing the zeal” between a couple is paramount. The male partner and family members must respect the WGP’s professional and non-professional activities and give her the time and space to conduct these activities. Without this respect and consideration WGs had little time for

...family, friendships, hobbies and personal activities. A direct result of this can be the feeling of isolation, loneliness or inadequacy (Bowman and Allen 1990, p. 118).
WGPs in the present investigation wanted to define relationships with their partners in a “pleasant and asserting way”. Some WGPs had partners who supported them and helped them perform domestic chores. Others were in an “unequal relationship” with their partner and bore the brunt of all the housework while maintaining a pleasant exterior and accommodating their husband’s demands. It appears that these unequal relationships are often sustained by some WGPs simply to keep a partner. The consensus appeared to be that men negotiate relationships and support for some domestic issues with women, while women support their male partners “unreservedly” and provide support for everybody else at the same time.

Having a wife at home to cater for his needs and care for his children is the good fortune of many male GPs. Some of the WGPs felt that it was difficult for men to accept the professional roles of their wives, and they had difficulty in dealing with successful wives, especially if her income was greater than his, or if he was unemployed. Unemployment of the male partner is a significant problem especially when a husband accompanies a WGP who is spending time training or working in a rural area where the male is unlikely to be able to find work.

WGPs who were married to other GPs sometimes worked together in a partnership at home and in clinical practice. They shared their professional and non-professional duties and found this a satisfactory arrangement. Despite the benefits of dual-doctor families Sobecks et al. (1999) point out that the professional and family lives of male and female physicians continue to reflect dominant gender roles, but also claimed that
...marriage between physicians is associated with higher family incomes, more enjoyment and satisfaction from shared professional interests, and more involvement for child-rearing for both partners (Sobeck et al. 1999, p. 318).

It was encouraging to note that the WGP's who took part in the research and some younger male GPs were not prepared to risk their relationships by working long hours or to have extensive involvement in professional and political pursuits as previous generations had done. The younger generations appear to openly discuss their relationships and the interface between the workplace and their families, whereas older professional GPs tend to leave their personal problems at home:

It may be peculiar to this under-35 generation but there does seem to be a difference in their approach to marriage, in their openness about the strains and difficulties they expect, their willingness to talk about relationships - probably because they are used talking to each other about what they want from their marriage and career (Bell 1996, p. 9).

In the past men have not had the commitment of nurturing the family that WGP's have had. It is the WGP's who bear and nurture the children and care for the sick, aged and dying:

...Because they give birth, women, who symbolize fertility, have been made responsible for every aspect of life dealing with fertility: rearing the newborns, but also nurturing nourishing and nursing so as to promote growth and development of the
8.2.7 Self-Care

In this thesis WGPs were seen to have shared similar interests as men before having children and in the years beyond their major family caring duties. However as their commitments as GPs, care givers and nurturers of families grew, they found that life as a WGP was a “hard row to hoe”. “Equality equated with exhaustion”; some WGPs experienced “burn out” and others came close to the breaking point. The WGPs frequently referred to the long complex and emotionally demanding clinical consultations that left them drained.

Exhaustion has previously been referred to but it is important to consider the link between exhaustion and burn out. Burn out as a syndrome has been characterised by emotional exhaustion, depersonalisation and a decreased sense of personal accomplishment. The key to burnout is emotional exhaustion which is caused by “excessive psychological and emotional demands that leave individuals feeling drained and depleted” (Deckard et al. 1994, p. 746).

Some WGPs participating in this study gave examples of both depersonalisation and burn out. One WGP spoke of being stalked by a patient with whom she became too closely involved. A male colleague with whom she discussed this problem explained that he remained detached to avoid becoming too involved although he acknowledged that withdrawal led to cynicism. Deckard et al. (1994) claim that depersonalisation
refers to an attitude that may arise as a means of protection against further emotional drain. Although some degree of emotional distance or "detached concern" is appropriate for effective performance, the excessive detachment associated with depersonalisation is characterised by callousness and cynicism. Burnout and lowered feelings of personal accomplishment reflects feelings of inadequacy and diminished competence (Deckard et al. 1994, p. 746).

Medicine is evidently a difficult and stressful profession and families and husbands can exacerbate the problem, especially when the husband is a full-time professional. The WGPs participating in this research study took seriously their responsibilities for caring for the physical and psychological well-being of their husbands and children while managing their own lives and looking after patients in their practices. This was largely achieved without appropriate support from the men in their lives. Both Smithers-Hammond (1959) and Riddle-Brian (2001) consider that having a supportive husband is protective to the health of both partners:

Marriage plays an important supportive function that contributes to well-being. It offers a secure base, intimacy, attachment, and connectedness. A strong marriage can buffer against depression and low self-esteem (Smithers-Hammond 1993, p. 1959).

The most important non-professional issue identified by the WGPs taking part in the Delphi Study was self-care, yet they were slow to give a high priority to their own self-care even when one local branch of the Medical Women's Society offered some of them the opportunity of going to a health farm for a weekend. These WGPs
argued that their perceived family responsibilities stood in the way of their taking up this offer to trial self-care.

WGPs in rural and remote areas experienced particular difficulties in practicing self-care and accessing health services such as gynaecological and psychological care. They had to travel long distances to find health carers who were prepared to see them. Some found that they had nowhere to go and nobody to go to in the local area when they suffered psychological or mental health problems. Their rural colleagues were not supportive and regarded them as “neurotic” or “looking for sympathy”. If it meant a WGP was going to drop out of the after-hours roster and therefore increase the work of other doctors, none of her colleagues were sympathetic. In such situations the WGPs confessed that they would rather be unemployed than feel ill and disenfranchised. Some rural WGPs reported that they began “cracking up” when their workload became intolerable or when they were working in an unsustainable practice position. Two collected their families and left town, while others found solutions through job-sharing with other WGPs, ceasing obstetric practice, or “coming off the after-hours roster”.

A few of the rural WGPs taking part in the research suffered verbal abuse after requesting that they take time off the after-hours roster because they were pregnant. This request raised the ire of their male GP colleagues especially when this was a second pregnancy and the WGP had made a similar request with her first pregnancy. The male GPs felt they had already made sufficient concessions. This opposition is very traumatic for a WGP especially if she is the only WGP in the town and also has obstetric patients.
Significant guilt was felt by WGPs if they thought that they were not fulfilling their professional roles to their own set standards, or that they were not doing their share of on-call work. Other causes of guilt for WGPs in this research investigation included not being home for the children, having a messy house, not having time to pay their bills, not caring for their partner or meeting his needs and desires, not taking part in professional activities and not being a super-woman. As Symonds (1983) noted:

> It is not only that a professional woman is impelled to divide her time and energy to cover both home and work, but also that, unlike the male professional, she is constantly beset with divided loyalties and a sense of guilt (Symonds 1983, p. 32).

Australian GPs who worked part-time were found to suffer less stress related to time-pressure than those working six or more sessions per week (Schattner and Coman 1998, p. 135). The combination of high workload, pace of work, lack of individual control or influence on decision-making plus lack of opportunities for skill development is reported to contribute to an increased risk of ischaemic heart disease and increased mortality (Michie and Cockeroff 1996). High workload (aggravated by time pressure, monotonous work and lack of social support by colleagues) has also been associated with other forms of ill-health such as musculo-skeletal disease (Michie and Cockeroff 1996, p. 921). Stress at work was consistently related by women doctors in the UK to lack of control over their working environment (Allen 2005, p. 570), a recurring theme in this study. Clearly a culture-shift is needed from male-oriented patterns of excessive work to one that incorporates flexibility,
teamwork and satisfaction.

At the time when this thesis was being undertaken the RACGP published *Emotional Health: The Conspiracy of Silence among Medical Practitioners* (Clode 2004), focussing on the health issues of GPs. This publication is a positive step towards addressing some of the issues relating to self-care for WGP s. Ensuring the continuing good health of WGP s will enable them to continue to provide valuable contributions in General Practice and demonstrate models of self-care for the next generation of WGP s.

8.3 WGP s in the Professional Workplace

The WGP s who took part in this research experienced a mix of responses regarding their activities in the General Practice and professional workplace. Their niche in the professional workplace was severely affected by gender differences and the dominance of men. Masculine models of practice and patriarchal attitudes are powerful forces that govern how WGP s are viewed by themselves and others. Masculine control in the workplace and society influences issues of pay, working conditions and recognition of the contributions of WGP s. As narrative theorist Nelson said, one's life is governed by oneself and others in the light of how we are viewed in society:

> How freely we can exercise our moral agency is contingent on a number of things. Most broadly, it depends on the form of life
we inhabit: the niche we occupy in our particular society; the practices and institutions within the society that set the possibilities for the courses of action that are open to us; the material, cultural, and imaginative resources at our disposal; the constraints arising from the moral flaws within our roles and relationships; the shared moral understandings that render our actions intelligible to those around us. More specifically, the extent to which our moral agency is free or constrained is determined by our own and others' conception of who we are (Nelson 2001, p. 11).

How WGP's in the workplace are seen is influenced by historical, sociological and environmental factors. In Chapter 4 feminist authors Millett (1973) and Walby (1990) claimed that patriarchy related to the gendered domination and male authority that controlled women's lives and social institutions. This was seen in this research in “how women are perceived as knowledgeable compared to men” and “how women have to gain higher levels of education and qualifications to occupy the same positions as men”. According to Loutfi:

Women are often better educated and qualified than men in the same job. Having to work harder and perform better than their male counterparts in order to move ahead are also characteristics frequently cited (Loutfi 2001, p. 244).

Parsons (1955) (Chapter 4) predicted that with fewer children born earlier to women, women would enter the workforce once the children became independent. He claimed that this would not change the role of the male as the chief income provider for the
family or that of the female as wife and nurturer. Women would continue to view their roles of caring for children and performing the domestic work as their primary responsibility and performing their paid roles would be a secondary consideration. The jobs women entered would have lower status and pay than their male counterparts. Parsons assented to the inequalities of power, access to resources, and life-option that this gendered division of labour perpetuates (Parsons and Bales 1955, pp. 12-26). Indeed, Parsons's prediction has proved generally correct, since the WGP's taking part in this research put the responsibility to their children above their professional work. They also experienced lower status and pay than their male peers, as well as the inequalities of power in their professional and non-professional lives.

As Rowland (1988) says, gender, power, sexual domination and patriarchy influence the lives of women in the workplace. In the 1990s feminist theoretical writings explored women's and men's paid and unpaid work with a view to gender equity. Millett (1972) declared that women's oppression was buried deep within patriarchy's sex/gender systems while Walby (1990) claimed that the power relations in patriarchy are not universal in strength or direction. According to Game and Pringle (cited by Rowland 1988 in Chapter 4) masculinity and femininity are socially constructed in relation to each other, and so are women's and men's jobs. Gender is fundamental to the way work is organised and work is central to the social construction of gender. Gender is essentially about difference, power, the domination of men and subordination of women, and change in the workplace depends on whether patriarchy's sex/gender system can be modified. Essential for change to occur is need for males to share prestige and power with their female peers.
A review of the critical literature and the wisdom of the research participants suggest sexual domination of women by men in the workplace may be subtle and not always overt. Control over women is achieved by exerting personal power over the individual, technical control of machines and bureaucratic control of organisations. Bureaucratic control gives power to the employer over women, especially those who work part-time, as many of the WGPs in this research did. This control is primarily achieved through rules in organisations, or General Practices, job description procedures, and evaluation of the workplace of General Practices through accreditation. GPs must pass the FRACGP examination in order to practice unsupervised, and QA and PD processes must be continued on a triennial basis. The sexual division of labour is also maintained through sex-labelling of jobs. As this thesis shows in General Practice, performing pap smears is an example of a sex-labelled job, one that is directed to the WGP in the practice.

Some WGPs in this research chose to work in part-time positions in order to provide flexibility in their professional and non-professional lives. However, part-time working conditions are poorer than those in full-time, with fewer non-wage benefits and less training or advancement (Rowland, 1988). Employers also have fewer obligations to part-time employees and restructuring of the workplace to suit the needs of women working full-time can be avoided. Rowland (1988) described women as a "free floating labour force" which is increased or decreased as appropriate by the male-run organisation (Rowland 1988, pp. 102-106).
A survey conducted by Mazza and Northfield (2000) showed that negative attitudes toward part-time work stemmed primarily from those GPs who had never worked part-time, those currently working full-time, those over 55 years of age and male GPs (Mazza and Northfield 2000, p. 903). In an AMWAC study this opposition to part-time work was highlighted by an interviewee who said that “one is not a doctor unless one works full-time” (Australian Medical Workforce Advisory Committee (AMWAC) 1998, p. 8). These attitudes are both cultural and generational and typical of how General Practice has been conducted, because traditionally a full-time workload is primarily undertaken by men. As these men have grown older, their attitudes have not kept pace with those of society. WGPs and young male doctors are increasingly adopting part-time practice as a way of enabling them to function as whole-persons in their professional and non-professional lives.

8.3.1 Women’s Work and Men’s Work

The characteristics of men’s work as described by Rowland (1988) include: “...the pursuit of advancement; an unbroken record of work [and] hierarchical structures”. In addition men show self-interest in the workplace and the male stereotype creates a “harsh, competitive, uncaring” work situation (Rowland 1988, p. 96). Women’s work is more multifaceted as their professional work is entwined with their domestic work, child bearing and caring. Rowland (1988) says women’s work differs from that of men in the dimension of time (age, marital status, the size and age of family) and space. This has been borne out by the WGPs in the present investigation; they were expected to perform work in men’s space doing the professional work that men
do, as well as some work that the men call women's work, namely the care of women and children. Women's skills lead them to work in caring work areas which include the elderly, those with mental health problems and the socially disadvantaged. The work that WGPs perform constitutes an asset focus, which Riska describes (Chapter 4) as a second strand of socialisation theory as applied to the medical profession. As seen in this thesis, WGPs conduct complex, long consultations which had the effect of freeing up the men so that they can do multiple short consultations and procedural work.

At home WGPs are generally expected to perform more women's work in the form of unsupported domestic labour. This constituted another area where the continuation of gender and sexual inequality is perpetuated. As Oakley suggests (Chapter 4) housework (unlike work in paid employment) is a component of the feminine stereotype that society discounts as work. An alternative interpretation of WGPs isolation as the primary source of housework and caring for a home is Riska's normative barrier theory (Chapter 4) which focuses on the socialisation process that shapes gender traits or gender roles. It assumes that women have been socialised in ways that stress the conformity to traditional female values of home, family and children.

This research has shown that WGPs build an emotional support system for their husband, family and the extended family. Alston. (Chapter 4) noted that the stereotypical position of women in the family explains the family as a haven and emotional refuge because it is women who provide this refuge. They are
"confidants", "soothers" and "emotional shock absorbers" and as has been observed, for women the emotional and sexual bonds seem harder to break away from than their economic dependence and exploitation in the workplace (Rowland 1988, p. 99).

Some participants in the present research expressed their optimism regarding the position of WGPs in the workplace and thought that "medicine had lead the field...in providing support for women particularly in General Practice". One male GP's participant expressed his appreciation of the work that WGPs perform by saying "...in General Practice females have a better capacity to provide the sort of care that you regard as being the ideal comprehensive whole family care...female GPs have unique qualities, which I think lend a lot to General Practice". However, this male GP was quick to exploit the WGPs' unique qualities for the benefit of his own practice by saying "...It's great to be able to take advantage of [those qualities] and use [them] within your practice".

In contrast some male GPs thought that increasing the numbers of women in General Practice (which they referred to as the feminisation of the GP workforce) cast General Practice into a position of low pay and low value status in comparison to other professional sectors. It was also suggested by some of these male GPs that medicine could divide into a male dominated specialist division and a female dominated General Practice division.

These male GPs were more concerned that the part-time mentality of WGPs and increasingly "men doing the same thing", could result in danger for General Practice
where GPs would divide into “the traditional professionally orientated GP” and the “part-time hobby GP”. They felt that having two classes of GPs may possibly “retard” the progress of General Practice compared with other professions. In addition these men thought that “by making academic training for women less rigorous because of their femaleness” there was a “danger of lowering standards”. There is a continuing fear among these men “that medicine may become devalued as a pink collar profession” (Ross 2004, p. 2).

Lorber (1998) (Chapter 4) argues that female-specific skills are grounded in patriarchal gender systems that assigns women a subordinate position in society, a claim strongly supported by the WGP participants in this research. Male GPs are concerned with economic, technical aspects and the status of General Practice while WGP are concerned more with human relation. The position that WGP occupy in the division of labour is described in Chapter 4 as having a deficiency focus, which highlights a lack of competitive traits, a lack of standards and a trend away from long hours at work.

8.3.2 Women in the Medical Profession

The perception of one male GP was that the entry of women into the profession had meant that their attitudes had “coloured the profession as a whole”. Such beliefs create an atmosphere of distrust by men regarding women in the medical profession. A few male GPs participating in this research were “terrified” when the WGP “talked about their intuitive behaviour”, as if intuition was something that they could
Intuitive behaviour is not based in evidence nor is it supported by science and therefore men think it cannot be regarded as valid. Yet intuitive behaviour is part of “women’s ways of being” and the way that they deal with their life. The medical profession has been slow to understand and validate that looking objectively at “the way you run your life” and what you’re “doing to your family” and how you are “addressing your work” is a “perfectly reasonable way to live your life”.

The WGPs participating in this research thought that men should be adopting more of the values that women display rather than trying to analyse and find an explanation for intuitive behaviour or find ways to disregard such a notion. Little (Chapter 4) noted that feminism supports the belief that women’s lives and experiences constitute a legitimate way of perceiving the world. Women’s actions and concerns must not be judged by male experiences and preferences, where dominant notions become social norms.

Denekens (2002) explains that feminisation has two meanings “firstly it means an increase in the number of women and secondly an increase in femininity” (Denekens 2002, p. 5). The male GP participants in the present research generally used feminisation to mean an increase in the number of WGPs rather than a reference to femininity. As Brook (1997) notes, although masculinity and femininity are both cultural constructs this does not mean that they are simply equal but different. In writing The Second Sex the French feminist philosopher Simone de Beauvoir declared, “one is not born a woman but becomes a woman”. Woman is constructed
as the "Other" of "man". "Woman" signifies a negative or an absence rather than a presence with any autonomous being (Brook 1997, p. 105). In contrast, as noted in Chapter 4 man is the one who determines that meaning of existence while the "other" is limited by this philosophy. The challenge for women is to conquer their limitations as the "other" and be able to make their own choices in their professional and non-professional lives.

The majority of WGPs participating in this research were not involved or interested in politics or positions of control in professional organisations and Colleges. One male GP was concerned that WGPs were not in tune with politics or positions of power and consequently may not fight for the future of General Practice. He thought that specialist women were "more feisty" and more prepared to stand up and argue for their Colleges. A suggestion made in this research to encourage women to become involved was that organisations should "head hunt" women who are "forthright" and prepared to "take a stand". These women needed to become central to the "power structures" of organisations and they must be mentored to "lift their game politically and educationally".

The WGPs taking part in this research were seen by the "hard right wing" of some professional organisations to be "too soft...give in too easily and [be] too cooperative". The men wanted women to act as they did, but it did not occur to these men that women want to "do it on their own terms" and in their own way. WGPs do not wish to be "honorary men" and men should not expect it of them. As one WGP participant said, "the women [that men] take notice of are really atypical, because
they wear the pants in the family”.

8.3.3 WGPs Owning and Managing a Practice

As shown in this thesis, in General Practice there are (usually male) GPs “who put their money into the ownership of a practice” and GPs (usually female) who don’t. These male GPs were seen to be taking a financial risk and a life-time commitment by buying practices and working full-time. As a result of this they became the major decision-makers in General Practice.

Men have also traditionally been the entrepreneurs of General Practice. According to Reed (1996) entrepreneurship is a capitalist socio-political concept that marks the emergence of public patriarchy. “Masculinity and femininity are reproduced through structural separation and few women engage in entrepreneurship which continues as a ‘normal’ masculine domain” (Reed 1996, pp. 103-104.). With some exceptions the WGPs who participated in this research were not comfortable with entrepreneurial models of practice that showed patriarchal and masculine structures and norms. These WGPs demonstrated a style of practice that was different to the male models, preferring “more insightful and thoughtful” workplaces, while avoiding conflict by “building consensus and a happy working environment”.

Some male GPs that were interviewed accused WGPs of not taking financial risk and making the life-time commitment of owning a practice. They said that WGPs “just want a salary, an hourly rate, to work part-time and then go home”. One male GP
participant viewed WGP employees working less than full-time as “the rest” who came in for convenience. As discussed in Chapters 1 and 2, these WGPs were seen as the “second-class citizens” of General Practice and excluded from decision-making processes.

Like WGPs, an increasing number of male GPs do not wish to be “condemned to a life-long 70 hour week” and like the WGPs, they are accused of taking advantage of “a model of convenience rather than a model of life-time commitment or financial risk”. The male practice-owners felt that WGPs “could not hope to have it all”, meaning working part-time while having someone “benevolent” own and run the practice. However true partnership models allow both growth in the practice and staff satisfaction. As seen in Chapter 3 fewer GPs of either sex now want to own and manage a practice and more want to work part-time.

The reason that WGPs found it more difficult to commit their money to a practice was because they had financial commitments at home or their husbands were likely to be transferred to another geographic location. WGPs were consequently employed as assistants in a practice as the practice superiors were reluctant to include women as practice principals or owners. Even though the WGPs participating in this research saw themselves as “marketable commodities” they were often not included as practice principals. It is also still uncommon for WGPs to become practice principals by joining with other WGPs to form a group practice. A structural barrier for two WGPs who attempted to establish their own practice as recently as 20 years ago took the form of a financial institution that did not wish to advance finance to them to
establish a practice unless they had a male guarantor. This has thankfully now become less of a problem in Australia.

As already noted in this chapter, most WGPS taking part in this research considered that they conducted a different style of practice to that adopted by male counterparts. They reported that practices owned and managed by WGPS sometimes followed male models of practice management, and these often appeared “dogmatic and directive” and more likely to have an element of conflict. In contrast, WGPS were seen by (some) male participants in the research as being more “insightful, thoughtful, industrious” and would avoid “conflict to a degree men wouldn’t tolerate”. It was also said (by the males) that WGPS built consensus and created a happy working environment for the staff and doctors. One male participant in the research commented that this was a “superior” and “very egalitarian” process. South-Paul and Grumbach (2001) confirmed these sentiments, noting that

...female physicians tend to attract more female patients, and they deliver more preventive services than do male physicians. Patients of female physicians may place more value on different aspects of the physician-patient relationship than do patients of male physicians. For example, patients of female physicians tend to have a higher level of complex psychosocial problems, and they value more time with and explanations from their physicians (South-Paul and Grumbach 2001, p. 282).

The Essentialist Approach (Chapter 4) suggests that professions and professional practices are linked to male and female cultures. Radical feminists view the medical profession as patriarchal with masculine ways of organising work. In contrast a more
moderate position is adopted by Reskin and Roos (1990), who maintain that women bring to organisations and practice workplace qualities that men appear to lack, namely empathy and a people-oriented leadership style. These qualities can make organisations and practices less hierarchial, and more team oriented (Reskin and Roos 1990, pp. 50-51).

One male GP participant said that WGPs had key issues that were “exactly the same as male key issues”, namely how to practice their profession effectively and be “good at the job”. This comment demonstrates a lack of understanding of the roles of WGPs in their professional and non-professional lives. It was assumed that WGPs work in a masculine model and therefore have the same requirements and values as men do. However the WGPs interviewed in this research made clear that their key issues regarding General Practice were about working “within a community”, providing “holistic health care”, exchanging “warmth...emotional commitment, communication and discussion” with patients. WGPs are interested in doing “different things” rather than “doing lots of procedures”. Even though the “medical process” is “quite a leveler” and “quite uniform” and WGPs want to work not only on a “one-to-one” basis but also with a community; “women see it collectively”. As Redman et al. (1994) noted:

Women were more likely than men to perceive that the type of patient contact and the opportunity for holistic care were important in career choice (Redman et al. 1994, p. 369).
Some male GPs interviewed as part of this research thought that those women who had never owned or managed a practice did not have “the knowledge” to operate a viable business, or that WGPs did not have the “training or education” in business matters to know the “ins and outs” of managing a practice. Clearly some male GPs thought that lack of expertise in practice management was a particular problem for employee doctors. One male GP said that to be able to run a practice WGPs had to demonstrate that they shared his “attitude” to the financial and administrative matters of a practice. In his view WGPs had to be responsible for the practice’s “financial well-being and the hiring and firing of staff”. The also had to charge the appropriate fee to the patient when they conducted long consultations and went “over time” as it was “almost like pulling teeth to get female GPs to charge for a long consultation”.

Overcoming the patriarchal attitudes held by male GPs regarding WGPs’ ownership and management of a general practice is a significant problem for WGPs who strive to develop expertise and credibility in running a practice.

The WGPs participating in this research acknowledged their need for education and training in the many aspects of practice management including human resources, writing position descriptions and marketing. They did not share the opinions of the self-appointed male experts (referred to above) who judged that they were unable to manage a business. However, they were wary of a new breed of practice managers in General Practice who dictate the day-to-day running of the practice in order to make the business a financial success. What was practice-management is becoming policy-management as general practices go thorough the process of practice accreditation and operate along commercial lines:
The general practitioner's needs are second to those of business managers who have become slaves to legislative conformity. GPs no longer have support staff to help them provide quality care; rather...the doctors assist the administration in toeing the company line...Time has become the single most valuable commodity. Quality care comes a distant second to the commercial interests of the firm (Lipscombe 2003, p. 51).

Practice administration issues are traditionally not taught to medical undergraduates, causing graduate GPs more stress than issues of clinical competence (Schattner and Coman 1998, p. 136). Job shadowing is a one-on-one participatory activity that allows a person to spend time with a host professional in his or her day-to-day working environment. As an experience-based learning activity, job shadowing enables a person to gain insights about career and professional environments as well as gaining personal interaction with the professional host (Gordon 2005, p. 1). Job shadowing is a flexible way to broaden one's occupational skill base, develop one's career and to experience business practices. As Kolb's model (described by Bruce and Roberts) shows, this experience can be transformed into a deeper learning experience by a process of critical reflection, whereby the learner contemplates what has been observed and makes an assessment about the host's working style and interpersonal skills. In addition a situational analysis is undertaken. These components form an action plan that is implemented in the learner's own workplace or used to further develop their personal career (Bruce and Roberts 2005, p. 3). A job shadowing program would enable WGs to gain the necessary knowledge and confidence to manage a general practice.
8.3.4 Job Satisfaction

In the Delphi study undertaken as part of this research, the WGP's rated job satisfaction as their highest key issue in their professional lives. Job satisfaction revolves about the amount and quality of work and having opportunity for creativity and autonomy. It also depends upon the WGP's having the time away from professional work so they are able to take up practices of self-care and hence have the energy to carry out professional work without feeling stressed or ill. Appleton et al. (1998) considered that women were more satisfied with their work than men, but no less stressed:

Greater job satisfaction might be explained by the fact that women, on average, work fewer hours, spend less time on call, and use deputising services more often (Appleton et al. 1998, p. 1061).

When reviewing the "paradox of the contented female worker" Phelan (1994) found that although women's jobs have lower pay and less authority than men, they are equally satisfied with their jobs and employers (Phelan 1994, p. 95). Possible explanations for this paradox are that women's work rewards are perceived as equitable, men value pay and authority more highly than women do, and satisfaction is determined by subjective job rewards rather than by salary-related factors. Phelan's results suggest that there is a disjunction between objective rewards and subjective satisfaction that may impede progress toward gender equity.
8.3.5 The Macho Approach to Work

This research showed that training in medicine had instilled a “subtle macho approach to work”. According to some male GP interviewees, life as a GPs consisted of “long hours of work such as a sixty-hour weeks, no complaining and sometimes no pay”. They said that that is “how it is” and “if you are not good enough to do that, you get out and do something other than medicine”. This macho ideal was extended by male GPs to being a “good rural solo GP on call seven nights a week”. Medical women choose to enter General Practice because of its flexibility, allowing for a comfortable fit between work, family care and other non-medical interests. A sixty-hour week at work is not an option for these WGPs and the challenge to either work excessively long hours or get out should be regarded with caution, as WGPs may choose to turn to other professional and non-professional pursuits that better suit their requirements.

Coulson (1994) refers to the “macho medical world” of medical practitioners and the clustering of medical women in the “Cinderella service industry” specialties such as pathology, radiology, psychiatry and geriatrics. “Macho surgical specialties” were however a “tougher nut to crack” (Coulson 1994, p. 21). This stereotype of the macho style is problematic when it comes to attracting female medical graduates to medical disciplines that are embedded in this ethos (Fye 2002, p. 384).

Barriers especially exist for WGPs who work in rural locations or practices where the
male ethos is particularly strong. One WGP participant in this research who had performed a rural locum found that a lack of support and the need to be "gung-ho" all of the time was exhausting and a disincentive to continue in rural practice. Since there are increasing numbers of WGs, creating realistic expectations of reasonable workloads for them in the profession, especially if they are pregnant or have children, is essential. Acknowledgement should be given to the excellent patient care already given by WGs and a structured support should be emplaced to allow this valuable work to continue. Practical barriers to balancing career and domestic commitments are "no longer insurmountable" but "chauvinism" must cease to be part of cultural and systemic change (Coulson 1994, p. 21).

As Burris (1996) explains, Technocracy is a form of patriarchal management where gender imbalance and segregation of women exists (Burris 1996, pp. 69-72). The emphasis in Technocracy is on conspicuous expertise consistent with the male gender and technical expertise linked with masculine self-identity. The rural WGs in this thesis are not typically seen as part of the expert sector of male GP proceduralists, even though procedural work in rural culture is the hallmark of distinction between rural and urban practice. This imbalance of expertise and hence power and privilege between rural WGs and rural male GPs corresponds to the domination of the WGs, who are "invisible" and "not heard". Furthermore despite the invaluable contribution rural WGs make to maintaining the health of the community, the absence of perceived procedural expertise is viewed negatively by rural males.
8.3.6 WGPs Style of Work

WGPs taking part in this research demonstrated a different style of work practice to that of male GPs. In their practices the WGPs used individuality to create warmth, commitment, communication and discussion. They preferred to work in teams and group practices where there could be a “mutual cooperative sharing of patients”. These WGPs were the “leaders in multi-disciplinary teams providing health services” and this suited their requirements for flexibility in their work and life. Some WGPs who were working part-time were made to feel “second rate”, as they were not able “to actively influence the practice” in matters of patient care. Being part of a team offered support and a better opportunity to have a voice in the system when decisions regarding patient care arise.

The long consultations that WGPs perform, especially those dealing with psychological or psychiatric cases are time-consuming, exhausting for the WGP, and stressful for waiting patients. Female patients sometimes take advantage of the WGPs in ways that they would not do with male GPs. They perceive a “sisterhood”, they think that WGPs understand their problems better and have more empathy than male GPs. These female patients discuss more time consuming matters with WGPs and this leads to longer consultations. However, Foster (1987) asserts that some radical feminists claim that regardless of the presence of WGPs

...modern medicine is an inherently patriarchal and oppressive institution. All those who work within it, including women
As seen in Chapter 4, some radical feminists used the patriarchal view of medicine as expressed in the works of Ehrenreich and English to be suspicious of all centralised medical processes. Rather they supported women's empowerment through an unregulated medical market within a strong feminist consumer movement. In contrast feminist theory espouses cultural feminism (Chapter 4) which defines women by their activities and attributes in the present culture. The female culture nurtures a special bond of womanhood through common experiences and caring.

Medical socialisation has a powerful influence over practice style and this is especially evident in the different form of communication of WGPs and male GPs with their patients. Although medical socialisation appears to dominate technical aspects of medical care, gender socialisation has a larger impact on female doctors' communication styles than on those of males. According to Martin et al. (1988), male physicians interrupt patients more frequently than female counterparts and use interruptions as a means of control over patients. In contrast, female physicians interrupted their patients no more often than they were interrupted. WGPs speech exhibits a lowered intensity and there are more frequent uses of hedges and euphemisms. Male GPs are more likely to decide the topic of conversation and dominate the turn-taking process. With respect to non-verbal communication, WGPs are more likely to look away when speaking to males, or smile and allow invasion of their 'private space'. In conversation WGPs are less likely to touch a male, to stare,
or point (Martin et al. 1988, p. 340). It became apparent that the WGP's in the present research experienced all these aspects of gender differences in their communications with patients and male doctors. This underlay their feeling that sometimes "their voice didn't count" or that they were required to "defer to men".

Even though communication is central to the success of the doctor-patient relationship, some patients think that because of shared experiences such as menstruation, pregnancy, labour, child-rearing and menopause the WGP's are also more likely to spend more time, be more caring and sympathetic and be easier to talk to than male GPs (Waller 1988, p. 128). Unfortunately, this tends to lead to long consultations which male GPs see as counterproductive for practice finances.

8.3.7 Perceptions of the Work Practices of WGP's

WGP participants in this research were concerned about maintaining standards and performing high quality work. Those who worked part-time were mindful of providing continuing comprehensive care to their patients. Some WGP's established practice procedures for handing over relevant information between doctors who were involved in caring for a particular patient. Other WGP's held case discussions between doctors when individual doctors held different views on the treatment of specific medical conditions.

Some male GPs in this research believed that the number of GP sessions that a WGP worked could be used to gauge her competence. These males also maintained that a
WGP needed to conduct a prescribed number of GP sessions to ensure that her contribution was a viable proposition for the practice. It is suggested by this writer that it would be more meaningful if the outcomes of patient's health and well-being were used as a measure of competence for all GPs, rather than head-counting patients. The focus should be on high quality patient care rather than a high quantity of patient consultations.

WGPs found the multiplicity of complex problems that patients presented in the consultation were often time consuming. Some male GPs in rural areas resented this because it did not raise the practice income. Other male GPs were quick to discover the useful roles that WGPs could fill in taking pap smears, women's health care or counseling. However repeatedly performing pap smears and being confined to women's health care and social problems was unsatisfactory and professionally unfulfilling for the WGPs. As shown in the Delphi Study diversity in clinical work makes the job satisfying whereas fragmentation of patient care constitutes "incomplete care" for the patient and is poor quality medicine.

Patterns of work are changing with the increasing numbers of WGPs and the "old time battalion" of "We did it hard and so must you" is fading. In the mid 1990s the AMA safe hours project was developed it encompassed a code of practice regarding hours of work, shift work and the rostering of hospital doctors. This code sought to change the organisational beliefs and culture of work practices in order to minimise risks and hazards associated with shift and extended working hours (Australian Medical Association 2004, p. 1). A 2006 audit of the AMA's safe hours campaign
showed that 62% of Australian doctors are working unsafe hours classified as high or significant risk of fatigue and stress. Such work conditions significantly jeopardises patient safety. The aim of the code remains unfulfilled because the average total hours worked in the 2006 audit week was the same as it was in 2001 (Flannery 2006, p. 3).

The present research supports the need for a cultural change from a male oriented to a flexible work pattern, particularly for the health and well-being of WGPs and their families. Men are being encouraged to work fewer hours but some WGPs are still working “male hours” so they don’t “cop flack” from male GPs. Other WGPs admit to being workaholics as they have “grown up that way and can’t get away from it”.

In the past, work practices have militated against women who want to become specialists and as a result medical women have chosen General Practice as a career because of the availability of part-time training and part-time work. WGPs prefer part-time and flexible work hours because it facilitates balance between their professional and non-professional lives and it is compatible with their non-professional responsibilities. It also allows them to become involved in non-medical interests and share social interaction with friends. In this way WGPs can occupy “mixed roles” rather than professional roles that entirely dominates their lives. More male GPs want to work part-time, but like the WGPs they have been confronted with barriers to their participation in part-time work. If they take this path, other doctors and even some organisations do not regard them to be “proper GPs”. Charles et al. (2004) reported that the proportion of female doctors working part time did not change between 199-2003 (Chapter 2 of this thesis) while there was a marked
reduction in the number of male GPs working longer hours over this period.

WGPs who took part in this research considered that “most patients were very accepting and accommodating of part-time work as long as they knew of this possibility from the outset”. These patients saw the work of WGPs as valuable and they appreciated their “whole-person” and “long-term view” of patient care. They also developed trust in the WGPs as their family doctor. It is however difficult for WGPs to work part-time and have the same sort of professional esteem in the practice as doctors who work full-time. Some patients (and some doctors) think that the more hours a doctor works the better that doctor is. Such patients perhaps have no understanding that the doctor has a life beyond medicine.

Male GP participants in the research were concerned that WGPs who worked part-time were not taking high profile positions in organisations concerning work conditions and remuneration. Some male GPs regarded WGPs who worked part-time to be “supplementing their husband’s income” or doing “something nice” to maintain professional contact. These male GPs sought to justify their belief by arguing that two classes of GPs (the “traditional professional GP” and the “part-time hobby doctor”) in General Practice would detract from the strong and professional orientation that is necessary to survive the changes that government has planned. What these changes might be was not revealed, but clearly these male GPs feared any change that could threaten their positions and power. In support of this contention Grbich (1996) (Chapter 4) linked power directly with male domination.
8.3.8 Models of Practice

There were a number of different models of General Practice embraced by the WGPs taking part in this research. One male GP said that those WGPs who worked in practices where all of the GPs were women were “refugees” from other models or “refining a path and embracing it”. Although WGPs preferred to be employed and work in a group, some worked in government salaried jobs where they had the opportunity to gain an understanding of government, finances and the bureaucratic process. These WGPs needed this type of work environment to give them flexible hours that fitted with their non-professional lives.

The introduction of the Medicare provider number legislation (referred to in Chapter 1) limited the flexibility of career choice and practical experience that may be gained by doctors who are not in a training program or practicing as a recognised medical practitioner. It also compartmentalised the practice of medicine into General Practice, a specialty, or hospital based medicine. Hence a woman doctor now has to commit to a stream of medicine at an early stage of her professional life, as the opportunity to sample work in various medical areas has been removed.

Another model of work in General Practice seen in this research was that of a husband and wife owning a general practice and working together. One of the benefits of this model was that the couple to share the “zeal” for both their professional work and also their relationship and family life. This model enabled
both partners to share common goals in their professional and non-professional lives. An example of this model where GP couples work together is found in pioneering medical women (Chapter 1).

Other models of General Practice referred to in the research are exemplified by practitioners holding shares in a company or practice partnerships (Chapter 1). WGPs in partnerships who worked part-time could not see the value of paying money into the practice and hence tended to become silent partners, not actively involved in the decision-making process of the practice. Some WGPs who worked part-time found themselves in this position and sensed they were second rate so just went to the practice to do sessions. Other WGPs who had become attached to a practice as long-term locums also experienced difficulty in having a voice and share of the power in the practice. In contrast those WGPs who worked full-time had more influence on the management of patients and in the business of the practice. Practices in which all of the GPs are women are usually conducted as partnerships or associateships, and these practices appear to have little problem about "how the money is divvied up or how the power is structured".

One WGP in this research set up her practice with a staff comprised only of WGPs. Eventually she also employed males GPs as she found that men were more willing to work out-of-hours and in the evenings. She said that WGPs "could not be off in school holidays and be off [in the] afternoons after three p.m. when they would collect their children". If WGPs wanted that sort of life "they shouldn't do medicine in the first place". There has to be "some loss for the doctor and family, as this was
the nature of the job and the nature of the demands of patients”. Having WGP staff who had children was not the only factor that proved to be difficult for this WGP as the practice principal. She claimed that there were “as many problems [with] WGPs who did not have children as those who did”. The WGPs without children had other priorities and activities in their lives that determined their availability in the workplace. For the WGPs who were employees, the practice work took second place to the role of being a mother or becoming involved in non-medical interests or performing self-care. For the female practice owner the business aspects of the practice were her chief concern.

WGPs who were employed by the RACGP Training program in this research, found that the RACGP attempted to provide part-time work and innovation in working conditions for WGs in senior positions. Unfortunately the organisation largely failed in its endeavour and the WGP employees ended up doing a full-time job in a part-time capacity. However one WGP in a senior position of the RACGP worked from home and this provided the flexibility that she required. However, she found that it was often necessary to visit the organisation’s office in order to network and communicate with colleagues. This model of work was thought to provide balance and it worked well for both the WGP and the organisation. Working from home using modern technology for communication may provide more scope in the future for WGPs who wish to continue working in professional roles where face-to-face interaction with others is not constantly required. This model may be especially useful for WGPs in academic or educational roles and for those who are working for professional organisations.
Working together with other GPs in General Practices has many benefits for GPs, for patients and for practices. It allows economies of scale with staffing and costs, sharing of after-hours work or the work of GPs who are on leave, and it decreases isolation from peers. Branson and Armstrong (2004) reported that resentment about perceived inequalities in workload is a common concern in General Practices.

Differences in style between the “fast consultant” and the “slow consultant” contribute to this problem. Fast consultants finished their work promptly only to be given other practice work which leads to resentment. The slow consultants often have more complex cases with psychological and social problems and multiple presenting problems. Hence these slow consultants believed that their workload was the greater and so was their stress levels (Branson and Armstrong 2004, p. 382). This could be the crux of the problem for WGs who conducted long complex cases (slow consultants) and male GPs (fast consultants) who resented the time the WGs took since long consultation earned significantly less money for the practice.

Difference in style regarding the pace of work was a concern for both WGs and male GPs in this research. Proposed solutions available in the literature include creating systems of working based on rules, points systems and better communication (Branson and Armstrong 2004, p. 382). Trust between practitioners is essential to healthy practice, and when this breaks down as in the case of some WGs seen in this research, the men sometimes resort to aggression, abuse and sexism. Ways to resolve these problems without aggression and abuse need to be facilitated at the practice level so that slow workers and the fast workers can understand their different styles and work in harmony.
8.3.9 Providing Continuity and Coordination of Patient Care

Having continuity defined as “a regular provider over time” does not necessarily lend itself to better care “unless it also results in an interpersonal relationship of knowledge and trust” (Gill 2004, p. 67). Accessibility to, and availability of, the same GP is becoming more difficult and Gill suggests that coordination of care is more important than continuity for patients. However, providing a comprehensive approach to whole-person care in a continuing relationship is the basis of quality medical care for patients and this continuing relationship is possible to achieve by GPs and practice staff forming teams that the patient can come to know and trust.

In the Delphi study conducted as part of this research the WGP participants when asked to come to a consensus on the key issues in their professional and non-professional lives did not rate continuity of care for patients as a key issue. Arnold (2002) in a criticism of this study considered that sessional work for GPs was threatening this continuity of care. Patients “have fallen through the cracks” and poor communication and lack of “handover” between sessional doctors had “seriously harmed” some patients. He claimed that “fail-safe” mechanisms of verbal and written communication between sessional doctors were also absent, and considered that developing these mechanisms came as close as possible to

...providing the continuity of care offered by the now nearly obsolete five-or six-day-a-week and after-hours family doctor (Arnold 2002, p. 463).
Although there is merit in Arnold’s deliberations on the importance of continuity of patient care, it is clear that he did not appreciate that the purpose of the Delphi study was to raise an issue of key concern in the lives of WGPs. As seen in the semi-structured interviews in this thesis, WGPs did discuss the ways they dealt with hand over of patient's cases and the methods they developed to ensure continuity of patient care.

Parkerton et al. (2004) reported that physician continuity, defined as “seeing the same designated physician during one year”, was not associated with any patient outcome, but it was inversely associated with patient satisfaction. However, practice coordination measured by shared practice members, team tenure and medical clinic size was significantly associated with outcomes such as cancer screening, diabetic management and patient satisfaction. Improved communication by the use of computers, use of supportive structures in practice models and coordination of practice care may replace some of the need for individual physician continuity. Having a single physician over a lifetime or even a period of illness may become a “luxury” (Parkerton et al. 2004, p. 21).

The present research shows that new work practises will continually evolve and be adopted in General Practice. These changes will favour part-time work, sessional work and job sharing that many WGPs and some male GPs desire to enable flexibility and balance within their professional and non-professional lives. Ways of achieving coordination of patient care will be a key issue to be addressed in future work practices of General Practice.
8.3.10 Safety at Work

The issue of ensuring safety for WGP s at work arose in this research when (as previously referred to in this chapter), one WGP reported that she had been stalked by a patient who had misinterpreted her style of care. Hobbs (1994) claimed that during out-of-hours calls women were significantly more likely to report intimidation and severity of fear than men (Hobbs 1994, pp. 390-394). Chapter 3 of this thesis examines the recent literature on the incidence of stalking and the issues of violence and harassment. Stalking of medical practitioners is frequent enough to warrant further attention and incorporating the subject into medical training curricula is important so that doctors

...are less confused about their responsibilities, less inclined to ascribe these experiences to their own shortcomings, and more likely to obtain help before their lives (...and those of the patient) are devastated (Pathé et al. 2002, p. 338)

Other WGP s in the study who worked in rural areas reported that they had met with "threatening situations" when conducting house calls to see patients especially at nights. It was felt that solutions for providing safe work environment for all GPs are urgently needed, especially during after-hours or when on house calls. One participant in this research described how a Division of General Practice has developed a model where services were delivered after-hours by GPs working in a secure environment in a central location in the town. This met the needs of the community and addressed the safety issues for the WGP s working in this facility.

Hobbs suggested measures that increase the protection of doctors, these including, a
hand held duress alarm linked to a central monitoring service and (for doctors in
deputising services) being accompanied by a driver or navigator who is in radio
communication with a central telephone exchange. Hobbs also suggested that
evidence indicates that attention to surgery design can reduce patient aggression
(Hobbs 1994, p. 304). Training programs are needed to teach early recognition and
handling of patient aggression and the provision of post-event counselling for victims
of abuse.

8.3.11 Remuneration

This research highlighted problems concerning pay and working conditions for
WGPs. Payment for superannuation, sick leave, parenting leave, recreational leave,
maternity leave, compassionate leave and study leave had "been foregone in
contracts" that some WGPs had signed. From both the Delphi study and in the semi-
structures interviews the view was expressed that the financial reward that WGPs
received for their work was inadequate. This low remuneration was partly a
consequence of the low Federal Government's Medicare rebates for GP services and
the level of discounts to the Medicare rebates for bulk-billing. There was also a poor
public understanding of GP finances or of the set schedule of Medicare fees. GPs
received no payment for the time that they spent on paperwork and dealing with
administration. Some GPs who worked in areas where patients were financially
disadvantaged bulk-billed their patients and as a result made little money. The WGPs
felt unrewarded financially for the many long consultations they performed. Highly
paid procedural jobs were known to attract better fees, but generally WGPs were not
involved in these lucrative forms of practice.
One male GP participant in this research claimed that there were no disadvantages for WGPs in professional life “except that WGPs earn significantly less than males”. He thought that this was linked to WGPs doing long consultations where the time spent was unrewarded by Medicare. The WGPs “free-up men to earn more” by their performing a greater number of shorter consultations and performing numerous procedures, hence the WGPs earned disproportionately less income than the men per hour. Another male GP participant saw the inequity of the system, saying the correct way to practice “was not [to be] gender differentiated”. Essentially this GP was endorsing Riska’s Contingent approach where the roles of doctors are seen as gender neutral.

The government financed Practice Incentive Program is explained in Chapter 2 of this thesis. The PIP is a cause of dissatisfaction for WGPs who work in practices but receive no financial benefit from the program. The practice can spend or distribute the PIP money as it wishes and the government claims that it cannot be responsible for an individual practices’ business arrangements (Health Insurance Commission 2004b, p. 1). Many WGPs are missing out on their portion of the PIP payment because their practice remuneration is a proportion of the medical fees they earned but it is not a proportion of the PIP (van Santen 2001, p. 37).

A question arising from van Santen’s report is how the PIP money could be distributed in an equitable manner to the WGPs who work in General Practice, especially those who work part-time or sessions. WGPs interviewed for the present research were frequently paid a percentage of the Medicare schedule fee for the
service that they performed, but they did not receive a share of the PIP money which rarely went beyond the principal owners and partners (usually men). One WGP participant in this research said that there has been "hush-hush" instead of open and transparent discussion with the Federal government about how to resolve this difficult issue.

A participant in this research noted that there has not been a study conducted in Australia to compare the payment made to WGPs and male GPs for equivalent work done. A study of this factor in the USA however revealed a persistence of sex differences in income and productivity by primary care physicians over a 10-year period, even when adjustment was made for physician-age and work hours (Wallace and Weeks 2002, p. 183). Although the relative hourly income of women has since improved, the changes are modest and show little progress from disparities reported 10 years before:

If the trend lines...continue, the hourly income of female primary care physicians should catch up to that of men within the next 12 years...it appears that the female primary care physicians are considerably more productive and perform the same work for substantially less pay...If that is the case, the future of female primary care physicians, while not bleak, is not equal to that of men (Wallace and Weeks 2002, p. 183).
8.4 The Differences Between Men and Women

The WGPs participants in this research "felt like any other doctor, but they aren’t treated like any other doctor because they have kids, other responsibilities and can’t work full-time". Some WGPs felt that they “were not good enough, didn’t match up and lacked the values and behaviour of the male role models”. This sense of relative failure may result from the training and socialisation that occurs in medicine, as there is little recognition that women have a different style of working than men. This view is a version of socialisation theory (discussed in Chapter 3) in which the professional role of the doctor is gender neutral, since both male and female students are socialised in the same way and the demand of studying medicine leaves little time for gender-socialised traits. Professional socialisation takes precedence over gender socialisation and doctors display gender-neutral behaviour, hence the medical profession appears as a homogenous body in which any changes are assumed to effect members equally.

WGPs generally spend the first decade of their professional lives exposed to male models who impose their ways of behaving and thinking. As a result, medical women become inculcated with male values and ways. Females who operate at senior levels in professional life and who have the capacity to modify the extremes of masculine behaviour have frequently remained silent. What is urgently required are female role models of younger medical women to show that there are other ways of conducting their professional lives and that they need not be governed by the values
and behaviour of males.

The WGPs thought that socialisation was complex and concerned with what is considered “feminine” and “attractive” in women. They also thought that socialisation was shaped by the roles that women take as mothers. Cultural socialisation, together with hormonal influences ensure that “women are programmed in a different way”. However, as the WGPs in the research attested, women are trapped into a form of cultural socialisation where the patriarchal, masculine, view of the world is that of “reducing it by chopping it up into little bits and paying lip service to the broader view in a holistic sense”.

As noted in Chapter 7 some WGPs in this research felt that women were biologically different in that “hormones influence the brain pre-natally” and hence, women are “programmed in a slightly different way”. Gur et al. (2004) reported neurobehavioral and neuroanatomical research showing that women perform better in verbal and memory tasks, whereas men excel in spatial tasks. Sex differences have also been observed to affect emotional processing, women performing better in speeded emotion-recognition tasks and in being more expressive:

Men and women differ in emotion processing including perception, experience and expression most notably reflected in greater male aggression...The most salient difference between men and women in emotional behaviour...is the discrepancy in aggression (Gur et al. 2004, pp. 998-999.).

The WGPs said that women have a “different perspective” of life, and society
devalues the female perspective. They considered women to be more qualitative, more person-centered and have a different emphasis and understanding, while “men are more organisational” and have a “more structural or functional” approach. Women have “more of a person focus” and men are more “problem focused”. Women are in the thinking, judging category and are more interested in the interpersonal aspects of their lives, and men are “more interested in objects, successes and activities”.

The WGPs participating in this research had to make some “difficult choices” in their lives, especially about their career. If men take more equitable share of domestic work they too will find their choices regarding their career and work will become problematical and their choices will then be governed by the same factors that determine the working lives of WGPs. Redman et al. (1994) emphasised the importance of flexibility and the availability of part-time training and part-time work in the career choice of medical students and doctors. However women were significantly more likely to choose General Practice as a career because

...the opportunity for part-time training, flexible working hours and part-time practice were important determinants of career choice and were of more importance to women than to men (Redman et al. 1994, p. 361).

This research showed that WGPs made excellent use of networks and that they were skilled communicators, whereas male GPs were very focused but some did not have the same social and networking skills. To achieve the best outcomes in the lives of
GPs, it is necessary to use the “strengths of both men and women”. Mentoring are valuable because mentors

...teach, advise, open doors for, promote, cut red tape for [the protégés]...show the politics and subtleties of the job...thus helping them [the protégés] to succeed...Most important, mentors have skills, knowledge and power that protégés lack and need (Freeman 1998, p. 31).

Networking is valuable because it promotes information exchange, especially relating to careers. Although the strength of mentoring lies in mutual support rather than “payback” (Freeman 1998, p. 32), networking also gives power, at least to a few:

Mentoring programs may help women meet key people in a company’s hierarchy, but they don’t change the fact that informal networks, to which few women are privy, determine who really gets resources, information, and opportunities (Meyerson and Fletcher 2000, p. 130).

Despite the value of programs that foster networking and mentoring there remains a substantial difference between the ways of women and men and how they conduct their lives. A better understanding of the value of the different approaches of women and men GPs would be helpful in fostering improved relationships and equity in their professional and non-professional lives.
8.5 Generational Change

Toomey (2002) draws our attention to the change that has taken place in General Practice:

The GP of 30 years ago was most likely to be a balding man who drove a Mercedes and worked full-time, including weekends and nights...The GP of today is most likely a young woman who works part-time, whose income is the secondary one in her family, and who drives a Commodore or Toyota. More than 60 per cent of graduating doctors are women, many of whom fit life practicing medicine around raising a family (Toomey 2002, p. 3).

The differences between the last three generations are shown in the three different eras in 20th Century Australia, and this is apparent in the considerable differences between the generations of GPs in this study. The WGPS who were among the older generation, were the children of the Great Australian Depression and the young adults of World War II. Those WGPS of the middle generation, the Baby Boomers, grew up in a period of unprecedented economic growth and prosperity, overshadowed by the Cold War. The younger generation have been born into a society that is experiencing radical and relentless social, cultural, economic and technological change "a society in the process of reinventing itself" (Mackay 1997, p. 11).

As this research shows, WGPS in the older and baby boomer generations tended to
work beside the men without admitting to inequities. The need for flexible work and study schedules if mentioned were poorly received, because the WGPs lived in the “blokes” world and did all the things that they did. These WGPs knew that if they had let the men know they were finding it “tough” they would be regarded as “wimps” or it would be said they “couldn’t do it because they were female”. As a consequence many WGPs retreated from the medical profession for long periods in order to be wives and mothers. Their husbands’ careers and needs were a priority and when WGPs managed to squeeze in clinical work, they were given the role of caring for women and children patients. Very few were found in senior professional roles or workplaces, although these WGPs were the “ground breakers” for change.

MacKay (1997) asserts that among the younger generations born in the 1970s and later there is a recurring theme of individuality and independence. They accept diversity and want to keep their options open. These generations want flexibility and freedom in their lives. They hold convictions that men and women are equal but different, and equal opportunities for men and women should be taken for granted. Men and women should be able to negotiate roles and responsibilities at home and at work in ways that respect the needs and preferences of each (MacKay 1997, pp. 135-176). The adults of this period are part the second wave of feminism (discussed in chapter 3) and feminist theory of the time was embedded in a political context that was all about change. This gave a political expression to problems faced in the public and private lives of women. Second wave feminists focused on liberation from the oppression of a patriarchal society and a significant focus of struggle was the female body, biological difference and the political context of sex. Most importantly second
wave feminism paved the way for the entry of women into areas of public life from which they had been previously marginalised or excluded. Hence, the number of women began to increase in medicine and law.

The young people of the present time Generation X and Y and the characteristics of generational change have been extensively reviewed in Chapters 3 and 4 of this thesis. These young men and women belong to the third wave of feminism and beyond. They are comfortable with the notion of full-time motherhood or combining motherhood with employment either full- or part-time. They are also willing to share with their partners in part-time parenting and part-time work and they do not feel that they have to conform to past norms. The problem for the young men of this generation is that although they hold these values they see their fathers and male senior members of their profession acting in opposite ways. It is difficult for these young men not to be seduced into prejudices of the older males (Mackay 1997, pp. 164-165). Young men interviewed in the present research were comfortable with "working wives" and the notion of WGP's holding leadership roles in organisations. They felt that it was their responsibility to job-share with their wives and share the care of "kids". Since this is happening "a lot" these changes may contribute to significant change in the professional and non-professional lives of WGP's in the future.
8.6 Training for General Practice

It was apparent during this research that the requirement for young GP's registrars to spend time working in rural or remote areas was threatening to their relationships. Some registrars have to choose either to continue to live with their partners and children or to separate from their families and move unaccompanied to a rural area. Others are happy to be located in a rural area and manage to juggle their relationships and lives during this period of training.

A prevailing attitude highlighted in this research was that if registrars did not have children then it was acceptable to separate a couple who were in a partnership to allow their training in rural areas. If children were involved then it was more problematical, as it generally meant removing the parent-partner (who may have been working part-time) and the children from their social supports. This also imposed considerable financial hardship on the family and strained the relationship. Larkins et al. (2003) reported that the proportion of registrars with problems in training was high and there was equal prevalence of problems in men and women. The registrars were also pressured to meet

...their rural commitment with its heavy workload and family disruptions...Registrars [also] have a reduction in autonomy during training, and this lack of choice emerges as an important issue particularly in terms of impact on other family members (Larkins et al. 2003, p. 475).
General Practice training is seen as less flexible and less able to accommodate the personal and professional needs of many registrars compared with the training for some other specialties (Kidd 2003, p. 16). This dilemma applies particularly to registrars and it appears that when considering work and their relationships, there is a trend for young men to think as young women do, about their wider interests in life. This is in contrast to the views of older men who hold different expectations of their lives. As a young trainee said:

The sentiment of my generation is that personal life and family are greater priorities for us than for generations immediately preceding us and we demand a different balance between work and personal life than previously seen. There is a need for a manageable balance between these two...[because] building relationships and marriages takes time and commitment, and finding adequate supplies of each for work and home is especially difficult during training (Walsh 2002, p. 667).

Registrars in the present research were more assertive than their predecessors of their rights and the number of hours of work they were prepared to do. In the past registrars and their families have bowed to mandatory requirements of their training. This frequently destroyed balance in their lives and the harmony of their family. As Sewell (2001) said:

What is clear is that our younger colleagues, both women and men, are demanding real change in the structure, organisation and practice of medicine to allow them to have a more balanced
Registrars interviewed in the present research were poorly represented in medical organisations. The general sentiment expressed was that a lack of exposure to the various organisations during training left them wondering what “relevance these organisations had to their lives”. They knew the RACGP was running the training program for registrar GPs but they “struggled to understand what the College is”. Some knew “nothing about Divisions of General Practice” and the AMA appeared to represent a “sort of foreign language” that some “guy” on televisions speaks when he is talking about “some issue”. Registrars are given educational emphasis on clinical teaching but they are not cultured or educated “about what General Practice is, or its culture and way of life”. They are actually “disempowered” and “disfranchised”. Clearly there is a need for enlightenment regarding medical organisations during training, so as to avoid the registrars feeling “isolated, burnt, hurt or damaged”.

The need for investigating and discussing gender issues, particularly the interaction between female medical students or registrars with senior hospital and academic staff, was highlighted in this study. There also needs to be a better understanding of the culture of the hospital environment, which can negatively influence female self-perception. This is not helped when hospital staff members react in a different manner to the “vocal male” and the “quiet female”.

This research found that women may be more severely affected than men by the “traumas of the intern years” as resident medical officers. Males who are seen as
successful and get on with the job, sometimes internalise their feelings and risk breakdown of their marriages. Women are frequently perceived as not being as strong and resilient as men, especially when they verbalise their emotions in the hospital environment. The result can be that women are judged as being less capable and less suitable for training as specialists.

It is evident that women carry their fears and anxieties into General Practice training when they are dealing with the uncertainty and unpredictability of General Practice, the fear of litigation and the harsh environment in which they find themselves. This is a particular concern when they are dealing with after-hours calls and patients who have several medical problems, when in contrast men appear to “cope better”. There is a need to examine how the RACGP, universities and hospitals treat GPs prior to their entry into General Practice. It is clear to this writer that a systematic attitudinal change is necessary to remove the punitive and abusive ways of dealing with junior doctors, replacing them with support for the development of self-esteem. As McKegney (1989) says

…the family of medical education often behaves in a neglectful and abusive fashion. It isolates itself from support and consultation, rigidly maintaining the training structure passed down from previous generations. Rather than supporting developing physicians, the system neglects their physical needs and trains by negative criticism rather than teaching by specific feedback. Secrets about inadequacies or mistakes are hidden or shared and inappropriately discussed across generational boundaries, rather than with role peers. Indirect communication
teaches loyalty rather than collaboration and reinforces the attitude that mistakes are shameful, never to be revealed. Forced to hide their uncertainties and errors, the trainees' self-esteem never matures. Because students and residents know they have not revealed themselves, they cannot respect either the praise or the criticism they receive (McKegney 1989, p. 456).

Willcock et al. (2004) noted that internship was a stressful time for medical graduates as evidenced by the high incidence of psychiatric morbidity including depression, anxiety and burnout among junior doctors. The factors that contribute to these health problems are mainly located in the work environment but include issues such as conflict between work and personal life and individual psychological vulnerability. Many interns develop compulsive 'type A' behaviour patterns oriented toward achievement and approval. However, exhaustion and mental distress sets in as the intern strives to achieve unrealistic expectations imposed by themselves, their professional teachers or the targets and standards set by the educational training bodies. Junior doctors are subject to bureaucratic requirements that equate to jumping through hoops for years on end. Subsequent years of residency and vocational training impose further stress for these professionals and this causes escalation of the risk of psychological ill-health, burnout, substance misuse and personal relationship problems (Willcock et al. 2004, pp. 357-359).

In 2006 two senior registrars in Victoria committed suicide, a tragedy that highlights the stress of life events for registrars. Statistics show that male doctors are twice as likely, and females up to five times more likely, to commit suicide than members of
the same sex and in the same age bracket of the population (Ahmed 2006, p. 10).

Senior registrars often have a wife, children and significant financial responsibilities while they are working and training for long hours. Thought must be given not only to how the increasing number of registrars, many of whom will be women, can be trained but also to how their well-being can be maintained and their non-professional needs met.

As more women medical graduates enter the health system the attitudes of health system employers and the community must be examined and solutions found to decrease stress in the medical workplace. Education and tangible support should be targeted towards the psychological vulnerability of medical graduates and the unrealistic goals and expectations that they confront. Providing support in the form of mentorship and female role models is invaluable for female medical graduates as many are faced with coping with caring and nurturing their partners and children and with domestic issues in the home.

There has been a significant investment made by society in educating medical graduates, but if further support for preventing ill-health and caring for unwell medical practitioners does not occur during residency and vocational training these doctors may become exhausted and unable to provide safe, high quality, medical care. These doctors are a resource that must not be abused because of political whims of governments, unrealistic demands of consumers or a masculine medical culture resistant to change.
Young WGPs hold different values and behave differently to older WGPs, and this new generation of doctors are not prepared to sacrifice home, husband and outside interests to an all-encompassing medical career. Nor do they accept a second-class medical career as a compromise. Similar views are held by male medical students who do not want to work the excessive hours that previous generations of doctors worked (Brogan 1982, p. 11).

Dissatisfaction by women patients in Australia, New Zealand and overseas with the medical profession has been long established, it being viewed as "disease-oriented, male-dominated, and seemingly unsympathetic to the health needs of women" (Brogan 1982, p. 10). These patients look to WGPs for the delivery of medical services. They also advocate the demystification of medicine, better health education for women, more women doctors, and women's health clinics that are more sympathetic to the special health problems of women. In Australia, studies have shown that most [66% according to Kelly (1980), 77% according to Challacombe (1983), 70% according to Britt et al. (1996)] female patients choose to see a WGP, indicating that there is an acknowledged patient demand for health services provided by WGPs (Kelly 1980, p. 427; Challacombe 1983, p. 848; Britt et al. 1996, p. 409).

Many authors contend that a struggle for power lies behind gender differences. Power has produced tension between men and women throughout the generations and younger women believe that the gender revolution has made them more powerful than their mothers ever were. They express this power by making choices. At the same time men are concerned that they are becoming relatively less powerful. The
key for happiness and success is for young women and men is to look to their relationships in their personal and professional lives and share the activities and the power that accompanies these activities:

The most successful partnerships are those that transcend the power struggle entirely and reach a point of concern where the whole question of gender role and the need to negotiate the apportionment of responsibilities has diminished (Mackay 1997, p. 109).

8.6.1 Educational Processes in General Practice

Registrars training for General Practice at the time of this research were firmly linked into the RACGP Training Program that prepared them to enter unsupervised General Practice. These registrars were required to pass a College examination in order to be granted the FRACGP. They were also required to successfully complete the requirements of a three-year full-time training program that included working for a term in a rural location or a disadvantaged area. If they completed a fourth year of advanced rural training skills they earned an additional qualification, the Graduate Diploma in Rural General Practice. Although there were some methods for accelerating parts of their training, completing the program would take twice as long if the registrar was training on a half-time basis, while those WGPs enrolled on a fractional basis could take many years to complete the program. There was an approved intermission of twelve months, available for parental leave or other pursuits that were deemed to be valid. However there was no formal definition of what was
valid and what was not so the power to grant this leave lay in the hands of those in charge of the training program.

Many changes have since taken place in the RACGP Training Program. The original program was open and flexible with no formal selection process, only formative assessment and with no endpoint qualification. Changes have included a competitive selection process, more defined stages, a more defined curriculum and improved linkages with an endpoint examination that certifies competence. Emphasis on training in rural medicine was increased and a defined rural training stream evolved which actively recruited suitable entrants and provided a substantially different ruralised program.

No consideration is given to women in the program for the skills acquired through their personal experiences of motherhood and child rearing, or for other experiences they had acquired through working in fields of medicine that were not accredited by the training program. As Candib et al. (1987) noted:

*becoming mothers, a significant life change, had a transforming effect on our clinical work with patients* (Candib et al. 1987, p. 114).

The benefits that flow to clinical medical practice from those WGPs who have taken time out to raise a family and manage a household have also been recorded by Poole. Time spent away from work to care for family is as valid a reason as any other not to
work full-time and the skills required to be an effective parent and to run a household are invaluable to medical practice (Poole 2000, p. 106).

Having obtained the FRACGP the Health Insurance Commission granted registrars the status of being ‘recognised GPs’. To maintain this recognition registrars like all other recognised GPs must pay for and complete the triennial requirements of QA and PD. Participants in this research thought that the RACGP (the professional body responsible for setting General Practice standards) was steadily becoming more involved with politics and there will “always be a political element to standards”. One participant said that a “degree of political clout was required for the College” to “establish its pathways of life-long education for GPs”.

All registrars were required to become an associate member of the RACGP while they were in the training program. They could choose if they wished to pay the annual subscription as a Fellow of the College after they had obtained their FRACGP and completed their training. There was an “unofficial contest” between medical organisations and Colleges to determine which had the greater number (and higher positions) of WGP in their organisations. However in the case of the RACGP, little credit could be given because 60% of the registrars belonging to the RACGP Training Program were female.
8.7 Medical Organisations and Colleges

In the course of this research the RACGP was compared to the "Church of England" because "diversity is its great strength" and it "has achieved enormous" and "unique" progress for General Practice. It was seen as "significantly ahead of other Colleges" and some participants acclaimed its achievements because it had a "much higher female representation" than any other College. It also had increased its numbers of WGs in the College decision-making process and had elected its first national female President. GPs called this increase of female membership as "creating a gender balance" and believed that this gender balance would be reflected in the way the College conducted its business. However, subsequent developments would indicate that this trend was illusory, and the changes observed could be more aptly described as a short-lived tilt in a different direction by an organisation largely dominated by men.

In 2000 the RACGP highlighted the needs and priorities of WGs by producing the St. Hilda's Resolutions (described in Chapter 2). WGs who were members of existing medical organisations and in government positions took part in a national forum to define these resolutions. It was intended that the St. Hilda's Resolutions would catalyse a process within the College to resolve the key issues for WGs, but this hope was never realised. The WGs who took part in this process were abandoned and the St. Hilda's Resolutions have been gathering dust ever since (Jorgensen 2000, pp. 1-127).
In 1996 a national Equal Opportunity Needs Assessment for the RACGP was published (Wirga 1996). The aim of this assessment was to determine why WGPs and doctors from non-English speaking backgrounds were under-represented in the decision-making process of the College. One reason given in this Assessment for WGPs not being involved with the RACGP, was that the organisation was run by "boring old men in grey suits". WGPs had also stated that they did not have time to be part of this organisation and that the RACGP was not user friendly. Other conclusions relating to the College was that it lacked clarity of structure, good communication and female role models. Committee work was regarded as unrewarding and there was a backdrop of language and cultural barriers. Female registrars also reported negative experiences in their training (Wirga 1996, pp. 3-4).

Wirga's report recommended that the organisational culture should change, so that the RACGP would become more accepting of difference and diversity. In addition an equal opportunity policy and program should be written and implemented. Support networks, a mentor program and better access for doctors with families was also recommended (Wirga 1996, pp. 3-4). Few of these recommendations have been implemented, the reason given being that the issues were not regarded by the membership to be a priority. The WGPs participating in the present research concluded that the outcomes from Wirga's work were "locked away in a drawer and forgotten". They felt that it was hard to make a change in an organisation "unless there was a critical mass supporting the change", and those who advocate change must be positioned at the top of the organisation for change to occur. When the AMA was confronted with the issue of equal opportunity, it was suggested that a
person be appointed to deal with this issue. However, this appointment did not proceed as the AMA found it "too threatening".

ACRRM describes its role as the peak professional organisation for rural medical practice and training in Australia. It maintains that its core function is to determine and uphold the standards that define and govern competent unsupervised rural and remote medical practice (Australian College of Rural and Remote Medicine 2004, p. 1). ACRRM has lobbied to train and educate those GPs who would practise in non-metropolitan areas. This lobby precipitated a power struggle lasting many years between ACRRM and the RACGP. Rural WGPs in particular were caught in the crossfire. WGPs taking part in this research were uneasy about joining ACRRM because its focus on the "big R-rural" which was not in accord with their wider vision of how rural medicine should be practised. These WGPs were distressed by the dissatisfaction and disunity that existed between ACRRM and the RACGP. A Women in Rural Practice (\'IRP) committee was founded by ACRRM with the role to ensure appropriate representation by female doctors in ACRRM activities. However, the WGPs interviewed in the research were not convinced that this was "actually happening".

One way of approaching disagreements between organisations is to employ Scott Peck's (1993) theory on organisational conflict. Scott Peck claimed that there can be sick dynamics at work in larger settings creating a hateful and destructive schism within the entire profession. He contended that different organisations comprises members with different personalities and once organisations disagree and become
hooked on conflict, they would rather fight than switch their position. However it was possible to heal such organisational conflicts using a process based upon a system of group learning techniques that cut through every-day narcissism, allowing individuals not only to see one another’s point of view but to accept them (Scott Peck 1993, p. 232).

In this research it was evident that rural WGPs were struggling to deliver health care in rural and remote areas. Some rural male GPs were hostile to the needs of WGPs and these males were reluctant to admit that they too were finding their work hard. The RDAA acts as an advocate for rural doctors and (Chapter 2) it supported the formation of ACRRM. Educational issues were frequently passed to ACRRM, the academic arm of RDAA. The RDAA deals with the political issues and ensures that the interests of rural doctors are heard and responded to. WGPs are nominally involved in the setting of rural policy, but their contributions and concerns are frequently overshadowed by the belief (fostered by males) that the procedural component of General Practice distinguishes rural from urban General Practice.

Over the period of this research the AMA aimed to increase the number of female members in the organisation, especially those who were under 40 years of age or of Asian background. The underlying reasons for this drive were that: women brought a “different slant”, “broadened organisational thinking and appeal”, and that it was important to “increase the public perception that the breadth of the profession was covered in the organisation”. However, the WGPs participating in this research said that the AMA appointed “token women” and this was “patronising”. 
In the light of the waning professional assertiveness by medical women after leaving the hospital environment, one of the research participants recommended that organisations should target women who could become central to the power structures and mentor these women to “lift their game politically and educationally”. Male GPs have said that women doctors needed to become more conversant with issues such as the government’s future plan for General Practice and be less focussed on doing paid sessions in General Practice.

The AAGP was described by a participant in this research as being in a fringe position with a membership of disaffected males over 50 who were previously in senior positions in the AMA. There has been a very small female membership in the AAGP as WGPs found the organisation “distasteful”. WGPs were either excluded or not represented and the men did not understand issues that concerned WGPs. The WGPs also found the culture of the organisation difficult to grasp and the membership appeared to discuss politics pertaining to General Practice “without having the power or career structure required to change it”. The participants in the current research also suggested that it would be difficult to create a universally appealing body for GPs, and that the AAGP required new life, new direction, new purpose and new candidates to stand for election.

The Australian Academic Association of General Practice represents men and women in academia and most of its membership are academic GPs. A participant in this research said that AAAGP was not a particularly active group. Hence this organisation did not significantly feature in the comments of the research participants
although some were academic GPs who conducted research and education. Since the time of this research the AAAGP has increased its activity and membership to more than 150 members and gained more relevance for academic GPs as it has successfully advocated for the advancement of their academic interests. This organisation “brings together researchers and teachers at the forefront of general practice primary health care research and medical education in Australia” (Gunn 2005, p. 1).

The Medical Women’s Society (described in Chapter 2) “listened to the issues of the WGP, respected [women’s] situations and tried to offer a perspective on the issue”. The WGP reporting on this organisation expected it to operate in an “open transparent way, without hierarchy or replicating the culture of the boys’ clubs”. The WGP participants thought that national validation of this organisation by its membership is important, as it is responsible for contributing to national policy regarding medicine and acting as an advocate regarding issues concerning women’s health and women in medicine. The WGP who had worked for the Medical Women’s Society found that this work could “sap the energy of individuals” and this “leads to cracks in communication”. Organisational policy requires the national executive body to rotate from State to State, placing a burden on smaller State groups of WGP who cannot meet this undertaking. Most States hold social and networking events that enable medical women to discuss current issues of concern. However, rural WGP who have an interest in this organisation find it hard to attend activities located in the city and feel isolated from its operations.

Although WGP tend not to join medical organisations, this research showed that the
organisation of choice for WGs was a local Division of General Practice. The
WGs felt “comfortable engaging in local based activities” especially where
networks for women existed. Divisions did not require WGs to pay a large
membership subscription and these organisations demonstrated an understanding
about the operation of WGs’ lives including how they juggle their responsibilities
and roles. The Divisions encouraged WGs to show leadership and their
contributions were perceived to be “an asset”.

8.7.1 Power in Organisations

As noted in Chapter 3 feminist critics focus on the transition from personal power to
impersonal legal rational forms of domination. The power of the traditional patriarch
who dominated women and children was social in origin but Weber visualised
domination as forming a base for power relations in bureaucracy and rationality.
Masculinity was associated with rationality and femininity with irrationality and
Weber’s theory was distinctly gendered with women being associated with the body
but not the mind. Hence, men generally hold the key roles and seats of power in
organisations. The connection between power and organisations recurs frequently in
this research as it does in the literature. As Becker et al. (1961) say:

Any organisation, no matter what its purposes, consists of the
interaction of men; of their ideas, their wills, their energies, their

With some notable exceptions organisations are the power-houses of men, women
occasionally being admitted as tokens or because they masquerade in the male model. It appeared in the present research that these organisations exert their power by making decisions that affect the private and professional lives of WGP s. Such decisions are frequently made in the absence of women, especially those women who will be most affected by them. As Martin said:

To look closely at any institution is to discover the power of men over the lives of women in and around that institution (Martin 1984, p. 483).

Martin noted that in academic institutions men thrive and are rewarded more grandly than women. Women in academic organisations are disadvantaged by arrangements in which male activities are seen as the norm and hence are significantly rewarded. As is apparent in the present research, the teaching and administration activities that women more commonly perform attract fewer rewards:

To look closely at most academic institutions is to see that in several different ways the reward structure places greater value on traditional male activities than on female activities (Martin 1984, p. 483).

It seems likely to this writer that organisations will work together to improve the issues that concern WGPS only when these bodies have reached the point were they appreciate that by sharing power they cannot only increase their membership of WGPS but also be in a position to use their talents to the benefit of General Practice.
These organisations must also come to understand the mosaic of WGP’s lives and appreciate the inequities that exist. This understanding will enable organisations to view the ‘bigger picture’ of General Practice. That organisations are keen to have WGP’s as members is shown by the participants in this research being inundated with offers to join the various bodies claiming to represent General Practice. This was especially confusing for rural WGP’s as a number of organisations, (the RACGP through its Rural Faculty, AMA, ACRRM, RDAA and Rural Divisions of General Practice) purport to represent the interests and concerns of all rural GPs.

Disappointingly WGP’s who joined these groups often found them to be masculine, hierarchical, preoccupied with the power of their organisation, and lacking concern for the issues of WGP’s.

8.7.2 Reasons Why WGP’s Do Not Join Organisations

Young WGP’s who are carrying the burden professional work and caring for a family find that “the major reasons they did not join organizations were competing obligations and lack of time” (Martin et al. 1988, p. 335).

Another reason raised by the WGP’s in this research as to why they didn’t join organisations was that the cost of a subscription was prohibitive on top of tax, childcare, medical registration, medical indemnity and QA and PD fees. Some of the WGP’s had the added cost of running a car to attend domiciliary patients. There appeared to be no rational basis regarding the cost of subscriptions to some of these organisations, especially subscriptions for GPs who worked part-time.
Although a joint subscription for medical organisation membership has been suggested it has not been embraced by any organisation. Each organisation sets its annual subscription of members at a financial level that will cover its projected budget. The greater the membership the more widely can an organisation spread its costs and activities. However, organisations such as the RACGP, AMA, ACRRM and the RDAA are in direct competition for the subscription dollars of WGs.

The WGs taking part in the research said that an organisation must "be appealing, have relevance to their lives and have had a degree of success". This is commonly referred to as having "runs on the board". Male GP participants were concerned with receiving member benefits and the public relations benefits that come from a figurehead in their organisation namely the President or Chairperson. A President must represent many aspects for the membership including issues relating to gender and ethnicity. WGP participants want to belong to an organisation that has a "broad understanding of health", a policy to improve issues of concern for General Practice and an acceptable bureaucratic structure. However, male GP participants have historically demonstrated a reactive approach and put their energy into "fighting the government and breaking down the system". This approach does not appeal to WGs:

A considerable proportion of female GPs...found the bureaucratic structure of many of the medical organizations unattractive to them (Ferguson 2001, p. 8).
8.7.3 Bureaucracy in Organisations

As previously referred to in this chapter, Weber’s theory of bureaucracy is pertinent for GPs to reflect upon when considering the increase in bureaucracy and the power of the bureaucrats. Weber developed the idea of bureaucracy as a system based on rationality that would be a progressive force in society. Bureaucrats are the employees of organisations or governments and the bureaucratic model is governed by rules rather than discretion. Rules set limits providing an easy way of saying no, but professional autonomy favours discretion rather than rules. The bureaucratic model fosters conservative policy that is not productive or progressive. Yet if an individual bureaucrat is to progress, he or she must be able to expand an empire. Bureaucrats require administrative and technical knowledge and these attributes fit well with hierarchical authority (Barker 1996, pp. 88-100).

GPs have both administrative and technical knowledge as well as the ability to become administrators in General Practice, governments or medical organisations. For some of the WGP's encountered during this research, bureaucracy and the rules that it sets was dominating their professional and non-professional lives. These WGP's lacked the power and voice to argue against the oppression they felt heaped upon them by administrators in government, medical organisations and Colleges.

8.7.4 Professionalism

An understanding of professionalism helps to explain how organisations concerned
with General Practice in Australia operate. Professionalism is concerned with the relationship between the physician and patient and the social contract between physician and society. Society grants the profession privileges, including exclusive or primary responsibility for the provision of services and a high quality of regulation. In return the profession agrees to use these privileges primarily for the benefit of others and only secondarily for its own benefits (Canadian Medical Association 2002, p. 539).

The major features of medical professionalism are the ethic of service, clinical autonomy and self-regulation. In addition there are requirements for specialised knowledge, training of new recruits, exclusive rights to practice in an area of expertise and the existence of a code of conduct. These features pertain to values and attitudes, but the length of training and prestige of the profession are important features especially in setting levels of fees and salaries.

According to Barker (1996) the powerful position of the profession arises because it has monopoly over a particular group, or has opportunities to provide specialist services to a specific patient group. Internal regulation supports the profession's monopoly, and autonomy allows the profession to organise its own works and set its own standards. This form of discretionary power goes beyond the competence provided by medical training and extends to decisions relating to health policy.

There is debate about whether the medical profession is losing its dominance and professionalism with reasons including the rise of alternative health providers and
corporate structures. There is also a tendency for re-stratification of the profession with some doctors in the rank-and-file losing status and autonomy while others in senior policy positions are able to retain and promote their status. Current challenges to professionalism are made by resource restraints, bureaucratic challenges, unprofessional conduct, commercialism, consumerism and industrialisation (Barker 1996, pp. 89-90). Examination of professional autonomy often neglects the distinction between the macro level and the micro level of a profession and the functions that these groups perform:

The elite (macro) level representatives of organized medicine negotiate with governments and health care organizations, and are responsible for knowledge, training, discipline and administration within the profession...the rank and file (micro level) of doctors [are found] delivering services (Lewis and Marjoribanks 2003, pp. 50-51).

WGPs in this research felt that they were “fighting for recognition of their experience” in order to become part of the elite macro level of GPs. As they aged, these WGPs said they were regarded as “past it” whereas the older men were revered for their experience or “wisdom”. The WGPs felt that they had to act in ways that were comfortable to them and that they must be able to set their own terms rather than assume the ways of men.

One significant challenge to the professionalism of Australian GPs is the increasing control by the Federal Government of the financing of General Practice. This control
is achieved by imposing financial constraints on General Practice services. There is a continuing imperative for government to manage budgets and contain costs while at the same time assuring quality for patient care. Particular concerns for GPs include uncertainty about their place in the professional hierarchy, changes in control over practice organisation and a requirement that they demonstrate quality assurance. Other health service providers such as alternative-medicine practitioners, as well as private insurers and lawyers constituted further threats for GPs. The changing patient-doctor relationship, on top of being overworked and undervalued is a major concerns for GPs (Lewis and Marjoribanks 2003, p. 52).

The many challenges to the profession from outside forces may help to explain the behaviour of organisations towards their WGP membership. Feminists argue that hierarchy reflects and reproduces masculine dominance and feminine subordination (Broom 1991, pp. 109-111). There are a few women who reach the higher position of authority and those who do

...often decided it is easier to accept the status quo than individually confront entrenched attitudes and structures. They therefore assume male centered frameworks and operate within them. They essentially become part of the "old boys' club" (Peterson 1994, p. 93).

Broom (1991) argues that the rationality of bureaucracy operates to exclude the feminine, since emotion and "women's concerns" (such a family responsibility and emotional feelings) are not seen as a legitimate part of decision-making
organisations (Broom 1991, p. 110). The focus on rationality also means that critical and creative thinking and experiential, intuitive and emotional kinds of knowledge tend to be excluded (Peterson 1994, p. 94). This research shows that although it is not always obvious, WGPs generally operate on the fringe of organisational activity and WGPs relate closely to the use of intuitive thinking and experiential knowledge in their professional life. However women's intuition is given little credibility by men who then consider that women are not safe to be in decision-making positions in organisations.

8.7.5 How Organisations Operate

Scott Peck (1993) declared that organisations have norms, mottos and myths that are established by the organisation's leaders. These give the organisation its personality or character and much of its definition. Organisations also harbour falsehoods and secrets that are conscious, deliberate falsifications of reality that do not give an organisation an identity but instead give it misdirection:

[These] falsifications initiated by the organization's leaders for the purpose of misinforming the organization itself...are acts of incivility invariably destructive to the organization's health (Scott Peck 1993, pp. 188-189).

In business, myths, mottos, norms, secrets, falsehoods, patterns of togetherness and separateness and power constitute what is called corporate culture. The culture of an organisation is less contingent upon its product than upon the personality or
personalities of those at the top (Scott Peck 1993, p. 234). There needs to be a balance between the individual and those in positions of power in an organisation.

The concept of community can be applied to any group such as a College, university or organisation. Community requires its members to "...honestly and openly speak their minds, to risk intimacy, to confess what is appropriate, to make the hidden known when doing so is helpful" (Scott Peck 1993, p. 284).

It is not possible to introduce community to an organisation unless there is whole-hearted support at the top. If this support exists community can usually be brought to an organisation under almost any circumstance. The only obstacle to introducing community into a business is politics. "Politics is the configuration of personality and power within the organisation" (Scott Peck 1993, pp. 328-329). The WGP's taking part in this research found it impossible to bring new concepts, such as equal opportunity, to fruition in an organisation unless others were willing to support the concept and those with power were ready to accept the concept. Evidently politics can be employed to promote or demote concepts within an organisation.

Some people consider the politics of an organisation to be its culture, since it is the personalities of those at the top that determines culture. Then organisational politics and culture are one in the same. Introducing community into an organisation may be viewed as introducing structure, since structure provides a way of being together, a way of communication. Community is lateral rather than hierarchical and all members of the community are leaders. An organisation that is flexible enough to
“vibrate between hierarchical and community modes of functioning is a vibrant organization” and it can become a “higher form of organizational life” (Scott Peck 1993, p. 336).

One of the WGPs participating in the present research referred to Scott Peck’s description of a “Hole in The Mind” when she was speaking of the organisations and Colleges concerned with General Practice. Scott Peck was addressing an audience mainly of physicians, nurses and other medical professionals trained “to be sensitive to others and conscious of their needs”. Yet when “confronted with their involvement in diseased organisations, they were uninterested, petulant, and missed the point. Yes, there is a hole in the mind” (Scott Peck 1993, p. 32).

In this research the some WGPs considered that the men who were attracted to organisations such as the AMA were unable to examine themselves dispassionately regarding their behaviour, their attitude or their values. These men saw WGPs as “different political animals” and not “like the boys”. They said that some women were “stronger willed” and “better accepted” but the real problem was that there were never enough WGPs engaging in the politics of the organisation. However, the men knew that the WGPs were outspoken on women’s issues and they thought this was “because of their personalities”. In reality, the WGPs were speaking about these issues because of their importance to them, and because of the deep concern that they felt when key issues were repeatedly recycled within an organisation without any decisions being reached.
8.7.6 Masculine Power and Patriarchy

Millett and Walby (referred to in Chapter 3) both supported the notion that women’s oppression lies within patriarchy’s sex gender system and patriarchy is a social system of structures and practices in which men dominate, oppress and exploit women. Men are the chief beneficiaries of power relation of patriarchy and this power creates a sexist society. Millett argued that patriarchy was historically not biologically created and that politics represented power-structural relationships where one group of people is controlled by another. Millet also argued that sex is political because the male-female relationship is the archetypical model of all relationships and that from “sexual politics” women are oppressed in both their public and private domains. As is shown in the final framework of the semi-structured interviews (Appendix 1) power and patriarchy pervaded every aspect of the professional and non-professional lives of the WGPs who took part in this study, so that maintaining healthy and happy relationships free from power and patriarchy became impossible for some.

While other professional women may also suffer difficulties related to power and patriarchy, WGPs are a special case in that they are locked into a doctor-patient relationship that is difficult to break for both the WGP and patient. The WGPs participants in this research took their duty of care for patients very seriously but when some tried to loosen the ties of the doctor-patient relationship so that they could perform their family responsibilities or exercise self-care, they were accused by male GPs of disappointing the patients and not performing as “real” GPs.
Attachment theory is used to explain the relationship between GPs and their patients and what makes these doctor-patient relationships different to those that other professional and business-women have with their clients:

Attachment theory is socio-biological theory of development which postulates that the propensity to make emotional bonds to a differentiated and/or preferred person, conceived as stronger and wiser, is a basic component of human nature, distinct from feeding and sexuality (d’Elia 2000, p. 1959)

This attachment is seen in the neonate who bonds to the care-giver to ensure survival and these attachments continue from the cradle to the grave. WGPs who have children or provide a caring role for aged family members have practical experience of this theory. When a person is threatened with loss, distress or illness they seek out an attachment figure who will provide protection. This theory has implications for GPs and by recognising the patient’s illness behaviour, and the GP’s response to it, manifestations of an attachment patterns can be seen (Thompson and Ciechanowski, 2003). Thus the physician can become more empathetic to patients who may seem difficult or demanding:

Patients commonly complain of medical and psychological symptoms as an expression of underlying relationship need, a need that they may not be able to express verbally or consciously (Thompson and Ciechanowski 2003, p. 224).

The key difference between WGPs and other professional women is that the doctor
patient-relationship incorporates an element of personal attachment and an attachment style that is not easily dispensed with. In other businesses and professions the client is not so closely attached to the provider and the attachment style is not so pronounced.

8.7.7 The Old Boys' Club and the Games that Boys Play

Organisations were seen by some participants in this research as accepting the work and good will of WGPs without giving them support or the opportunity to have a voice and share of power at the most senior levels. As long as the WGPs “play the game” and do not upset the primacy of the senior men in an organisation, these women are regarded as sensible and safe enough to be included in the inner circle. Occasionally a WGP who has demonstrated that she operates in the masculine mould and is not sidetracked by women’s issues may be nominated to occupy a leadership position. The unwritten proviso is that that these women appear to the public as being loyal and in tune with the male-dominated organisation.

Some WGPs participating in this research who identified that they were in this situation, said that their contributions were heard at the committee level in the RACGP and AMA and maintained that those who accused organisations of being a closed shops or old boys’ clubs were basing their comments on false impressions. However, Conley (1992) details the position and “rules” that govern women who are admitted to the “old boys’ club”. According to Conley the hierarchy of “good old boys,” analogous to a Greek fraternity, is dedicated to preservation of its upper echelon in its own image, and the secret rites of passage are revealed and extended.
only to those who mirror the appropriate visage:

Some members of the club leadership are cemented in a mindset that thinks lady members of the club could never possibly possess equal, or even superior, ability of their own...Lady members rarely are allowed to forget that they are there by invitation, are expected to demonstrate eternal gratitude, and always to obey the rules...Ah yes, the rules-fox lady club members, most of the rules remain fuzzy and indistinct except for the cardinal one: never question the behavior of the good old boys, for they direct the destiny of the membership’s career paths (Conley 1992, p. 740).

Conley (1992) relates the fine points of the games that boys play. First of all there is the “guilt game” where the woman is made to feel guilty for taking up the time and effort of the male teacher when the position could be filled by someone who will not drop out and have a baby. Next there is the “salary game” where the male acknowledges that the woman is working as hard as he is but she does not need a salary equal to his because she has a husband to support her, and anyway money is a tangible measure of worth in society so she will be paid less. Then there is the “you must retain the proper position in life game” which has two versions. Version one is the “lets go to bed together game”, so that the male can demonstrate to the world that he is controlling this relationship. Version two is the “honey answer my beeper game” so that if the woman wishes to bask in his light then she must do his bidding as he directs so all can observe her subservience. Finally Conley describes the “don’t bother me with your brain I want your body game”. This is sometimes seen as the
“Let’s go out to lunch to discuss your research project game”. The table conversation has little to do with research but a great deal to do with his sexual preferences, perhaps even his prowess. The woman is dependent on the male for letters of recommendation and references while the male appears to be helping her develop her career. Multiple combinations and permutations of these erosive games are played daily, weekly, yearly, endlessly. Hence, a cultural norm develops that is accepted by all and becomes impervious to change (Conley 1992, p. 740).

Eventually the price becomes unacceptable and the oath of silence that protects the men is broken. However since resignation and the revelations of secrets brings trouble for the members of the old boys’ club, ranks close against the rebel:

Threats bind the good old-boys together in increased solidarity. [The woman concerned] is “too sensitive,” a “bitch”, an “opportunist”, or “crazy”. Former club compatriots of the woman once thought to be “friends” no longer communicate, and the rapidity with which a work place eliminates a former colleague is awesome. The future will always be jeopardized; no one wants to take chances on a “troublemaker” (Conley 1992, p. 740).

Finally the club returns to the set of rules that the boys understand and the male bonding proceeds without the intrusion of women. Although women may be allowed into the club, the boys are much more comfortable when they have departed. Any disturbance that letting women into the club has caused means that considerable time will pass before women are again admitted.
Many authors have made reference to the “club” and the “old-boys” who are its members (Bauder-Nishita 1980; Ruhe and Salladay 1983; Springer 1988; Conley 1992; Holloway 1993; Wenneras and Wold 1997; Loder 1999; De Angelis 2000; More and Greer 2000; Kondro 2002; Levitt et al. 2006). The WGPs taking part in this research experienced the “guilt game” when they were made to feel guilty for not caring for their children, home or partners. They experienced the “salary game” when they were not paid appropriately for the long and complex consultations they performed. They were also not paid a share of the PIP money that the practice received and they were not beneficiaries of the capital gain or profit that came from the business of the practice. As already stated, the verbal or written contracts that these women agreed to frequently did not allow payment of superannuation, sick pay, holiday pay, parental leave, study leave or long service leave. The women were commonly personally responsible for paying registration fees, medical indemnity fees, membership fees of organisations and Colleges, QA and PD fees and the cost of educational sessions and conferences. In addition they also paid for all child-care including care that was required for out-of-hours or on-call work.

The WGPs interviewed in this research also experienced the game of keeping their “proper position in life” when they were cast into the low ranks and back rows of professional organisations and Colleges and they were rarely elevated beyond these levels. In their practices they were given the status of the “pap smear” doctors and the doctors to whom the difficult and mentally ill patients were channeled. Women patients who had social or emotional problems were added to the WGPs list, as were the “disadvantaged” patients. WGPs were not given a share of the short clinical
consultations that the male GPs performed. Is there any wonder that doing
procedural work was frequently impossible for the WGPs who were trapped into
playing this game?

Some WGPs who had demanding, controlling husbands or partners unwillingly
played the "honey answer my beeper game" as they struggled to preserve meaningful
relationships. Other WGPs played "sexual politics", "paraded as honorary men", or
played the "lets go out to lunch to discuss your research game". For many of these
women their future career and professional standing was dependent on the men who
could choose to promote them or not.

However as one WGP participant in this research pointed out, some women achieve
more in their professional life by playing sexual politics but her preference was to
remain true to her own values and beliefs. The case of this WGP is representative of
Riska's Essentialist approach (discussed in Chapter 4) where the dissimilarities
between men and women are openly viewed but the emphasis is on women's
different experiences, values, or way of behaving, feeling and thinking. Alternatively
cultural-feminism (referred to in Chapter 4) could explain the view of the WGP who
clung to her own values and beliefs. In cultural-feminism women have a different
culture and rationality than men because of their childhood experiences. Hence,
women express their cultural beliefs by not taking part in the work and culture of men
but by holding fast to their own values and interests and therefore achieving their
goals as women in their own right.

In considering how to break the old boys' network Springer (1988) maintained that
women doctors needed to learn how to market themselves, build networks and hold positions of authority in organisations. Women need to develop their leadership skills, be assertive and express their worth to potential sponsors (Springer 1988, p. 420).

8.7.8 Token Women and Achieving Gender Balance

On a number of occasions tokenism was referred to by WGPS participating in this research, they being endorsed to fill a position in an organisation in a "token" role. These women provide an opportunity for the organisation to be seen as inclusive rather than misogynistic. According to Briant (1988) tokenism means that

...most male doctor's believe that if one women is evident in a specialty or on a committee then fair play is alive and well. But when one woman has achieved such a place, the process has just begun it is certainly not completed (Briant 1988, p. 299).

Kanter's work (in Chapter 4) proposes a theoretical approach to structural barriers that the WGP participants in this thesis relayed. Kanter focused on organisational behaviour related to a person's position and the opportunity structures in the organisation. Regardless of gender, Kanter hypothesised that in order to understand jobs and the relation of people to them, one must first understand how the contemporary division of labour operates. Kanter further maintained that the key to understanding how organisations function is by discovering the way in which people manage their work experience. When considering the features of a job one must
consider where its occupant stands in terms of organisational opportunity, power, and spheres of influence. Kanter postulated that the first women to enter a “male” field were unlikely to encounter tokenism but rather to experience sex discrimination. She assumes that when an organisation becomes more gender balanced the proportion of a particular social category would influence the power and behaviour of that organisation and its leaders. However, many critics disagree with Kaner on this issue and argue that it is not the numbers that are crucial but rather the male-gendered characteristics of the organisation.

Some organisations appoint a few women to committees or on their boards in order to satisfy a fashionable notion of achieving “gender balance”. These appointments are not actually about dealing with issues of gender at all, as the organisation members mistakenly believe that appointing a female satisfies any need for further consideration of gender inequity:

That doesn’t mean, however, that gender inequity has vanished. It has just gone underground. Today discrimination against women lingers in a plethora of work practices and cultural norms that only appear unbiased. They are common and mundane and woven into the fabric of an organization’s status quo which is why most people don’t notice them, let alone question them. But they create a subtle pattern of systemic disadvantage, which blocks all but a few women from career advancement (Meyerson and Fletcher 2000, p. 128).
An area in organisations that is jealously guarded by the men is the domain of finance. Money is a source of power and is essential for organisational governance. WGP s are usually absent or distanced from having control or dealings with organisational finances. Some male GPs interviewed in the research said that WGP s do not have the experience or training to take part in financial negotiations and business matters, even at the General Practice level. Money is regarded as men’s business and men presume that they know about money and financial dealings by “intuition”. As previously mentioned, men are dismissive of women’s intuition, but when men direct the finances of an organisation without training and experience this is regarded as acceptable.

WGP s who are excluded from professional financial dealings in organisations are sometimes given limited budgets that have been set by the men, so that these WGP s can carry out a “woman’s” project or conduct a committee about women’s issues. The AMA’s Women and Medicine Committee (established in 1989) was said by WGP s participating in this research to be about “sidelining women who were becoming noisy”. By inventing this committee and giving them a few dollars it was hoped that they could be disregarded and ignored. There was confusion about the role of this committee and what it was expected to achieve. According to a male GP participant in a senior position of the AMA, the Women and Medicine Committee was set up to draft policy, promote women’s health issues and to monitor issues relating to women in the medical workforce. Other male GPs who were also in senior
positions in the AMA thought it was about fostering the involvement of the WGPs in politics and to present a public image of women involved in the AMA, which would promote the organisation as being women-friendly. In any case regardless of the intentions of establishing this committee it was clearly not about issues of finance.

8.7.10 Fairness, Femininity and Feminism

In 1999 to celebrate the 10th anniversary of the Women and Medicine Committee two AMA awards were established. The Women in Medicine award was set up to recognise female doctors who were AMA members and had made a major contribution to the medical profession. The second award was The Women’s Health Award that could be awarded to any person who had made a contribution to women’s health. There was no requirement to be an AMA member to receive this award. A possible reason why both males and females were eligible for the Women’s Health Award was, as one WGP said in the research, that it was seen to be “fair to the men”. However in the past it has been generally accepted as fair when only men received awards, but when there is an award that acknowledges women’s achievements the concern of exclusivity is raised. As one of the research recipients said, these issues must be done in a way that does not “put off” the men.

As previously discussed in this chapter, the purpose and function of The Women and Medicine Committee was frequently questioned even though it had both male and female members. Some WGPs in the research study said it was a “feminist organisation” and even though these WGPs professed to be “committed feminists” they claimed to have
difficulties with “feminist type” organisations. They thought that many of the issues that concern women could be dealt with without any need for a dedicated committee. Possibly these WGPs realised that opposition to feminism is common in organisations and that 

...developing “gender awareness” is a long term and complex process and despite an enormous amount of literature and educational methodology being devoted it, “gender sensitivity” is still low in government and non-government agencies. Antagonism to feminist ideas remains a major problem, especially where they threaten traditional male privilege and position (Rea 1997, p. 289).

Why else did these WGPs who professed to be feminists reject the concept of the women in medicine committee? Did they think that the male members of the AMA might regard them as unattractive and unfeminine if they revealed that they were feminists? Possibly they took account of Naomi Wolf’s words in *Fire with Fire*:

> Those supportive of equal rights for women have always been labeled as unfeminine and unattractive...Mary Wollstonecraft, for example who was an early feminist, was called a “hyena in petticoats” which was the eighteenth century equivalent of insults [applied to feminists] (Pritchard Hughes 1997, p. 3).

Perhaps the women in the AMA shared Wolf’s belief that femininity is attractive to men. Femininity is something to aspire to and consists of looking and behaving in certain ways. In Australia women base their conduct on a model of femininity and decide to what extent they will conform to this identity. Femininity involves
...being slim, probably having blond hair, blue eyes and clear skin, wearing clothes that display the body yet not in an openly sexual way. In terms of behaviour, feminine women are perceived as heterosexual, sexually active, good communicators with soft voices, caring towards others (but not themselves), either mothers or planning to be mothers, but perhaps most important of all feminine women are women who do not challenge the authority of men (Pritchard Hughes 1997, p. 4).

Likewise, some women who had become successful in the AMA may not have disclosed the price of their success:

Women doctors who have made it to the top often present themselves as ultra-feminine. This may be a strategy of masquerade designed to disguise their inroads to men's power...they make light of their talents, career struggles, or personal sacrifices (Pringle 1994, p. 209).

Another possible explanation for rejecting feminism by some WGPs participating in this research was that they believed that there had been no discrimination against WGPs in the profession and that women already occupied appropriate positions in their professional lives. These WGPs had difficulty in agreeing with the doctrine of feminism outlined by Abercrombie which claims that women are systemically disadvantaged in modern society and feminism advocates equal opportunity for men and women. Feminism is also a social movement which has gradually improved the position of women in the 20th Century Western society in respect of voting rights,
position in the workplace and marriage (Abercrombie et al. 2000, p. 131).

Perhaps the ‘anti-feminist’ WGP interviewees in this research had lived an advantaged life and had not been challenged by experiencing want or not being able to fill roles that men more commonly occupied. As Wear argues, failing to call oneself a feminist does not necessarily mean that one is not in accord with the views of feminism:

If we really believe that feminism is an inclusive collection of ideologies, agendas, and theories working together toward a common goal, then third-generation feminists (and those working for social change in gender relations who may not even call themselves feminist) are to be included in that collective. Failing to label oneself as a feminist is not necessarily positioning oneself against the various and multiple agendas of feminism. (I say wryly: “A rose by any other name...”)(Wear 1997, p. 55).

Returning to the purpose of the AMA’s Women and Medicine Committee, the question of whether it was about politics, women’s health, women doctors, or placating women in the AMA was removed from consideration in 2000 when the first woman president of the AMA came to power. The Women and Medicine Committee was disbanded and women’s issues were mainstreamed in AMA Committees such as the Public Health Committee, The Council of Doctor’s in Training and The Economics and Workforce Committee. A representative from the Australian Federation of Medical Women was to be invited as an observer, to sit on a relevant AMA Federal Council Committee.
Nobelius and Wainer (2004) claim that "mainstreaming" means that a concept (or process) be fully integrated into all institutional processes so that it becomes a 'mainstream', common or an everyday concept. In the case of gender mainstreaming, the purpose is to identify all points at which gender roles limit access to, and equity in, improved health and social development in the social, structural and institutional context of individuals (Nobelius and Wainer 2004, p. 8). The evidence as to whether this is actually happening in organisations that claims gender mainstreaming has to be examined.

8.7.11 Male Domination and Bullying

Participants in the present research reported that medicine and General Practice has been a "male" culture with "systems" and "processes" put in place to suit men. This male culture not only excludes the ever growing number of women who are becoming doctors but it encourages practises that cause ill-health for both patient and doctor:

The culture of medicine was constructed by men over hundreds of years with long established mores of stoicism, machoism, workaholism and fierce competitiveness, which we now know is damaging for both sexes (Perable 1995, p. 17).

Although women are "no longer recognised as the legal property of men", the WGP's participating in this research identified that they needed to boost their self-esteem so that they could enjoy an independent and enriched professional and non-professional
life. Organisations are slow to progress these concepts for WGPs and the profession has shown a singular lack of recognition for the competence of WGPs to conduct their own businesses and run their own practices. WGPs taking part in this study have been refused a bank loan to establish a practice unless their husbands or fathers acted as guarantors for the loan. In this way a coalition of men retained unwitting control over the women.

"Male dominated" medicine has been tardy in progressing support for WGPs even though there are significantly larger numbers of women graduating from medical school and entering the profession. They have also met extensive barriers to professional advancement and they have had difficulty in being recognised and acknowledged for their professional expertise. WGPs require better acceptance from their male peers and increased support from organisations if advances are to be made in General Practice. As this research show, the professional "working" environment for WGPs needs to change, not because there are more women, but because many will walk away from the profession if it doesn’t fit in and provide women with an opportunity to be part of it. These "intelligent" women are capable of using their talents and being "successful at anything they choose" and should medicine fail to include them in a meaningful way then they will take up that "opportunity to be part of what they decide to do for the rest of their lives".

Although the RACGP was seen in this research as having the potential to support and develop all of its membership, a culture of "bullying, egotism, power, exploitation of positions of power and subversion" existed and the RACGP State Faculties were said
to “harbour the remnants of patriarchal arrangement”. Males demonstrating these undesirable characteristics had pushed their way to powerful positions and “bullied other people into position where they should not be”.

Women within an organisation can have a moderating effect on male bullying and domination, even when these women are not holding prominent positions. However as seen in this research, WGPs who contributed time and effort to the activities of medical organisations were often exposed to “the bullies” and they received little support from them in ascending to positions of power. These WGPs were then left to compensate their practices for absences necessitated by their organisational and domestic commitments. One female research participant told how a female colleague was always “popping in and out” of meetings making calls on her mobile phone to organise her “kids” and her “cat”. While the males gathered to caucus and network, the women attended to their ongoing domestic issues. These WGPs did not have the opportunity as the men did to talk business uninterrupted.

Most definitions of workplace bullying share three elements that are influenced by case law. Firstly, bullying is defined in terms of its effect on the recipient and hence it is subject to variations in personal perceptions. Secondly, there must be a negative effect on the victim and thirdly, the bullying behaviour must be persistent. Bullying is therefore defined as

...persistent, offensive, abuse, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions,
which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress (Quine 1999, p. 229).

Quine (1999) showed that staff who had experienced bullying reported lower levels of job satisfaction and higher levels of job-induced stress. They were more likely to be clinically anxious and depressed and were more likely to report wanting to leave. As Quinn says

...[being] depressed, stressed, or anxious may cause a person to be bullied by unscrupulous workers who choose weaker people as their victims. Anxiety and depression may also weaken a person's ability to cope with stressors such as bullying or make them more likely to perceive other people's behaviour as hostile and critical (Quine 1999, p. 231).

8.7.12 Styles of Management in Organisations

Organisations have different styles of management and the WGPs in the current research experienced organisations that had an authoritarian style of management where communication was from top to bottom. There were less frequent reports of examples of consultative management, and even less common was the empowering style of participatory management where subordinates and superiors communicated as a collective to make decisions. As a result of being better informed by participatory management a manager might make better decisions. However, the manager must want to share power and authority and take on a facilitator's role as
participatory management encourages information gathering, debate and constructive argument between all staff.

Some WGP participants experienced consensual management where decisions were made without voting but rather by achieving a consensus. The requirements that Scott Peck described for a consensual process were not always met in the organisations identified in this research, these including the issues being fully aired, all members being adequately heard, and everyone sharing power and responsibility. Influence by individual stubbornness or charisma is avoided and everyone taking part in the process is maximally empowered. Significant decisions are best made through participative management or by consensus, and this process of sharing power is called collaboration (Scott Peck 1993, pp. 260-265).

8.7.13 Aggression

Some WGP participants in this research felt that the male GPs in organisations were fighting for an improvement in the economic situation of General Practice and a better quality of life. However, some males blamed WGPs for problems existing in General Practice, claiming that General Practice might “fall by the wayside” as it becomes populated by more WGs who would be “happy” with a “less than ideal career status and income”. These men used “bald aggression” to achieve success in the “race” for leadership positions in organisations because “the boys ultimately set the rules” and these rules are based on aggression.
A male GP participant in this research likened the rules in medical organisations to the rules that operated when Britain ran the Empire. Provided you “adhere to the rules you are right” but if you don’t you were “chucked into jail”. How many GPs have been “jailed” by medical organisations for defying the boys’ rules? How often have WGP’s been isolated and ignored because they questioned these rules? These questions must be considered because there are many ways of silencing those who do not comply with rules they consider unjust. Individuals who flout the rules have been commonly subjected to verbal attack, defamatory statements or the withholding of professional rights and privileges. Conversely, those seen to be maintaining the status quo may be awarded honours and decorations. Historically men have received more awards than women in medicine and science and this perpetuates the perceived superiority of men and reinforces their dominance in the system. If an individual opposes the boys’ rules, a tactic sometimes used is to employ that person within the organisation and in that way silence them.

The WGP’s in taking part this research witnessed men who were “appallingly rude” to their male colleagues and “slashed them to bits” but these men were unsure how to deal with WGP’s. They feared that WGP’s might “burst into tears” or “fall over” and “crumble if they were unpleasant” to them. As previously mentioned, the men said that the women were “weak”, “too soft” or “too cooperative” and gave in “too easily”. Even if a woman was “capable” she had to contend with factions such as the “hard right wing of the AMA” which could by “nasty”.

In Western societies it is considered “masculine” to be aggressive, independent and active (Abercrombie et al. 2000, p. 217). It is questionable whether these qualities are characteristics of gender or whether they are biologically or socially determined. Masculinity for young men revolves around aggressive sport as well as group toughness and physical strength and this reinforces macho aggressiveness in society. Connell (1987) examined how competitive sport helps create domains of masculine identity and the negative side of masculinity, saying that the social definition of men as holders of power is translated into mental body-images and fantasies of sporting excellence. “The shape and feel of the body itself is sustained in fantasy and reality by competitive sport. Men’s physical power is exaggerated through it and sustains images of physical aggression. Men and boys demonstrate their affection for each other by hitting each other” (Connell 1987, p. 85).

Testosterone in males is linked to aggression and aggressive characteristics are institutionalised in sport and war. Roland (1988) cites earlier reports that claim that the physiological differences between the sexes create a “preparedness to learn aggression” in males. The social culture of males rewards aggressive behaviour and this ensures the dominance of men as a social group (Rowland 1988, pp. 22-23). Rowland also cites Aida who claimed that

...until now it has been thought that the level of testosterone in a man is normal simply because they have it but if you consider how abnormal their behaviour is, then you are led to the hypothesis that almost all men are suffering from testosterone poisoning. Testosterone poisoning is particularly cruel because
its sufferers usually don’t know they have it. In fact when they are most under its sway they believe they are at their healthiest and most attractive. They even give each other medals for exhibiting the most advanced symptom of the illness (Rowland 1988, p. 22).

Those WGPs interviewed in this research who had taken part in the politics of medical organisations found that it was a “rough game”, a “boisy deal” and “pretty aggressive”. An organisation such as the AMA needed to have women that were “tough nuts” to help carry the load, but there were too few of them and those involved were being “worked to death”. As has already been shown in this research, if the WGPs stayed true to their own knowledge, understanding, and experience their chances of success in organisations were limited, but by engaging in “sexual politics” they had better chances of remaining above the fray, but at the expense of losing their independence and of being beholden to men for their successes.

8.7.14 The Decision-Making Process of Organisations

Some of the males interviewed in this research study were struggling to come to terms with the reality that women who attended a committee meeting could be their equals and not simply secretaries who took the minutes. Some of the barriers and obstructions to WGPs involved in the decision-making processes of the RACGP in particular were starting to break down, but the large number, varied locations, and inopportune times chosen for meetings made it difficult for women to participate. It is a struggle to change the culture, habits and routines of men, and medical women in
the AMA also found difficulty in participating in meetings that were held in the evening or weekends, since many were caring for their family at those times.

In the RACGP some male GP participants believed that women came to the decision-making table through a process of “natural evolution” and “nothing special” had happened to involve these WGPs. The AMA participants also said that the election of females to official organisational positions was a “natural occurrence” rather than a “gender based thing”. One State Based Organisation of General Practice participant claimed that WGPs fit naturally into organisations that are not political. However, once elected they are seen to be “consciously or unconsciously making decisions of a political nature that affect all GPs”, a process that was not considered to be healthy by this participant. This statement is in accord with Riska’s socialisation theory as applied to medicine (discussed in Chapter 4) which claims that one strand of socialisation theory concerns gender difference and another explains the lack of gender difference. In the case discussed above the inclusion of WGPs in the decision-making process was perceived as not being gender based, while their activities in making decisions that affect both female and male GPs was distinctly gender based.

One male GP asserted “positive discrimination did not work and he did not believe in it”. A RACGP participant claimed that the selection of employees for the RACGP National Training Program was made “strictly on quality [and] not gender”. This individual did not think that positive discrimination was needed because the program already had a very high representation of women. Men appear to be uncomfortable
with positive discrimination as it gives advantage to women and this is seen as “unfair” for men.

There were notable changes at the RACGP Council when women first joined as councilors. “Consensus versus confrontation” was the order of the day and a “positive attitude prevailed”. Initially the women who joined the Council “behaved like men” and “endorsed” decisions made on the basis of equal opportunity. They “did not confront or debate men’s decisions” and they “wore the same uniform as men” which enabled them “to get through the door”. James Barry (referred to in Chapter 1) showed that dressing as a man enabled a woman to participate in the power and benefits available only to men in the higher positions of an organisation. Eventually these “champion women” penetrated the club environment and represented a constituency that supported WGPs. They “spoke the language of women” canvassed their issues and did not “blow their own trumpet” or “advance their individual agenda”.

There is a paucity of women doctors in decision-making bodies around the world.

Although the percentage of female medical students and doctors in practice is steadily increasing, women are inadequately represented in the upper hierarchies of medical professional organisations. Internationally, the literature indicates that

...male hegemony in the medical profession continues to determine the patriarchal culture of medicine, impacting on the
way in which medicine is taught and practiced...this situation is detrimental to medical students, doctors and patients and is unlikely to change unless women doctors achieve greater representation in medical academic hierarchies and in professional decision-making bodies (Kane-Berman and Hickman 2003, p. 69).

In this research participants said that the AMA “used confrontation as a tactic” and this caused problems. Some WGPs spoke of individuals starting with enormous “passion, enthusiasm and vision” trying to make change in the AMA, but eventually these individuals “burned out” or the “silent majority” saw that “the guillotines” came down. Long-term AMA members are found “in low risk activities” and the “power brokers” of the organisation are men who are often specialists, in the $1M a year category. WGPs’ salaries by contrast are “chicken feed”. The WGPs identified that they felt uncomfortable taking part in a process of industrial negotiation to receive more money for those doctors who already had comparatively large incomes. Consequently a number of WGPs who took part in the present research found the AMA to be “a negative organisation”. They felt disappointment and hopelessness with the AMA as an organisation and eventually these WGPs “gave up on the AMA” as they felt that it was an organisation “that did not make any comment” to “support” the interests of women.

At the time of this research Divisions of General Practice (established in 1994 and commonly called Divisions) were being established as “fledgling” organisations that had started “from the ground”. Divisions attracted new members because they
offered the opportunity to establish a new culture and they did not commence with a “pre-established hierarchy”, or “power structures”, or take part in the “games that boys play”. The WGPs were aware of “how men love to have their structures, their positions and titles which create rigidity”. Divisions were seen to be “more free-flowing” and open to all GPs in the local area.

Divisions employed the talents of local GPs and “cut through the red tape and the culture of power, hierarchy and requirement for qualification in the form of degrees”. WGPs felt very comfortable in this environment and worked with men who were not accustomed to being bullies. “Flexibility, part-time work, remuneration for work done in a local area, infrastructural support, a culture of inclusiveness, lack of gender bias and lack of constraint by the males” were features of the Divisions that were very attractive for WGPs. Divisions “made the life of WGPs easier and supported their active role” and WGPs thought that Divisions catered for WGPs who previously “were conditioned to defer to men”. Divisions were “not perfect organisations” but they were a “jolly lot better than a lot of others” said one WGP.

8.7.15 The Rural Ethos

In this research one male model of General Practice was defined as being, “trained 20 to 30 years ago, in solo or small practice, on call seven nights a week, family life came second and the rest of the world came third”. Rural Divisions of General Practice were very new at the time of the research and rural WGPs were isolated from rural Divisions and organisations by male domination, “hairy-chested attitudes”, lack
of concern for women’s issues and deafness to the voice of women. Rural WGP\s also felt threatened by male GPs who practised in the male model and hence, unlike urban WGP\s, rural WGP\s were slower to become part of the Divisional movement.

The voice of WGP\s or the lack of it has been referred to by several participants in this research. Indeed the WGP\s in the Delphi Study listed having voice and a share in power as a key issue in their professional life. Gilligan’s work (discussed in Chapter 4) refers to the “silence of women” and “the difficulty in hearing what they say when they speak”. She also comments on the “voice of men” that have for centuries employed their experience to inform moral development. As Gilligan explains men and women “speak in different languages” that they assume are the same, using similar words to encode disparate experiences of self and social relationships.

Unfortunately men sometimes show deafness when women speak. Is this because women speak in a different voice or is it because men exhibit blatant sexism by choosing to ignore what women are saying? The latter is possibly the case according to one of the research participants who suggested that women’s words and suggestions are ignored, but men’s words and suggestions are “acted upon”.

Male rural GPs and the culture of rural General Practice organisations did not appreciate the needs of WGP\s who were working or training in rural General Practice. These WGP\s were interested in providing a different style of practice to the community but there was not any acknowledgement of the rural WGP\s’ needs or interests in the community-health issues of the local population. The “rural ethos” was of a “macho procedural male” who operated in a culture of paternalism and “big
Rural”. The “hairy-chested” rural male was a “big turn off” for WGPs, as was the emphasis that the RDAA placed on large rural operational and procedural issues.

According to Kamien (2004):

...the ability to cope in depth with procedural presentations and emergencies, both in the consulting room and the hospital, defines the rural and remote doctor (Kamien 2004, p. 2).

A possible solution to the observation that “a lot of female GPs...go into rural practice but don’t want to go into full-blown procedural practice” (van Santen 2002) may be to train doctors in a procedural skills program, so that WGPs feel they are adequately equipped to deal with emergencies and procedures. Then they will not be “scared” of procedural medicine, which has been presented up until now as a “male bastion”.

When the rural WGPs in the present study wanted to pick up their children from school they sometimes became victims of male sexism. Sexism has been defined as a public prejudice against women which culturally characterises them as submissive, dependent and supportive, the consequence being the emergence of women as second class citizens in society (Kim and Johnson 1984, p. 61). This tag of second-class citizenship applied well to two rural WGPs who took part in this research who were told by rural male GPs to “choose between motherhood and medicine” or to “get out if the kitchen was too hot”.

Those WGP s training in rural medicine formed a negative image of a rural career after being confronted with pre-World War II procedural employment practices, together with the practice of male GPs “notching up incredible numbers of procedures, 24 hours a day”. Only a few rural WGP s who were located in remote areas “fired shots” that had impact on policy and rural practice. When ACRRM elected a WGP as their President, the women GPs in the research group said they hoped there would be a change in the image of women in rural medicine, so that it would not be necessary to be “ten foot tall and bullet proof” to be a rural doctor.

The rural models of practice were said by the participants in this study to be “damaging and destructive” for those WGP s who were “non ego bound people”. There was no allowance given to WGP s with young children who were required to work or train in rural areas. Going to the country without support or guidelines of appropriate discretionary policy regarding practice, “could wreck their lives”. Even though there was a shortage of rural WGP s, there was no resolution of these problems. Contrary to popular belief rural WGP s work the same number hours as their male counterparts (Kamien 2004, p. 2), inevitably to their considerable cost:

Rural doctors are not homogeneous...[and] there are important issues in relation to workload and the intersection of personal and professional life for women that require immediate attention (Wainer 2004, p. 52).

The changes proposed by Wainer to assist rural WGP s included having fewer work hours and a secure place for everyone in the doctor’s family. Flexible practice
structures, mentoring for WGP\(s\) and personal and financial recognition were also identified as necessary to support rural WGP\(s\) (Wainer 2004, p. 49).

8.7.16 WGP\(s\) in Academia

This research demonstrated that universities do not readily support part-time work for senior academics who are parents. This is a problem for WGP\(s\) who want to work part-time in order to achieve both a successful academic career and a happy family life. The WGP\(s\) reporting on this aspect thought that universities did not seriously consider their careers and they recommended that a culture of legitimising parenting for both men and women be adopted by academic organisations. This would enable both parents to share the task of parenting and at the same time allow the development of a rewarding career in academic General Practice.

These WGP participants in this research who worked in academic departments were faced with a shortage of both academic and support staff and sometimes the professorial position in their department was vacant. Therefore these WGP\(s\) took on heavy responsibilities in administration, leadership and teaching, but as they were often employed part-time and on low remuneration they were unable to undertake research. In the USA the Carnegie Foundation underscored the second-class status of academic women by highlighting their low academic salaries. However, the overall salary differential between women and men is partly due to the relative absence of women faculty members at the higher paying institutions such as research universities (Carnegie Foundation for the Advancement of Teaching 1990, p. 41).
Women in academic institutions are reported to be disadvantaged in their academic career by their participation in clinical patient care (Kaplan et al. 1996, p. 1288). While time spent in teaching and patient care has a negative effect on the academic productivity of all faculty members, institutional support of research, in terms of protected time and access to research space, research assistants and support staff, is substantially lower for women than for men. Although work-site child-care and other such arrangements have a high social value, these endeavours alone are reported to be unlikely to diminish the difference in academic advancement between male and female physicians. Instead there is

...a pervasive prejudice against women, despite similar scholarship, that is manifested throughout academia and is not unique to medicine...[and the] greater representation of women in medical training and entry-level faculty positions will not eliminate sex differences in academic advancement over time (Kaplan et al. 1996, p. 1288).

A critical issue that emerged from the present research was the difficulty that academic WGsPs have in being selected for the “top jobs” such as professorships. WGsPs are kept “moving sideways” and it was very hard for a woman to “crack” a senior appointment. When the “chips are down” the people selecting applicants who have applied for important jobs generally select someone “like themselves”. Men select someone with a “little hair on their face” and who “talk the same language”. Having an equal opportunity officer (generally female) seems to make little
difference to the outcome of the appointment process. In this research women were said to be “acknowledged and respected” in universities but not appointed as professors of General Practice.

Selection of a successful candidate for a top job is said to be based on merit, but merit is subjective and difficult to define. Burton, as cited by Gray (2004) noted that attempts to define merit frequently emphasise what it is not, such as appointment based on patronage or favoritism or a person’s sex, race, marital status. Merit primarily “refers to a relationship between a person’s qualities and those required for performance in a particular position” (Gray 2004, p. 1).

There are subtleties in the selection process for senior positions and according to the Association of American Medical Colleges (AAMC) research “comfort level” is an important factor. If a culture’s leadership is dominantly male, even highly qualified women will be viewed as “risky” because they do not look or sound like the traditional executive. Selection committee members and interviewers may well be unconscious of this kind of bias in themselves (Association of American Medical Colleges (AAMC) 1996, p. 805).

Women academics who exhibit a particular brand of feminism that academic institutions can tolerate are the chosen few who are appointed to show that women are included:

What [happens] with women in academia is a microcosm of what has happened with women in society... a few are let in so
that there are a few women in visible positions who can be pointed to as evidence that women have made it... This means that much of what has succeeded in academia has been allowed to succeed because it's the kind of feminism institutions can live with (Wear 1997, pp. 54-55).

This research also highlighted that having a "doctorate" and a "number of published papers" are benchmarks for promotion in academia. The process of "peer review" of papers has a "club image" and "if you were in the club you "get published" and if not, it is "harder to achieve publications". Also desirable for appointment to a medical professorship is the ability to bring in significant grant-funds and to have trained and worked overseas, especially if the applicant is in clinical medical practice. These expectations mean that most women are destined to remain at lower levels in the hierarchy. One concern is that

...many women are not getting the coaching, research experience, and guidance needed to obtain grants. One study reports that male residents in internal medicine publish about twice the number of articles as their female counterparts (Weilepp 1992, p. 739).

In order to become key players in research and attract research grants, academic WGPs need financial and structural support and experienced researchers to assist them to achieve higher degrees and publications in prestigious peer reviewed journals. Protected time should be available and their achievements should be
promoted in the medical profession and the community. Presentations within schools and at national and international conferences coupled with collaborative interdisciplinary research could provide scaffolding to assist women to progress (Johnsrud and Atwater 1993, pp. 11-12).

While, sexual harassment and unfair treatment in the workplace are defined and monitored, senior academics do not have any requirements in their job description to stop discrimination. A strategy of “small wins” has been suggested since gender discrimination is frequently unrecognised in these institutions:

Gender discrimination now is so deeply embedded in organizational life as to be virtually indiscernible...Even the women who feel its impact are often hard-pressed to know what hit them. That is why we believe that the glass ceiling will be shattered in the new millennium only through a strategy that uses small wins, incremental changes aimed at biases so entrenched in the system that they’re not even noticed until they’re gone...Because the small-wins strategy creates change through diagnosis, dialogue, and experimentation, it usually improves overall efficiency and performance (Meyerson and Fletcher 2000, pp. 127-128).

As also reported in the international literature, informal power structures and “boys’ games” were found in this research to be thriving in universities. The “real power lies with small groups of people, usually men, conferring behind close doors”.

Despite the existence of organisational structures, adverse outcomes for women academics appear to originate in the informal power structures. Informal power
structures also exist in Colleges and other professional organisations despite their claim of openness, transparency and duty of care for staff and students.

Organisations generally do not "conceptualise" or "work out" what to do with issues of discrimination against their staff. According to WGP's participants in this research, emphasis is placed upon describing organisational procedures without including the people who make the "charts flow" and "get things done". In universities, hierarchical bureaucratic structures are used "to block people out from power or money" or manipulate the availability of these attributes for the benefit of people "depending on who it is and where they sit in decision making and power". Yet organisational structures that are transparent, open and democratic can be instituted for the benefit of all staff if organisations wish to have this happen.

One WGP academic described her experiences of gender discrimination when she was applying to join the GP Training Scheme in the UK. During her interview she was asked "Who is going to answer the telephone if you are out, as you do not have a wife". The support that female medical mentors give is critically important for all female GPs and a supportive family, especially a mother or grandmother is also a very important asset for a WGP. As Epstein states (Chapter 4) traditionally the mentor is a senior colleague who provides informal professional socialisation in the secrets of professional conduct and knowledge. Women and medical students are not connected into the mentoring scheme to the same extent as their male counterparts and hence lack the same degree of informal socialisation and information transfer.
Allen (2005) in a study of women doctors and their careers in the UK also drew attention to the importance of mentors and role models for medical women in areas of consultancy, specialist registrars and academic medicine (Allen 2005, pp. 570-571).

WGPs do not tend to be “organisational people” but organisations hold the political power to determine what happens in their lives. This research suggests that “women have to get in there and work and understand how hierarchies work. Caring and sharing does not work well” and women fail if they cannot cope with established power processes. Little has changed regarding the appointment of women in universities:

Robbins...points the finger at “the old boys’ network of deans and academic vice presidents that shuts out women...Several universities have not appointed a single woman...One would have thought, by now, that enlightenment would have prevailed”...affirmative action plans and more aggressive recruitment are needed to make a real difference in the short run (Kondro 2002, p. 2319).

Harvard’s Grosz (cited by Lawler, 1999) thought that gender balance was an issue for the university rather than an issue that women had to confront: “If we are not getting the best women, we are not getting the best people...we ought to have the best women. Why don’t we?” (Lawler 1999, p. 1278). Not having the “best women” in medicine and academia is of grave concern not only for academia but for the
community. If the community expects the delivery of high quality medical care it has a role in ensuring that those women who are the “best” practitioners are supported in senior positions in academia and clinical practice. It is likely that little will change in the immediate future since those charged with responsibilities of selection continue to choose those who “speak their language” and support the status quo.

The main barriers to women’s academic advancement are now cultural but as previously stated in this research, changes in values and expectations take time to occur. Gender factors such as hiring and promotion, personal style, self-promotion and networking are more accessible to men than to women. The categories which are used to define merit “appear...to favour male academics” (Hawkes 1996, p. 61). Some WGPs participating in this research found that they were kept “moving sideways” instead of being promoted. With the increasing numbers of women in medical schools and General Practice, there needs to be a systemic change to accelerate the appointment of more women into senior academics positions. This will be uncomfortable for men who have thrived in a patriarchal academic culture. However the old boys’ system must be shed and academic organisations must move away from the “…male model that has been perpetuated by cultural hegemony where men benefit from both formal and informal patriarchal support systems that ensure they are promoting each other” (Bagilhole and Goode 2001 p. 176).

Bennett advises that in order to increase the presence and contribution of WGPs in professional organisations:
Women must be brought into the power structure of medical schools by being recruited to dean, chair, and unit head positions and by being asked to serve on important administrative committees. They must become more visible to students by teaching in basic science courses and by being invited to speak at grand rounds and at special teaching conferences and symposia... If medicine hopes to continue to attract the best...students, the needs of women in medicine must be addressed and their enormous contributions recognized (Bennett and Nickerson 1992, p. 118).

8.7.17 WGs in Leadership of Medical Organisations and Colleges

Sinclair (1998) has defined leadership as a

...social construction - the product of the emotional and often unconscious need, early experiences and group aspirations of the led, as well as the traits and skills of the leader (Sinclair 1998, p. 1).

Sinclair espouses four stages of conceptualisations and explanations for the absence of women in senior management. Stage one is the denial phase because the absence of women from executive levels is not regarded as a problem or a core business issue. In stage two, women's differences are the problem and the solution lies in women learning to adapt to (male) norms. In stage three the organisation recognises that there is a problem and tries to solve it by incremental adjustment at the margin to allow access by individual women. One or two targeted appointments of women are made. These women already have a track record and are not seen as "high risk".
Stage four consists of commitment to a new culture. The exclusion of women is recognised as a symptom of deeper problems requiring solutions focussed on the existing culture. New initiatives examine the way things are currently done and the need for "inside out change" (Sinclair 1998, p. 19).

This research shows that most medical organisations have not yet progressed to stage four (and many have not made stage three) or committed to a new culture. Examining the way the organisation operates and the way "things are done" or providing the opportunity for leadership was not on the agenda of senior management for the organisations reported in this thesis. As an example, one male GP participant said that he approved of the possibility that a woman would "follow him into a senior position in the organisation" but he did not want her to "beat" him during the election process.

The participants in the present research claimed that a "glass ceiling" had prevented WGP from achieving senior positions in general practitioner and academic bodies, yet in the years 1998 to 2003 the RACGP, AMA, ADGP and RDAA had each elected a WGP for the first time as their president. This was applauded as a measure of the bodies progressing with time. However, this may have been a sophisticated version of a boy's game namely "follow the leader", so that each organisation was publicly seen to be on par with each other. Time will confirm whether the election of women in top positions signifies a real cultural change in these organisations or rather that these organisations have reached stage three of Sinclair's progression.
By 2005 Australian universities appointed some women to leadership positions. There have been at least five women WGP appointed as Associate Professors of General Practice. Some of the appointments fill newly created positions rather than being promotion through the ranks. However, there is no female in the Deans of Medical Schools Committee and no WGP has ever held the position of Vice Chancellor although one has been Chancellor of an Australian university and another was recently appointed as Deputy Chancellor.

Why it has taken so long for WGP to obtain top appointments in institutions has been explained thus:

It’s not the ceiling that’s holding women back; it’s the whole structure of the organizations in which we work: the foundation, the beams, the walls, the very air (Meyerson and Fletcher 2000, p. 136).

This and other research shows that the status quo must change so that WGP are able to make a real contribution in medical organisations. Women must be seen as “comfortable, attractive and loved as strong and intellectual” said one WGP.

Socialisation is a process by which societal values and expectations, such as those concerning ‘proper’ gender attributes, are accepted by an individual and internalised, thus becoming part of the person’s sense of self or identity. The initial socialisation in a person’s life is modified through secondary socialisation by being part of other groups and institutions such as the education system, peer groups and professional organisations (Wearing 1996, pp. 92-93).
Socialisation is based on fixed and complementary roles for both adult sexes. Traditionally the male is father, provider and protector and the woman is mother, carer and nurturer. Gender socialisation commences in the family and is a life-long process, but unless there is significant change in the power relationships between women and men...the construction of gender will continue to ensure that men remain the more powerful and that women accept their submission (Wearing 1996, p. 113).

Socialisation can be thought of as a process by which people selectively acquire the interests, skills, knowledge and culture of the groups in which they seek to become members (Martin et al. 1988, p. 333). WGPs respond to the socialising forces so that some of their attributes are similar to those of their male colleagues while others are very different. Gender and medical socialisation interact to determine professional values, attitudes and behaviours. Gender socialisation has a major influence on the career paths of WGPs and medical socialisation has a more powerful influence on practice style.

The position of WGPs in society was seen in the current research to be related to the role that they played as the "care givers" for children and aged family members. Consequently women are not regarded as the leaders of a heterosexual group and
rarely do they form part of a majority leadership group. WGP s taking positions of leadership “on an equal footing with men” was seen as “a big thing” by WGP s taking part in this research and this gave “courage” to those who thought they also had potential to play a role in organisations.

The question of how to involve women “without being unfair to men” was raised by the participants in the research. The solution offered was that there had to be other ways of socialising women through schools and the education system so there is room for women in organisations. It is interesting that women’s push for equity is required to be “fair to men” as the experiences of women in the past has hardly been fair to them. “A fair go” is a sacred part of Australian society, but the expression tends to be used by males as a way of protecting their territory, positions and interests. It is acceptable for men to set the rules of involvement or engagement but any challenge to these rules by women who want to trespass on the men’s territory is quickly pronounced as being unfair.

8.7.17.1 Creating Change to the Barriers Preventing Leadership

It was readily apparent during this research that there are many barriers to WGP s achieving leadership. Organisations have functioned in the same mode for a long time and changing them is very difficult; they are dominated by “strong willed personalities who believe their view of life is the only view”. For change to be made it is necessary to wait until the old set of individuals move on, but this is hardly
possible as "they are surrounded by a whole lot of clones who think and feel the same way".

Some participants in this research thought that barriers to WGPs gaining leadership no longer existed. This particularly applied to women who waited until they were "40 plus" before they applied for leadership positions, a necessary wait because "there is no gender equity in caring for children". Perhaps one reason that organisations do not encourage younger men and women to leadership positions is that they prefer older men (and women if necessary) who are in tune with the old boys' ways of thinking and acting. However, lack of qualifications for high position cannot be the answer:

Among the reasons given for the discrepancy [of young women] in leadership positions is that younger women have not yet accumulated the experience necessary for leadership positions or that they are not interested because of family responsibilities. That these reasons are questionable is attested to by the data indicating that despite their commitment and hard work, women continue to rise more slowly in organizational structures than men of comparable qualifications (Nadelsnn 1989, p 26).

There is now a large cohort of younger women in the medical pipeline who may not be prepared to wait out their apprenticeship to take command. However past experience has shown that

... this pipeline is a misleading metaphor, implying that what
goes in one end eventually comes out of the other, suitably groomed and trained for leadership. The metaphor obscures the numerous invisible barriers and twists through which most men, but very few women, emerge (Sinclair 1998, p. 33).

The participants in this research reported that when women occupy high positions it is “exact hard work” and demanding of time. They have to work harder, and make sure they are dealing fairly with people. They attract a deal of criticism and many WGP are not prepared to put up with the “cruel attitudes” that are displayed towards women in positions of power and therefore do not want to take up the challenge. One male participant in this research said that it takes years of dedicated work “puting in one’s heart and soul to reach the position of President” and requires sacrifice of one’s family and practice. Some organisations allow their ex-Presidents to become “feather dusters” or members of the archives committee, while others create positions where the past-Presidents become culture carriers.

One way of attracting women to positions of leadership in organisations is by offering them support and promotion. It is essential to provide support for individuals at the “macro level” in the medico-political environment and on the “micro-level” at a one-to-one daily basis. It is about finding women who are prepared to be involved in key positions. It became clear during this study that the AMA did not consider that being a woman has any influence on the candidate selection process. Such denial brings to mind

...“micro-inequities” [used] to describe aspects of the work
environment that are legally non-actionable and they may even escape conscious attention, but that are inappropriate, unfair, painful, and destructive (Bickel 1995, p. 166).

Bickel cites a broad collection of micro-inequities including supportive discouragement, friendly harassment, radiant devaluation, benevolent exploitation, considerate domination and collegial exclusion (Bickel 1995, p. 166). These micro-inequities interfere with the professional development of WGPs and exact a costly toll on their self-confidence and relationships.

WGPs who had been involved in leadership positions in the AMA reported their “isolation and lack of guidance or affirmative feedback” creating a situation where they were “leading from a vacuum”. One WGP said that this appears to be acceptable until something was done that is not agreeable to the members, then they come down like a “ton of bricks”. Leading from the front was difficult especially when one has an agenda for change. A WGP likened it to feeding the chooks “You have to sort of spray it out and wait for them to come and think they had actually found it all on their own”.

Some WGPs participating in this research knew that holding leadership positions could emotionally harm them. One WGP emerged from her position of leadership in the AMA feeling “sapped, bitter and twisted”. Negotiation with the government was “negative and nasty” and she found the process to be very adversarial as she came from a feminist background and “she was used to a process of consensus thinking”. 

This WGP decided to take preventative action for her health, through debriefing with a person who had the skill to deal with her emotional responses. She wondered whether she was representative of the WGP membership at large. In recounting the experience of another young male member discouraged from seeking a leadership position, she considered that those blocking his way wanted to “revert to the old traditionalism”.

8.7.17.2 The Future for WGPs in Leadership, Organisations and the Medical Profession

It was reported by some participants in this study that “number crunchers” and “bean counters” may try to limit the number of women in medicine because they “consider they do not get their money’s worth” and WGs’ practice could be thought to be “not worthwhile”. “Medicine is becoming increasingly technocratic and the focus is not patient centred”. One female participant said that medicine could “rise up” and say “enough” and demand that the patients be given centre stage so they can select the type of medical service that WGs deliver.

The place of women in leadership is still not on solid ground, and there are murmurs that if there are too many women in medicine, some action may have to be taken. What such action may be is uncertain. A parallel could be drawn with the lack of male teachers in Australia. The response of the Federal Education Minister to this situation was to offer teaching scholarships for male applicants. Women were excluded and the Minister thought that it was “important” that the Sex Discrimination
Act be amended to allow these scholarships to be exclusively for male applicants (Clarke 2004, p. 4).

In 1998 two reviews concerning General Practice, were commissioned by the Commonwealth Minister of Health and Family Service. The purpose of the General Practice Strategy Review was to evaluate progress, to identify achievements and areas for improvement, and to provide advice on future direction (General Practice Strategy Review Group 1998, p. 1). The review of General Practice Education and Training arose from the need to consider the future of General Practice education and make sure it was capable of meeting the needs of the Australian community into the 21st Century (General Practice Education & Training 2004, p. 1). Changes arising from the recommendations of both reviews have contributed to the shape of General Practice as it is today, and the position of WGP in it.

The participants in this research noted that the General Practice Strategy Review and the Review of Education Training advised that there was an urgent need for the profession to address the issues of the increasing number of women in the medical profession. If these women were not to be lost to the profession then change was necessary in the environment of the General Practice, the workplace and training. These reviews tackled workforce, finance and training, and acknowledged that significant issues exist for organisations and the profession. The challenge for the future is to identify opportunities that will allow WGP to have a significant role in the General Practice workplace and organisations while also having a fulfilling non-professional life.
8.8 Conclusions

In this chapter the themes that arose from this research have been critically explored by using literature, theory, history and the wisdom found in the words of the research participants. Hence, the mosaic that forms the professional and non-professional lives of WGPs in Australia and the socio-political space they occupy in medical organisations and Colleges have been examined. It is apparent that WGPs' lives revolve around the interplay of their professional and non-professional relationships, and their socio-political position in organisations and Colleges. While younger generations of GPs are responding differently to the power and patriarchy that affects their lives and to the existing culture within the medical profession, it appears that patriarchy remains an enduring issue. In the words of Zerbe (1992):

> Historically, it has been difficult for women to find and maintain close affirmative ties with men while they also strive to advance their careers... When mentor or supportive partners are available to women, their creative productivity flourishes... In contrast when male partners seek greedily to control or enviously to attack the woman's aspirations, her creativity wanes and her life may be ravaged... The lives of men and women may be enhanced when neither partner disavows or seeks to denigrate the talents of the other. Creative partnerships that support the emotional and productive intensity of both members of the dyad can lead to great personal expansion and enrichment of the culture at large (Zerbe 1992, p. 311).
Chapter 9

Significant Conclusions Reached in this Thesis

This research shows that we cannot examine the professional lives of WGP's without also considering their non-professional lives. The final framework of this research (Appendix I) illustrates the dynamic interactions between the WGP's private relationships, self-care, professional work, and the socio-political space they occupy in medical organisations and Colleges. In addition the final framework shows that a significant influence on WGP's lives was the continuing domination of masculine power and patriarchy over all aspects of their professional and non-professional lives.

When the research results are combined with a review of the literature, history and sociological theory it becomes apparent that gender differences have had a major effect on the professional and private lives of WGP's, but generational change is tending to ameliorate the detrimental effects that result from professional socialisation.

The WGP research participants sought ways of providing a family focus for their relationships with their partners, children, family and friends. They also searched for realistic ways of achieving balance as wives, mothers, and professionals. It emerged that relationships are fundamental to the lives of the WGP's who perceive that these
relationships are being adversely affected by the demands of the professional workplace. Major difficulties for the WGP participants were lack of time for self-care and for non-medical interests. They also had limited time to nurture their relationships with their partners and found it difficult to find appropriate, high quality, affordable and accessible child-care.

By adopting non-masculine models of work in General Practice some WGP participants managed to achieve job satisfaction and escape discrimination or male domination. Factors conducive to job satisfaction included part-time work, job sharing, supportive work practices, flexibility, safety in the workplace and fair remuneration. These factors encourage the continuing presence of WGPS in the professional workplace. Improving the presence and activity of WGPS in the workplace is not just a matter of increasing numbers. It is dependent upon fostering a diversity of work, autonomy, choice of workplace location, and a culture change that addresses patriarchy and better supports WGPS in their quest for equity in all aspects of their lives. The combined burden of rigid rules and bureaucracy during training, education and professional work and the political interference in their private lives has been found in this research to drive WGPS from General Practice towards non-medical pursuits in life.

The WGP participants in this research highlighted the need for organisational endorsement of their valuable contributions to the field of medicine and the validation of the different styles they use in conducting their lives. The operation of hierarchy, politics, discrimination and masculine structures and systems, were negative factors
that the WGP participants faced in professional organisations and Colleges. The presence of a club mentality, masculine power and control in organisations were not tolerable for many of the WGP participants and tended to work against them in leadership roles. They also rejected tokenism but rather sought to have a voice, share the power of organisations and become part of the decision-making process. They also desired mentors and role models to assist them in reaching their full potential as individuals and as active contributors to the medical profession and society.

It is an issue of justice to address such profound issues of gender inequity, and move beyond the concept of equality in the professional workplace, organisations and Colleges, where the guise of equal opportunity has not addressed the structural dimension of inequity. Equity implies fairness and justice, and the responsibility for the implementation of equity lies with the individuals who govern organisations and with the membership who elect them. In this research lack of equity was evident in the processes and requirements for promotion and appointment of WGP's to positions of leadership in academia and some medical organisation and Colleges. Injustices for WGP's were seen to be expressed not only in overt ways but also as micro-inequities in professional practice and organisations. Future progress can be made toward attaining equity by examining gender and cultural beliefs pertaining to the professional workplace and medical organisations and by incorporating these issues into the training and professional development of GPs and medical students.

It is anticipated that generational change will continue to challenge patriarchy and inequities that constrain the lives of WGP's. This will enable them to lead more
diverse and cohesive family lives and enjoy satisfying professional work. To achieve this we need to continue to critically explore the way GPs live and interact with their peers by closely examining the powerful discourses, norms and structures identified and explored in this thesis.

This research has examined the composite structure of the mosaic of the professional and non-professional lives of WGPs in Australia, but further research is recommended to discover how best to preserve the whole-person dimensions of WGPs' lives, and how to engage policy makers to draw upon this concept when making decisions regarding WGPs. The socio-political space WGPs occupy and the organisations and Colleges concerned with General Practice is permeated by a dominant masculine culture. A culture inclusive of both male and females must be fostered to enable all GPs to have a balanced and satisfying professional and non-professional lives.

The hope for WGPs in the future is encapsulated in the words of Bell Burnell who, when writing about the future for female astronomers, said:

I no longer believe that making women more courageous, more assertive, more like men, is the right way to move forwards. Women should not have to do all the adapting. It is time for society to move toward women, not women toward society... Women have begun to move society toward them, and familiarity will help to breed acceptance. I hope that younger women will find the field increasingly open and accepting and
that their achievements will be readily recognized (Bell Burnell 2004, p. 489).

The wisdom of WGPs can assist in fostering personal and professional lives which enriches General Practice for all stakeholders in society. How this can be achieved remains an enduring challenge not just one for WGPs but also for the profession, medical organisations, Colleges, government and wider society.
FRAMEWORK OF THE PROFESSIONAL
AND NON-PROFESSIONAL LIVES OF WOMEN GPs

Masculine Power and Patriarchy

- Relationships and Self-care
- Women GPs in the Professional Workplace
- Women GPs in Medical Organisations and Colleges
- The Differences between Men and Women
- Generational Change
The Wonca Working Party on Women and Family Medicine (WWPWFM) was charged with the responsibility for developing recommendations on how to achieve and maintain gender equity within the World Organisation of Family Doctors (Wonca). Twenty-five leading women from 16 different countries and all six Wonca regions met in August 2006 at McMaster University, Hamilton, Canada.

The WWPWFM makes the following statement:

1. Cognizant of the fundamental aspiration of all individuals, families, communities and peoples to achieve and maintain the highest quality of life;
2. Recognizing the centrality of improved and optimal health to the achievement of the highest quality of life;
3. Recalling the important provisions of the charters, declarations and instruments of the United Nations, WHO, UNDP and other international organizations regarding human rights, equity, development, health and human dignity;
4. Convinced of the centrality of women's and girls' status as a determinant of the health of women and children, and of the families and communities of which they are part,
5. Recognizing that the elimination of gender inequality (as well as other violations of universal human rights) is an important prerequisite for development, including the improvement and achievement of optimal health;
6. Affirming that the improvement and achievement of optimal health is dependent on high standards and levels of health care provision, organization, teaching and research;
7. Convinced that general practice/family medicine is the cornerstone of the achievement of high standards and levels of health care provision, organization, teaching and research throughout the world;
8. Noting the global benefit of organization and knowledge exchange between general practice/family medicine organizations and practitioners, and between general practice/family medicine and other organizations concerned with health and medical care;

The WWPWFM urges the general practice/family medicine organizations of the world that are constituted as the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (Wonca) to adopt the following fundamental recommendations regarding gender equity:

1. Enshrine the principle of gender equity within Wonca governance by amending the Wonca By-laws and Regulations, as proposed by the WWPWFM.
2. Implement gender equity in all activities of Wonca, in particular the scientific programs of its triennial, regional, and rural meetings.
3. Promulgate the pivotal role of gender as a key determinant of health.
4. Promote the equitable inclusion and advancement of women general practitioners/family physicians in Women.

Signed in Hamilton, Ontario, Canada
24th August 2006

Dr. Cheryl Levitt
Chair, WWPWFWM
Family Physician
Professor, Department of Family Medicine
McMaster University, Hamilton, Canada
President, Ontario College of Family Physicians

Dr. Susana Alvear
Family Physician
Family Practice Residency Director
Catholic University and Vozandes Hospital
Quito, Ecuador

Dr. Marie Andrades
Family Physician
Family Medicine Department
Aga Khan University
Karachi, Pakistan

Dr. Kate Auteyi
Family Physician
Abuja, Nigeria
West Africa

Dr. Liliana Arias-Castillo
Family Physician
Dean of Health Sciences
Universidad del Valle
Cali, Colombia
Dr. Nandani de Silva  
Family Physician  
Professor of Family Medicine  
Vice Chancellor  
Open University of Sri Lanka  
Vice President  
College of General Practitioners of Sri Lanka  
Colombo, Sri Lanka.

Dr. Sheila Dunn  
Family Physician  
Women's College Hospital  
Toronto, Canada

Dr. Kymm Feldman  
Family Physician  
Pre-clerkship Director  
Department of Family Medicine, University of Toronto, Women's College Hospital  
Toronto, Canada

Dr. Linda French  
Family Physician  
Associate Professor  
Department of Family Practice  
College of Human Medicine  
Michigan State University, USA

Dr. Betsy Garrett  
Family Physician  
Professor of Clinical Family and Community Medicine  
University of Missouri-Columbia  
USA

Dr. Lisa Heitmann  
Family Physician  
Austrian Representative to the Council of the European Society of General Practice/Family Medicine  
Graz, Austria

Michelle Howard, MSc,  
Research Coordinator  
Department of Family Medicine, McMaster University  
Hamilton, Ontario  
Canada

Dr. Marlene Joseph  
Family Physician  
St. John's, Antigua and Barbuda

Dr. Flor Ledesma  
Family Physician  
Associate Professor, Dpto. Integral Public Health  
University of Zulia  
Maracaibo-Edo.Zulia  
Venezuela

Dr. Barbara Lent  
Family Physician  
Associate Dean  
Schulich School of Medicine and Dentistry  
The University of Western Ontario  
London, Ontario, Canada
Dr. Zorayda Leopando
Family Physician
Professor of Family and Community Medicine
Vice Chancellor for Planning and Development
University of the Philippines
Manila, Philippines

Dr. Dorothy Pieters-Janga
Family Physician,
Director of CCFP for Curacao,
Netherlands Antilles (Dutch West Indies)
Curacao, Netherlands Antilles

Dr. Somjit Prueksaritanond
Family Physician
Associate Professor Family Medicine
Department of Family Medicine
Ramathibodi Medical School
Mahidol University
Bangkok, Thailand

Dr. Sue Smith
Family Physician
Assoc Prof, Dept of Family Medicine
BPKIHS
Dharan, Nepal

Dr. Ruth Strasser
Family Physician
Associate Professor Family Medicine
Northern Ontario Medical School
Sudbury, Ontario, Canada

Dr. Ruth Stewart
Family Physician
Director of Women in Rural Practice
Australian College of Rural and Remote Medicine
Camperdown, Victoria, Australia
Appendix 3

THE SPIRALING RESEARCH APPROACH
The Delphi Study Position Paper

I am inviting you, as a woman who has expertise in General Practice to take part in a Delphi study. The question for consideration in this study is “what do women general practitioners in Australia consider to be the key issues in their professional and non-professional lives?”

Women GPs have a wealth of experience and wisdom about their professional and non-professional lives. However significant gaps exist in the knowledge and understanding about the lives of women GPs in Australia. A meaningful picture cannot be constructed until those gaps are researched and the forthcoming information is fitted into a global picture. It is vital for the future of women GPs to tap into this valuable pool of expert information during the Delphi study.

The objectives of the study are:

- To identify priorities and reach a consensus on the key issues.
- To verify important issues for the future and suggest strategies for tackling and dealing with them.
- To establish guidelines about the concerns and priority areas for women in general practice.

The outcomes from this study will assist me to progress the work I am conducting as part of my PhD program at the University of Tasmania. This study uses the Delphi Technique. It will involve a group of women GPs participants who respond to written material that has been generated by the participant group until a consensus is achieved. The time commitment will be minimal and material will be sent for your consideration on three occasions. The participants and their personal responses will not be identified in the study and a person may withdraw from the study at any time. A reference group of women general practitioners will be overseeing the process and providing wise council throughout the study.

The study has been granted ethical approval by The Royal Australian College of
General Practitioners Ethics Committee and a grant from The Royal Australian College of General Practitioners College Foundation has provided funding. I look forward to working with you during this study.

Yours sincerely,

Margaret Kilman
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
### Selection Criteria for the Participant Experts in the Delphi Study

<table>
<thead>
<tr>
<th>Criteria</th>
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<tbody>
<tr>
<td>1) Working full-time as a general practitioner (GP)</td>
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<td>2) Working part-time as a GP</td>
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<td>3) Locum GP</td>
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<td>4) Royal Australian College of General Practitioners (RACGP) registrar in the RACGP Training Program</td>
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<td>5) Training in rural General Practice</td>
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<td>6) Retired</td>
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<td>7) On leave from General Practice</td>
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<td>8) Vocationally Registered</td>
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<tr>
<td>9) Not Vocationally Registered</td>
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<td>10) In solo General Practice</td>
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<td>11) In group General Practice</td>
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<td>12) Principal in General Practice</td>
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<td>13) Associate in General Practice</td>
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<td>14) Partner in General Practice</td>
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<td>15) Government employee in General Practice</td>
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<td>16) In private General Practice</td>
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<tr>
<td>17) Works in a community health centre as a GP</td>
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<td>18) Works in a women's health centre as a GP</td>
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<td>19) Works in a hospital as a GP</td>
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<td>20) Works in special interest areas of General Practice e.g. family planning</td>
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<tr>
<td>21) Works as a GP with a special interest in counselling</td>
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<td>22) Works in migrant health</td>
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<td>23) Works in aboriginal health</td>
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<td>24) Works in telemedicine</td>
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<tr>
<td>25) Lives with a partner</td>
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<td>26) Lives without a partner</td>
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<tr>
<td>27) Hospital resident in the RACGP Training Program</td>
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<tr>
<td>28) Hospital resident in the Rural Training Program</td>
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<tr>
<td>29) In academic General Practice</td>
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<td>30) Provides postgraduate education in General Practice</td>
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<td>31) Provides postgraduate education in rural General Practice</td>
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<td>32) Provides undergraduate medical education in General Practice</td>
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<tr>
<td>33) Provides undergraduate medical education in rural General Practice</td>
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<tr>
<td>34) Is a State director in the RACGP Training Program</td>
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<td>35) Medical educator in the RACGP Training Program</td>
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<td>36) General Practitioner from a non English-speaking background</td>
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<td>37) General Practitioner of Aboriginal or Torres Strait Islander descent</td>
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<td>38) General Practitioner with a disability</td>
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<td>39) In General Practice in a capital city</td>
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<td>40) In General Practice in a metropolitan centre (population equal to or greater than 100,000)</td>
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<td>41) In rural General Practice in a large centre (population 25,000 or more)</td>
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<td>42) In rural General Practice in a small rural centre (population 10,000 to 24,999)</td>
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<tr>
<td>43) In rural General Practice in a remote centre (population of 5,000 or more)</td>
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<td>44) Has children/child 0-5 years</td>
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<td>45) Has children/child 6 to 11 years</td>
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<td>46) Has children/child 12 to 17 years</td>
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<td>47) Has children/child 18 years and over</td>
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<td>48) Has a Fellowship of The Royal Australian College of General Practitioners</td>
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<td>49) Member of the Australian Medical Association</td>
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<td>50) Member of a Division of General Practice</td>
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<td>51) Member of the Rural Doctors Association of Australia</td>
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<td>52) Member of The Medical Women’s Society</td>
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<td>53) Member of Australian Association of General Practice</td>
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<td>54) Member of Australian Association of Academic General Practice</td>
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Delphi Questionnaire #1

Instructions for responding to Delphi Questionnaire #1

Please read all the questions before beginning to respond to this questionnaire.

Under each question in this Delphi study there are two columns. In the left hand column, entitled Key Issues, please list the key issues, as you perceive them in (Q1) the professional and (Q2) the non-professional lives of women general practitioners.

The right hand column is entitled Examples. It is very important that you give an example corresponding to your opinions in the left hand column. The example should be brief but should demonstrate why you think this is a key issue for either you personally or for women general practitioners in general. The answers in two columns will give me two ways of viewing your answers to be sure I don't misinterpret your responses.

Please consider the broadest possible definition of "professional and non-professional life" in your answer.

Professional life includes a variety of work in a number of workplaces with numerous people and an array of additional factors. A few examples are: clinical, academic, administrative, business, teaching, research, self-education, community group projects, governments, councils, health consumers, professional bodies, Colleges, Divisions of General Practice, special interest groups, committees, politics and patients. This list is incomplete.

Non-professional (private) life includes an array of people, work, activities, places and additional factors that are part of life in society outside the medical profession. A few examples are: involvement with partners, families, colleagues and friends, Domestic responsibilities, child-care, self-care, life-style. This list is incomplete.

If your writing is difficult to read please print your responses.

Please return the completed questionnaire in the mail using the reply-paid envelope. Please notify me, if you change your address and/or contact numbers.
From your experience as a woman general practitioner, what are the key issues in the professional lives of Australian Women General Practitioners as you see them?

Please consider the broadest possible definition of "professional life" in your answer. Please see the cover page for an explanation of "professional life".

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Examples</th>
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Q2. From your experience as a woman general practitioner, what are the *key issues* in the *non-professional lives* of Australian Women General Practitioners as you see them?

Please consider the *broadest possible definition of "non-professional life"* in your answer.

Please see the cover page for an explanation of "non-professional life".

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Examples</th>
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Dear Doctor .................................

The first round of the Delphi Study has progressed very well. The study participants have responded enthusiastically and I have received replies from 40 out of a possible 41. Each of their replies have been carefully analysed and round two has been sent out. I am enclosing for your information a copy of round two that has been sent to the experts.

Thank you for your help in contacting possible participants for the study and assisting me to set up the participant group. The demographic characteristics of the participants are wide and varied and all the selection criteria were filled by the participants.

Please contact me with any comments regarding the study. I will analyse the responses form questionnaire #2 and then send questionnaire #3 ready to the participants. I plan to have another teleconference for the reference group after round questionnaire #3 is returned and analysed.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
Dear Doctor.............................

Thank you for responding to the contact made by a member of the reference group to take part in a Delphi study regarding the key issues in the lives of women GPs in Australia. I invite you to take part in this Delphi study and I have enclosed the following documents for your perusal and attention:

- A copy of the Delphi Study position paper.
- A copy of Delphi Questionnaire #1 to be completed and returned in the enclosed pre-paid envelope.
- A copy of the demographic questionnaire to be completed and an ethical permission slip to be signed and returned in the enclosed pre-paid envelope.

The data collected will remain de-identified and is required to record the demography of the participants. The names of the participants or their personal responses will not be identified and a participant may withdraw from the study at any time.

I look forward to working with you during this study. Please contact me at any time for further details.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
Instructions for responding to Delphi Questionnaire #2

I have listed on separate pages the responses to the questions from the first Delphi questionnaire regarding the key issues for women general practitioners in their professional and non-professional lives. Please do three things to this list:

1. Read and review all items on each list before commencing to write your reply. Comment, in one or two statements, on items in the column provided for comments. You may argue in favour of or against an item, or request clarification. Brevity and clarity will facilitate analysis.

2. Select the ten key issues that you feel are the most important for Australian women general practitioners in their professional lives from list (a), and then the ten (10) key issues that you feel are the most important for Australian women general practitioners in their non-professional lives from list (b).

Write the number of your vote in the column with the heading “vote”. Assign the value ten (10) to the key issue that you feel is most important in list (a), the key issues in the professional life of Australian women general practitioners and the value ten (10) to the key issue that you feel is most important in list (b), the key issues in the non-professional life of Australian women general practitioners. Assign nine (9) to the next most important, and so on until the tenth item (the least important of the ten) is assigned the value of one (1). This is a preliminary vote. It is not binding.

It is important to remember that 10 should be assigned to the key issue that you think is most important in list (a) and list (b).

3. Return your responses in the enclosed, reply-paid envelope.

4. If you have any difficulty with this questionnaire, please do not hesitate to contact me for clarification.

Phone: (03) 6226 7734
Fax: (03) 6226 7730
E-mail: M.Kilmartin@comm.utas.edu.au
Delphi questionnaire # 2 (a)

**Key issues for women general practitioners in their professional life.**

<table>
<thead>
<tr>
<th>Vote</th>
<th>Key issues in professional life</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. Achieving job satisfaction in general practice through mental stimulation, challenge and a variety of work.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Appropriate communication with allied health professionals and access to facilities required for health care</td>
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<td>3. A strong sense of self, self esteem and self image leading to autonomy and control over professional life.</td>
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<tr>
<td></td>
<td>4. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life.</td>
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<tr>
<td></td>
<td>5. Sufficient income to cover professional expenses and provide financial security.</td>
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<tr>
<td></td>
<td>6. Fair remuneration for medical services rendered by women general practitioners, considering the nature of their work eg. long and consultations and service provision to disadvantaged patients.</td>
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</tr>
<tr>
<td></td>
<td>7. Having a presence, voice and share of power in decision making about political issues affecting women general practitioners and their patients.</td>
<td></td>
</tr>
</tbody>
</table>

1. Choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments, arguments for or against or points of clarification on any item(s) that you wish.
8. The current climate of uncertainty and change in general practice and its effect on women general practitioners. Changes identified include:-
   - Provider number limitation
   - Medicare cuts
   - Budget holding
   - Increasing litigation
   - Practice accreditation
   - Differential flex fees
   - Vocational Registration
   - Continuing medical education and quality assurance
   - State and Commonwealth agreements on health care managed care
   - Better practice program (B.P.P.)

9. Availability of appropriate locum cover for women in general practitioners.

10. Balancing non-professional and professional life through the drawing of boundaries to protect yourself, family and interests.

11. Juggling the complexities of competing priorities in professional and non-professional life and activities.

12. Conflicting multiple roles for women in professional and non-professional life.

13. Stereotyping by the community and the profession of women general practitioners’ work by streamlining service provision in general practice and external agencies to specific areas including:- prevention, counselling, health promotion, women and children’s health, psychosocial issues and populations with specific health needs e.g. aboriginal health.

14. Stereotyping of women general practitioners health service provision resulting in long, complex and difficult consultations which are emotionally and mentally exhausting and of limited financial return.

15. Availability of flexible hours and part time work so that women general practitioners can perform the responsibilities of multiple non-professional roles.
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<table>
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<tr>
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<tbody>
<tr>
<td>16.</td>
<td>Developing strategies for women general practitioners who work part-time and flexible work hours to provide continuing comprehensive care, home visits and after hours care to patients.</td>
</tr>
<tr>
<td>17.</td>
<td>Recognition of the need to vary work practices to complement the various stages of the life cycle of a woman general practitioner.</td>
</tr>
<tr>
<td>18.</td>
<td>The nature of part-time and flexible working hours which results in the lapsing of a wide variety of procedural skills.</td>
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<tr>
<td>19.</td>
<td>Competence in a broad range of skills for part-time work and flexible working hours to provide a comprehensive range of quality care to patients.</td>
</tr>
<tr>
<td>20.</td>
<td>The ability to train and retrain (after time out) in a flexible part-time training program in general practice that caters for the individual needs and circumstances of women general practitioners.</td>
</tr>
<tr>
<td>21.</td>
<td>The capacity to gain, through training, special skills available in specialist college training programs.</td>
</tr>
<tr>
<td>22.</td>
<td>Time to attend and access a variety of educational programs and activities in order to satisfy quality assurance and continuing medical education (QA and CME) requirements (points) for women general practitioners in a variety of locations and situations.</td>
</tr>
<tr>
<td>23.</td>
<td>Self-education and professional development through participation in courses, post graduate degree programs, teaching activities and evaluation.</td>
</tr>
<tr>
<td>26.</td>
<td>Consideration by administrative staff of the professional work roles and practices of women general practitioners.</td>
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<tr>
<td>27. Difficulty for women general practitioners who work part-time and flexible hours in becoming a partner or associate in a group practice and hence having input to decision making and practice administration.</td>
<td></td>
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<tr>
<td>28. The perception of safety for women general practitioners performing evening and after-hours surgery/ work and house calls.</td>
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<td>29. Harassment of women general practitioners by patients and colleagues.</td>
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<td>30. Having support and opportunity for mentoring from partners, peers and community.</td>
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<tr>
<td>31. Having a house and workplace with facilities and location appropriate to needs.</td>
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<tr>
<td>32. Equity in professional life for female general practitioners.</td>
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<tr>
<td>33. The decision to practise in an urban or rural location.</td>
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</tbody>
</table>
Key issues for women general practitioners in their non-professional life:

1. Choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments, arguments for or against or points of clarification on any item(s) that you wish.

<table>
<thead>
<tr>
<th>Vote</th>
<th>Key issues in non-professional life</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Availability and access to appropriate child care at reasonable cost.</td>
<td></td>
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<tr>
<td></td>
<td>2. Providing a focus for family life and all the requirements and activities of the family.</td>
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<td></td>
<td>3. Deciding if and when to have children.</td>
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<td></td>
<td>4. Having the time to keep in touch with children to provide for them and to share their life experiences.</td>
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<td></td>
<td>5. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life.</td>
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</tr>
<tr>
<td></td>
<td>6. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life.</td>
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<tr>
<td></td>
<td>7. Having support and opportunity for mentoring from partners, peers and community.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Having time to nurture a quality relationship with a partner.</td>
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<tr>
<td></td>
<td>9. Finding the balance between your own career and that of your partner.</td>
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Delphi questionnaire # 2 (b)
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<tbody>
<tr>
<td>10.</td>
<td>Responsibility for the organisation or performance of domestic duties.</td>
</tr>
<tr>
<td>11.</td>
<td>Making time for self care to avoid stress, guilt, burn out, physical and mental ill health.</td>
</tr>
<tr>
<td>12.</td>
<td>Accessibility of appropriate health care services for consumers who are women general practitioners.</td>
</tr>
<tr>
<td>13.</td>
<td>Balancing non-professional and professional life leading through the drawing of boundaries to protect yourself, family and interests.</td>
</tr>
<tr>
<td>14.</td>
<td>Juggling the complexities of competing priorities in professional and non-professional life and activities.</td>
</tr>
<tr>
<td>15.</td>
<td>Conflicting multiple roles for women in professional and non-professional life.</td>
</tr>
<tr>
<td>16.</td>
<td>Recognition of non-professional life and respect for individual privacy by colleagues and patients.</td>
</tr>
<tr>
<td>17.</td>
<td>Having a house and workplace with facilities and location appropriate to needs.</td>
</tr>
<tr>
<td>18.</td>
<td>Time for non-medical interests that allow for a range of life experiences.</td>
</tr>
<tr>
<td>19.</td>
<td>Time and ability to engage in social contacts and foster friendships.</td>
</tr>
<tr>
<td>20.</td>
<td>Sufficient income to pay for private expenses e.g. child-care, children’s education, mortgage and personal requirements.</td>
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</table>
# DELPHI QUESTIONNAIRE #3 SECTION A

Key issues for women general practitioners in their professional life.

<table>
<thead>
<tr>
<th>Code</th>
<th>Date of reply</th>
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</table>

1. To cast your final vote choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments and suggestions on where to from here to address each key issue.
4. Comment on the role of further research to address key issues.
5. Add any important key issues that have been missed, including your vote for that item and argument as to why it should be included.

<table>
<thead>
<tr>
<th>Vote Scores</th>
<th>Key issues in professional life</th>
<th>Comments</th>
<th>Final Vote</th>
<th>Suggestions on where to go next to address this issue and any final comments</th>
</tr>
</thead>
</table>
| 242         | 1. Achieving job satisfaction in general practice through mental stimulation, challenge and a variety of work. | a. My reason for staying in a remote area, the work in a city is less rewarding.  
b. Otherwise the incentive to work is lost.  
c. Job satisfaction is important but the "vocation" of medicine more so.  
d. One must enjoy work in order to achieve maximum satisfaction. This is achieved by not being limited to "women's health" and by not doing general practice alone.  
e. I feel I currently do this. | | |
| 163         | 2. Management and organisation of time to allow for successful participation in all aspects of professional and non professional life. | a. We need to acknowledge our "whole person"-ness.  
b. We have access to credible time management schemes.  
c. Legal reports and insurance reports should be recognised as part of our work load. | | |
3. Balancing non-professional and professional life through the drawing of boundaries to protect yourself, family and interests.
   a. Vital to mental well being.
   b. This has been a major downfall in my own professional life - lack of self care.
   c. This is the hardest of all especially when you are the only doctor in the community.
   d. Includes saying no to demands by the practice and the patients e.g. social consultations
   e. This applies to every working person. Not a key issue for female GPs.

4. A strong sense of self, self esteem and self image leading to autonomy and control over professional life.
   a. A strong sense of self esteem is essential for happiness.
   b. We tend to put ourselves last. It is very easy for women to take on a "carer/nurturer" role and take too much responsibility for patients time.
   c. It is a pity if self esteem is lost.

5. Sufficient income to cover professional expenses and provide financial security.
   a. Why is this an issue doctors are a well paid profession?
   b. Being single and supportive of myself financial security for my old age is important.
   c. A reasonable and sufficient income provides good motivation.
   d. Very practical.
   e. Working part-time much of your income goes to medical defence, professional fees, college dues etc.
   f. I contribute almost 50% of our household income.
   g. Actually immensely important.
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</table>
| 6. | Fair remuneration for medical services rendered by women general practitioners, considering the nature of their work e.g. long consultations and service provision to disadvantaged patients. | a. Financial independence is important for all women.  
 b. Not just true for women. Possibly truer for remote rural GPs.  
 c. By whom?  
 d. Style of practice reflects personal needs and wants for males and females.  
 e. Sought after work is not fairly remunerated.  
 f. Higher remuneration for general practice work in comparison with procedural specialists. Our work is harder and more complex. |
| 7. | Juggling the complexities of competing priorities in professional and non-professional life and activities. | a. This is my current hurdle.  
 b. Applies to every working person not a key issue for female GPs. |
| 8. | Availability of flexible hours and part time work so that women general practitioners can perform the responsibilities of multiple non-professional roles. | a. This best covers the issues as important to me. Covered also in 10, 11, and 12.  
 b. Especially once your children start school.  
 c. Very hard to find the right schedule.  
 d. Not an issue for full time general practice. Women should be prepared to work full time. |
| 9. | The ability to train and retrain (after time out) in a flexible part time training program in general practice that caters for the individual needs and circumstances of women general practitioners. | a. Working part time I can barely afford the fees for life and evening courses offered. Yet I need to keep up. |
10. The current climate of uncertainty and change in general practice and its effect on women general practitioners. Changes identified include:-
- Provider number limitation
- Medicare cuts
- Budget holding
- Increasing litigation
- Practice accreditation
- Differential HECS fees
- Vocational Registration
- Continuing medical education and quality assurance
- State and Commonwealth agreements on health care
- Managed care
- Better practice program (B.P.P.)

1. Having a presence, voice and share of power in decision making about political issues affecting women general practitioners and their patients.

a. This is the issue that causes me the most stress currently.
b. Widespread impact for males and females.
c. I am working toward VR through the practice eligible route. I fear the rules will be changed before I succeed. I have no trust in the current climate of uncertainty.

d. Many decisions made by males working full time.

b. Through which organisation?
c. I often notice in a big meeting that I am "invisible". It is often hard to be empowered in a mixed gender setting.
d. Follows naturally from a strong sense of self-esteem and autonomy with control over professional life.
<table>
<thead>
<tr>
<th></th>
<th>12. Developing strategies for women general practitioners who work part-time and flexible work hours to provide continuing comprehensive care, home visits and after hours care to patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Working part-time I sometimes feel guilty I'm not always there for my patients.</td>
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<td></td>
<td>b. If possible</td>
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<tr>
<td></td>
<td>13. Self-education and professional development through participation in courses, post graduate degree programs, teaching activities and evaluation.</td>
</tr>
<tr>
<td></td>
<td>a. I have always participated in self-education and recognised its inherent importance to me.</td>
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<td></td>
<td>b. This is where the profession should be looking at funding / tax initiatives as other professions do.</td>
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<td></td>
<td>14. Recognition of the need to vary work practices to complement the various stages of the life cycle of a woman general practitioner.</td>
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<tr>
<td></td>
<td>a. Ability to work and study varies throughout the cycle.</td>
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<td>b. I think there is a significant need.</td>
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<td></td>
<td>c. Very hard to accomplish.</td>
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<td></td>
<td>15. Respectful recognition of the serious contribution and credible performance of female general practitioners.</td>
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<tr>
<td></td>
<td>a. There still seems to be a feeling that real medicine is full time.</td>
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<td>b. I feel female GPs are often belittled by colleagues especially in areas of conflict.</td>
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<td>c. Women are just as capable as men and have specific strengths.</td>
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<td>d. Many people still regard female GPs as a &quot;joke&quot; - the takers of pap smear; not doing the real &quot;doctoring work&quot;</td>
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<td>e. I think this already exists.</td>
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<td></td>
<td>f. I disagree. I think women are well recognised in general practice. I have found preference given to women when applying for a job.</td>
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<td>g. This cannot occur when the medical profession emphasises doctors and not patients.</td>
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</table>
|   | 16. Appropriate communication with allied health professionals and access to facilities required for health care. | a. Not having trained in these areas. "who" or "what" is available takes time to find.  
   b. Appropriate use of resources. |
|   | 17. Stereotyping of women general practitioners health service provision resulting in long, complex and difficult consultations which are emotionally and mentally exhausting and of limited financial return. | a. Very true.  
   b. I disagree, an individual doctor should be able to control length of a consultation. |
|   | 18. Conflicting multiple roles for women in professional and non-professional life. | a. The interface between the culture of women and that of medicine needs to be acknowledged.  
   b. I sometimes oscillate between feeling I am a bad mother and a bad doctor.  
   c. There should be no conflict.  
   d. Applies to every working person. Should not be a key issue for female GPs. |
|   | 19. Equity in professional life for female general practitioners. | a. We have to earn it.  
   b. Even if they work part time. |
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<thead>
<tr>
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<tr>
<td>20.</td>
<td>Time to attend and access a variety of educational programs and activities in order to satisfy quality assurance and continuing medical education (QA and CME) requirements (points) for women general practitioners in a variety of locations and situations.</td>
<td>a. Very important b. Also quality of CME talks</td>
</tr>
<tr>
<td>21.</td>
<td>Difficulty for women general practitioners who work part time and flexible hours in becoming a partner or associate in a group practice and hence having input to decision making and practice administration</td>
<td>a. Since a partnership is business arrangement - this is negotiated in business terms. b. Often women delay becoming partners until they have family. c. Decision making is the key here. There is also readily available work without having to take on running a business this is a real plus. d. I can never make our weekly doctors meeting due to lack of available child care. e. Working part-time eliminates the chance of becoming a partner or associate.</td>
</tr>
<tr>
<td>22.</td>
<td>Competence in a broad range of skills for part time work and flexible working hours to provide a comprehensive range of quality care to patients.</td>
<td>a. True b. I like to be able to offer a full range of services and not have to refer a lot. c. I think this is available. d. The reason I have been a remote procedural GP. e. As much for patients as our reward.</td>
</tr>
</tbody>
</table>
|   | 23. The decision to practise in an urban or rural location. | a. I feel this should be a choice for the individual whether male or female and no one should be forced into working anywhere, especially without extra incentives.  
b. Major  
c. Becomes more important for rural as children grow older. |
|---|---|---|
| 24. Having support and opportunity for mentoring from partners, peers and community. | a. Women have traditionally supported the partners not the other way round. My traditional partner does not hold the medical profession in very high regard. This can be hard.  
b. I have always had support from partners, peers and community. |
| 25. Availability of appropriate locum cover for women in general practitioners. | a. This was and still is the big problem  
b. Locums hard to get especially rural.  
c. Difficult to find female locums for all female practice.  
| 26. Lack of female role models in general practice and academia. | a. I feel this very strongly  
b. This is gradually improving but a long way to go and in medical politics.  
c. There are no role models. I am now one of the younger female doctors and see that as myself and express it. A big responsibility to be a role model.  
d. I disagree. Plenty and increasing numbers of good female GPs.  
e. I do not consider there is such a lack.  
f. Rubbish. They are there. Women are best/worst at putting others down.  
g. Not true. |
<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>The capacity to gain, through training, special skills available in specialist college training programs.</td>
<td>a. Recognise my need to obtain further skills. Often hard to negotiate.</td>
<td>b. The more knowledge and expertise one has the better job one is able to do.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>The nature of part-time and flexible working hours which results in the lapsing of a wide variety of procedural skills.</td>
<td>a. This is particularly applicable to me.</td>
<td>b. True</td>
<td>c. I do not agree with this statement.</td>
</tr>
<tr>
<td>17</td>
<td>Stereotyping by the community and the profession of women general practitioners' work by streamlining service provision in general practice and external agencies to specific areas including prevention, counselling, health promotion, women and children's health, psychosocial issues and populations with specific health needs eg. aboriginal health.</td>
<td>a. Very true.</td>
<td>b. Yes if this means we are being pushed into &quot;women's medicine&quot;.</td>
<td>c. I disagree. Individuals get known for what they are good at or are interested in.</td>
</tr>
<tr>
<td>13</td>
<td>The perception of safety for women general practitioners performing evening and after hours surgery work and house calls.</td>
<td>a. No problem in rural practice.</td>
<td>b. I have never worked in unsafe places.</td>
<td></td>
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<tr>
<td></td>
<td>31. Having a house and workplace with facilities and location appropriate to needs.</td>
<td>a. Important</td>
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<td>-------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>
| 4 | 32. Consideration by administrative staff of the professional work roles and practices of women general practitioners. | a. Administrative and nursing staff.  
  b. I think this is easily achieved.  
  c. What administrative staff are these? |
| 2 | 33. Harassment of women general practitioners by patients and colleagues. | a. I have never lost control in a patient situation. Harassment of women GPs by nursing staff and allied health professionals.  
  b. I have never been harassed.  
  c. Not generally experienced.  
  d. This has never happened to me. |
# DELPHI QUESTIONNAIRE #3 SECTION B

Key issues for women general practitioners in their non-professional life.

<table>
<thead>
<tr>
<th>Code</th>
<th>Date of reply</th>
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</table>

1. To cast your final vote choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments and suggestions on how to address each key issue.
4. Comment on the role of further research to address key issues.
5. Add any important key issues that have been missed, including your vote for that item and argument as to why it should be included.

<table>
<thead>
<tr>
<th>Preliminary Vote Scores</th>
<th>Key issues in non-professional life</th>
<th>Comments</th>
<th>Final Vote</th>
<th>Suggestions on where to go next to address this issue and any final comments</th>
</tr>
</thead>
</table>
| 245                     | 1. Having time to nurture a quality relationship with a partner. | a. Have to find a partner first.  
b. Work tends to overtake my private life at times.  
c. I feel children rather than work is the barrier here.  
d. Difficult when caught up with work and education. Often partners are in professional jobs too.  
e. An important issue that was neglected.  
f. This is very important.  
g. My current relationship with my partner is arguably the only quality relationship with a partner that I've had. It began almost as soon as I began to work part-time. I used to feel that my work was more important than any relationship. This never brought me any joy.  
g. My least successful issue in this time frame. My responsibility and having little to do with being a GP. | | | |
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</table>
| 237 | 2. Making time for self care to avoid stress, guilt, burn out, physical and mental ill health. | a. All this has happened to me. I do not want it to happen again.  
   b. I came close to breaking down earlier this year.  
   c. I have changed positions significantly three times in my life as I have been unable to protect myself from burn out - time for self care was never acknowledged.  
   d. Hard because my husband is unemployed and wants my attention when I get home.  
   e. Added to by pressure of general practice and home life.  
   f. I am afraid to admit I don't have any time for myself.  
   g. Goes without saying. |
| 200 | 3. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life. | a. I am very organised.  
   b. It is important to value that we are whole people.  
   c. My responsibility |
| 182 | 4. Having the time to keep in touch with children to provide for them and to share their life experiences. | a. My children are the most important part of my life.  
   b. They need me more than my patients.  
   c. Issue for most working women.  
   d. I like to keep an active role in my children's growing up, education and being there for them when needed.  
   e. Make time. If I fail as a mother my hard won self esteem would be rocked. |
| 5. Time and ability to engage in social contacts and foster friendships. | a. The girl/boy network is essential to me.  
b. My friends have always been important to me. I still do not have enough time to spend with them.  
c. I can't find the time.  
d. Relationships and friends become much more important as one matures.  
e. Time to develop oneself as a person as well as a doctor.  
f. Long hours has meant it is hard to have enough time for this.  
g. Between work and children my husband and I are losing contact with friends.  
h. My responsibility. |
|---|---|
| 6. Finding the balance between your own career and that of your partner. | a. Have to find a partner first.  
b. e.g. going overseas for further experience and rural terms.  
c. Especially in a remote areas where employment opportunities are few.  
d. Particularly as I am planning to work in a rural setting.  
e. Important  
f. Ongoing source of fights in my marriage  
g. My husband is a general practitioner so we don't have a conflict of interests. |
| 7. Providing a focus for family life and all the requirements and activities of the family. | a. The family includes immediate and extended family.  
b. My family is very important to me and I find it necessary to spend quality time with them.  
c. After myself this is my key personal issue.  
d. The balance is very delicate. |
<table>
<thead>
<tr>
<th>Page</th>
<th>Question</th>
<th>Answers</th>
</tr>
</thead>
</table>
| 119  | 8. Time for non medical interests that allow for a range of life experiences. | a. There is a life after medicine and other experiences are important.  
b. Definitely more of an issue now we have children.  
c. Time to develop oneself as a person as well as a doctor.  
d. Have to get out of the medical world to appreciate the real world of patients.  
e. My responsibility.  
f. I can't find the time. |
| 98   | 9. Balancing non-professional and professional life leading through the drawing of boundaries to protect yourself, family and interests. | a. Family comes first. Some patients don't realise that you have a life outside work.  
b. It is hard to switch off especially when on call which I am for approximately 140 hours a week.  
c. This is based in a series of white lies - that one's children learn to tell early "Mum's on a house call" |
| 88   | 10. Sufficient income to pay for private expenses e.g. child care, children's education, mortgage and personal requirements. | a. It is very essential.  
b. As I think through this it seems that if the income were higher, that a lot of the issues would be easier to attain.  
c. Being a single mother this is very important - value for work put in - more remuneration for the difficult job that we do.  
d. With children there are more expenses but less time to work.  
e. Includes accessible affordable child care. |
<table>
<thead>
<tr>
<th>86</th>
<th>11. Deciding if and when to have children.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Have to find partner first.</td>
</tr>
<tr>
<td></td>
<td>b. I keep putting it off because I love my job too much.</td>
</tr>
<tr>
<td></td>
<td>c. Never the right time.</td>
</tr>
<tr>
<td></td>
<td>d. This is a very important issue for me. I have not resolved it.</td>
</tr>
<tr>
<td></td>
<td>e. Often based on career advances and commitments.</td>
</tr>
<tr>
<td></td>
<td>f. Something I was not aware of but regret the most.</td>
</tr>
<tr>
<td></td>
<td>g. My responsibility unrelated to being a GP.</td>
</tr>
<tr>
<td></td>
<td>h. I passed this stage but know it is very important.</td>
</tr>
<tr>
<td></td>
<td>i. This was never a question for me.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>81</th>
<th>12. Responsibility for the organisation or performance of domestic duties.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Better since I have been working part time.</td>
</tr>
<tr>
<td></td>
<td>b. We share those responsibilities.</td>
</tr>
<tr>
<td></td>
<td>c. This is often sorted out early and is an expense. A fairer tax system would recognise this.</td>
</tr>
<tr>
<td></td>
<td>d. Expected to work all day, keep the house tidy and then entertain your partner because he has had a busy day.</td>
</tr>
<tr>
<td></td>
<td>e. My pet hate. I bring in half the money so why doesn't he do half the house work.</td>
</tr>
<tr>
<td></td>
<td>f. Paid cleaning/ironing/gardening makes life bearable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>81</th>
<th>13. Juggling the complexities of competing priorities in professional and non professional life and activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. This issue must be the main contributor to &quot;burnout&quot;.</td>
</tr>
<tr>
<td></td>
<td>b. I always try.</td>
</tr>
<tr>
<td></td>
<td>c. Recognise early - that as a doctor at the local pre school committee you are never an ordinary mum.</td>
</tr>
</tbody>
</table>
| 79 | 14. Availability and access to appropriate child-care at reasonable cost. | a. Actually very important.  
b. All working women want this.  
c. My children were born overseas and looked after by my family.  
d. This is an issue that should be a professional and political issue. All working women need more cost effective child care. This is a community political issue. Suggest taking the lead at the highest level for tax reforms.  
e. Childcare is very expensive and often doesn't cover the hours.  
f. I need to feel that my working is not compromising my children's development.  
g. Working part-time.  
15 - 20% of my salary goes to child care. |
|---|---|---|
| 77 | 15. Conflicting multiple roles for women in professional and non-professional life. | a. Women are expected to work, be a wife, mother and cleaner.  
b. I resent greatly some of the roles I've been given because I'm a woman.  
c. Especially as relates to family relationships.  
d. Not just female GPs. This is about any working adult. |
| 62 | 16. Recognition of non-professional life and respect for individual privacy by colleagues and patients. | a. Do your patients really care about you?  
b. In a remote community you are often asked for results when out and people seem surprised when you relax and have a good time. I do belly dancing performances. It shocks some people in the community. |
<table>
<thead>
<tr>
<th></th>
<th>17. Having support and opportunity for mentoring from partners, peers and community.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a. Support is very important.</td>
</tr>
<tr>
<td></td>
<td>18. Having a house and workplace with facilities and location appropriate to needs.</td>
</tr>
<tr>
<td></td>
<td>a. Patients expect you to be there 24 hours a day.</td>
</tr>
<tr>
<td></td>
<td>b. My responsibility.</td>
</tr>
<tr>
<td></td>
<td>19. Accessibility of appropriate health care services for consumers who are women general practitioners.</td>
</tr>
<tr>
<td></td>
<td>a. Particularly the need for mental health.</td>
</tr>
<tr>
<td></td>
<td>b. I have had a female GP for just over a year. It is a relationship I value deeply.</td>
</tr>
</tbody>
</table>
Dear Doctor ........................................

During 1996 you took part in a research Delphi study. Thank you for your contributions to this Delphi study and the cooperation that you extended during the study. Thirty nine out of the forty women general practitioners who commenced the study completed all of the three questionnaires that that were sent to them.

All responses have been analysed and the individual response of any participant will not be able to be identified and confidentiality has been maintained. The respondents represented women general practitioners from all States in Australia and from geographic locations including, urban, rural and remote. The participants taking part in the study were from all stages of their career and life cycle including: General Practice registrars, women GPs working part-time and full-time, women GPs who had recently retired and women GPs who have other professional work such as public health or academic General Practice. A reference group of six women general practitioners from various states in Australia has overseen the project and provided wise counsel throughout the project.

The most significant key issues identified by the GPs in the professional and non-professional lives were job satisfaction and time for self-care respectively.

Other issues considered to be important in their professional lives were: achieving a balance, time management, juggling professional and non-professional commitments, flexibility in training and work, fair remuneration, sufficient income, high self-esteem and autonomy and having a presence, a voice and share of power in decision making about issues concerning women GPs.

In their non-professional life other important issues were: time to nurture a quality relationship with a partner and find a balance between his/her career, time for children, family life, social contacts and friendship, sufficient income, achieving a balance by drawing protective boundaries and time management.

A review of the study is being prepared for publication in a peer review journal. The study has been invaluable in achieving a consensus of the key issues in the
professional and non-professional lives of women GPs in Australia and also providing me with ideas for further research concerning these issues of concern. I will be continuing research regarding these issues for women general practitioners during 1998.

I acknowledge the invaluable help and assistance of the following people during the study: Dr J Walker; Dr C Newell; the Reference Group of women general practitioners and Mr E Rock. I also acknowledge the funding received from the RACGP. My sincere thanks for your assistance, patience and invaluable contributions to this study.

Yours sincerely,

Margaret Kilmarin  
Senior Lecturer  
Division of Rural and Community Health  
University of Tasmania
INTERVIEW GUIDE

Questions for the Semi-structured Interviews

1. Which professional bodies or Colleges are you a member of?

2. Do you have an active role in any of these organisations?

   Prompt: If not, why? If yes, please tell me about this role or how you see your role.

3. What do you think are the key issues for women GPs?

   Prompt: In their professional lives and non-professional lives.

4. How do the professional bodies and Colleges that you belong to identify and consider the key issues that exist for women GPs?

   Prompt: When and where - give examples - tell me that story.

5. Why is that?

6. How could these issues be better tackled and addressed?

   Prompt: Can you give me an example? I wonder if you would like to see these issues change? Regarding these issues how could it be different?

7. Can you suggest anyone else or anything else that could assist with this research?
Dear Doctor..............................

I am seeking your agreement to be interviewed as part of a study on the key issues in the professional and non-professional lives of women general practitioners in Australia. This study has received ethical approval from the Research and Evaluation Ethics Committee of the RACGP and funding has been granted by the College Foundation of the RACGP. The objectives of the study are:

• To identify the key issues in the professional and non-professional lives of women general practitioners in Australia and how these issues are being considered by professional organisations and Colleges.
• To analyse the discourse and knowledge used in professional bodies and Colleges in identifying and tackling these key issues.
• To identify strategies that will address these key issues.

The outcome of the study will form part of my PhD thesis supervised by Dr Christopher Newell, University of Tasmania and will also be used for publications in peer reviewed medical journals.

An ethical permission slip will be available for signing prior to the interview. The outcome of the study will use de-identified data so that it will not be possible to recognise individuals who have participated in the study. Confidentiality is assured.

Throughout the interview the responses of the participants should reflect their personal view on the subject and not the official policy of any organisation. The interview (approximately one hour in length) will be taped, and a transcript of the interview will be sent to the participants for confirmation. I am enclosing for your perusal a copy of the outcomes of a Delphi study. This study was conducted in 1996 as part of my thesis.

I look forward to you agreeing to be interviewed by myself in the near future.

Arrangements including a time for the interview can be made by replying to me at the
Q1.
From your experience as a woman general practitioner, what are the key issues in the professional lives of Australian Women General Practitioners as you see them?

Please consider the broadest possible definition of "professional life" in your answer. Please see the cover page for an explanation of "professional life".

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
From your experience as a woman general practitioner, what are the key issues in the non-professional lives of Australian Women General Practitioners as you see them?

Please consider the broadest possible definition of "non-professional life" in your answer. Please see the cover page for an explanation of "non-professional life".

<table>
<thead>
<tr>
<th>Key Issues</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
The first round of the Delphi Study has progressed very well. The study participants have responded enthusiastically and I have received replies from 40 out of a possible 41. Each of their replies have been carefully analysed and round two has been sent out. I am enclosing for your information a copy of round two that has been sent to the experts.

Thank you for your help in contacting possible participants for the study and assisting me to set up the participant group. The demographic characteristics of the participants are wide and varied and all the selection criteria were filled by the participants.

Please contact me with any comments regarding the study. I will analyse the responses form questionnaire #2 and then send questionnaire #3 ready to the participants. I plan to have another teleconference for the reference group after round questionnaire #3 is returned and analysed.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
Dear Doctor,

Thank you for responding to the contact made by a member of the reference group to take part in a Delphi study regarding the key issues in the lives of women GPs in Australia. I invite you to take part in this Delphi study and I have enclosed the following documents for your perusal and attention:

- A copy of the Delphi Study position paper.
- A copy of Delphi Questionnaire #1 to be completed and returned in the enclosed pre-paid envelope.
- A copy of the demographic questionnaire to be completed and an ethical permission slip to be signed and returned in the enclosed pre-paid envelope.

The data collected will remain de-identified and is required to record the demography of the participants. The names of the participants or their personal responses will not be identified and a participant may withdraw from the study at any time.

I look forward to working with you during this study. Please contact me at any time for further details.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
APPENDIX 9

UNIVERSITY OF TASMANIA
Division of Community and Rural Health

DELPHI QUESTIONNAIRE #2

Instructions for responding to Delphi Questionnaire #2

I have listed on separate pages the responses to the questions from the first Delphi questionnaire regarding the key issues for women general practitioners in their professional and non-professional lives. Please do three things to this list:

1. Read and review all items on each list before commencing to write your reply. Comment, in one or two statements, on items in the column provided for comments. You may argue in favour of or against an item, or request clarification. Brevity and clarity will facilitate analysis.

2. Select the ten key issues that you feel are the most important for Australian women general practitioners in their professional lives from list (a), and then the ten (10) key issues that you feel are the most important for Australian women general practitioners in their non-professional lives from list (b).

Write the number of your vote in the column with the heading “vote”. Assign the value ten (10) to the key issue that you feel is most important in list (a), the key issues in the professional life of Australian women general practitioners and the value ten (10) to the key issue that you feel is most important in list (b), the key issues in the non-professional life of Australian women general practitioners. Assign nine (9) to the next most important, and so on until the tenth item (the least important of the ten) is assigned the value of one (1). This is a preliminary vote. It is not binding.

It is important to remember that 10 should be assigned to the key issue that you think is most important in list (a) and list (b).

3. Return your responses in the enclosed, reply-paid envelope.

4. If you have any difficulty with this questionnaire, please do not hesitate to contact me for clarification.
   Phone: (03) 6226 7734
   Fax: (03) 6226 7730
   E-mail: M.Kilmartin@comm.utas.edu.au

GPO Box 252-33  Hobart
Tasmania 7001  Australia
Telephone: 03 6226 7734
Faxnumber: 03 6226 7730
Mobile: 0418159094
E-mail: M.Kilmartin@utas.edu.au
**Delphi questionnaire # 2 (a)**

**Key issues for women general practitioners in their professional life.**

1. Choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments, arguments for or against or points of clarification on any item(s) that you wish.

<table>
<thead>
<tr>
<th>Vote</th>
<th>Key issues in professional life</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----</td>
<td>1. Achieving job satisfaction in general practice through mental stimulation, challenge and a variety of work.</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>2. Appropriate communication with allied health professionals and access to facilities required for health care</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>3. A strong sense of self, self esteem and self image leading to autonomy and control over professional life.</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>4. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life.</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>5. Sufficient income to cover professional expenses and provide financial security.</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>6. Fair remuneration for medical services rendered by women general practitioners, considering the nature of their work eg. long and consultations and service provision to disadvantaged patients.</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>7. Having a presence, voice and share of power in decision making about political issues affecting women general practitioners and their patients.</td>
<td></td>
</tr>
</tbody>
</table>
8. The current climate of uncertainty and change in general practice and its effect on women general practitioners. Changes identified include:-
- Provider number limitation
- Medicare cuts
- Budget holding
- Increasing litigation
- Practice accreditation
- Differential fees
- Vocational Registration
- Continuing medical education and quality assurance
- State and Commonwealth agreements on health care
- Managed care: Better practice program (B.P.P.)

9. Availability of appropriate locum cover for women in general practitioners.

10. Balancing non-professional and professional life through the drawing of boundaries to protect yourself, family and interests.

11. Juggling the complexities of competing priorities in professional and non-professional life and activities.

12. Conflicting multiple roles for women in professional and non-professional life.

13. Stereotyping by the community and the profession of women general practitioners' work by streamlining service provision in general practice and external agencies to specific areas including: - prevention, counselling, health promotion, women and children's health, psychosocial issues and populations with specific health needs e.g. aboriginal health.

14. Stereotyping of women general practitioners' health service provision resulting in long, complex and difficult consultations which are emotionally and mentally exhausting and of limited financial return.

15. Availability of flexible hours and part-time work so that women general practitioners can perform the responsibilities of multiple non-professional roles.
<p>| | |</p>
<table>
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<tbody>
<tr>
<td>16.</td>
<td>Developing strategies for women general practitioners who work part-time and flexible work hours to provide continuing comprehensive care, home visits and after hours care to patients.</td>
</tr>
<tr>
<td>17.</td>
<td>Recognition of the need to vary work practices to complement the various stages of the life cycle of a woman general practitioner.</td>
</tr>
<tr>
<td>18.</td>
<td>The nature of part-time and flexible working hours which results in the lapsing of a wide variety of procedural skills.</td>
</tr>
<tr>
<td>19.</td>
<td>Competence in a broad range of skills for part-time work and flexible working hours to provide a comprehensive range of quality care to patients.</td>
</tr>
<tr>
<td>20.</td>
<td>The ability to train and retrain (after time out) in a flexible part-time training program in general practice that caters for the individual needs and circumstances of women general practitioners.</td>
</tr>
<tr>
<td>21.</td>
<td>The capacity to gain, through training, special skills available in specialist college training programs.</td>
</tr>
<tr>
<td>22.</td>
<td>Time to attend and access a variety of educational programs and activities in order to satisfy quality assurance and continuing medical education (QA and CME) requirements (points) for women general practitioners in a variety of locations and situations.</td>
</tr>
<tr>
<td>23.</td>
<td>Self-education and professional development through participation in courses, postgraduate degree programs, teaching activities and evaluation.</td>
</tr>
<tr>
<td>26.</td>
<td>Consideration by administrative staff of the professional work roles and practices of women general practitioners.</td>
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<td>---</td>
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</tr>
<tr>
<td>27.</td>
<td>Difficulty for women general practitioners who work part time and flexible hours in becoming a partner or associate in a group practice and hence having input to decision making and practice administration.</td>
</tr>
<tr>
<td>28.</td>
<td>The perception of safety for women general practitioners performing evening and after hours surgery / work and house calls.</td>
</tr>
<tr>
<td>29.</td>
<td>Harassment of women general practitioners by patients and colleagues.</td>
</tr>
<tr>
<td>30.</td>
<td>Having support and opportunity for mentoring from partners, peers and community.</td>
</tr>
<tr>
<td>31.</td>
<td>Having a house and workplace with facilities and location appropriate to needs.</td>
</tr>
<tr>
<td>32.</td>
<td>Equity in professional life for female general practitioners.</td>
</tr>
<tr>
<td>33.</td>
<td>The decision to practise in an urban or rural location.</td>
</tr>
</tbody>
</table>
Delphi questionnaire # 2 (b)

Key issues for women general practitioners in their non-professional life.

1. Choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments, arguments for or against or points of clarification on any item(s) that you wish.

<table>
<thead>
<tr>
<th>Vote</th>
<th>Key issues in non-professional life</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Availability and access to appropriate child care at reasonable cost.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Providing a focus for family life and all the requirements and activities of the family.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Deciding if and when to have children.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Having the time to keep in touch with children to provide for them and to share their life experiences.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Having support and opportunity for mentoring from partners, peers and community.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Having time to nurture a quality relationship with a partner.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Finding the balance between your own career and that of your partner.</td>
<td></td>
</tr>
</tbody>
</table>
10. Responsibility for the organisation or performance of domestic duties.

11. Making time for self care to avoid stress, guilt, burnout, physical and mental ill health.

12. Accessibility of appropriate health care services for consumers who are women general practitioners.

13. Balancing non-professional and professional life leading through the drawing of boundaries to protect yourself, family and interests.

14. Juggling the complexities of competing priorities in professional and non-professional life and activities.

15. Conflicting multiple roles for women in professional and non-professional life.

16. Recognition of non-professional life and respect for individual privacy by colleagues and patients.

17. Having a house and workplace with facilities and location appropriate to needs.

18. Time for non-medical interests that allow for a range of life experiences.

19. Time and ability to engage in social contacts and foster friendships.

20. Sufficient income to pay for private expenses eg. child-care, children's education, mortgage and personal requirements.
**DELPHI QUESTIONNAIRE #3 SECTION A**

Key issues for women general practitioners in their professional life.

Code------- Date of reply-----

1. To cast your final vote choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments and suggestions on where to from here to address each key issue.
4. Comment on the role of further research to address key issues.
5. Add any important key issues that have been missed, including your vote for that item and argument as to why it should be included.

<table>
<thead>
<tr>
<th>Preliminary Vote Scores</th>
<th>Key issues in professional life</th>
<th>Comments</th>
<th>Final Vote</th>
<th>Suggestions on where to go next to address this issue and any final comments</th>
</tr>
</thead>
</table>
| 242                     | 1. Achieving job satisfaction in general practice through mental stimulation, challenge and a variety of work. | a. My reason for staying in a remote area, the work in a city is less rewarding.  
b. Otherwise the incentive to work is lost.  
c. Job satisfaction is important but the "vocation" of medicine more so.  
d. One must enjoy work in order to achieve maximum satisfaction. This is achieved by not being limited to "women's health" and by not doing general practice alone.  
e. I feel I currently do this. |   |   |
| 163                     | 2. Management and organisation of time to allow for successful participation in all aspects of professional and non professional life. | a. We need to acknowledge our "whole person"-ness.  
b. We have access to credible time management schemes.  
c. Legal reports and insurance reports should be recognised as part of our work load. |   |   |
<table>
<thead>
<tr>
<th>148</th>
<th>3. Balancing non-professional and professional life through the drawing of boundaries to protect yourself, family and interests.</th>
</tr>
</thead>
</table>
|     | a. Vital to mental well being.  
b. This has been a major downfall in my own professional life - lack of self care.  
c. This is the hardest of all especially when you are the only doctor in the community.  
d. Includes saying no to demands by the practice and the patients e.g. social consultations  
e. This applies to every working person. Not a key issue for female GPs. |

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<th>138</th>
<th>4. A strong sense of self, self esteem and self image leading to autonomy and control over professional life.</th>
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</table>
|     | a. A strong sense of self esteem is essential for happiness.  
b. We tend to put ourselves last. It is very easy for women to take on a "carer / nurturer" role and take too much responsibility for patients time.  
c. It is a pity if self esteem is lost. |

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<tr>
<th>131</th>
<th>5. Sufficient income to cover professional expenses and provide financial security.</th>
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</table>
|     | a. Why is this an issue doctors are a well paid profession?  
b. Being single and supportive of myself financial security for my old age is important.  
c. A reasonable and sufficient income provides good motivation.  
d. Very practical.  
e. Working part-time much of your income goes to medical defence, professional fees, college dues etc.  
f. I contribute almost 50% of our household income.  
g. Actually immensely important. |
6. Fair remuneration for medical services rendered by women general practitioners, considering the nature of their work e.g. long consultations and service provision to disadvantaged patients.
   a. Financial independence is important for all women.
   b. Not just true for women. Possibly truer for remote rural GPs.
   c. By whom?
   d. Style of practice reflects personal needs and wants for males and females.
   e. Sought after work is not fairly remunerated.
   f. Higher remuneration for general practice work in comparison with procedural specialists. Our work is harder and more complex.

7. Juggling the complexities of competing priorities in professional and non-professional life and activities.
   a. This is my current hurdle.
   b. Applies to every working person not a key issue for female GPs.

8. Availability of flexible hours and part time work so that women general practitioners can perform the responsibilities of multiple non-professional roles.
   a. This best covers the issues as important to me. Covered also in 10, 11, and 12
   b. Especially once your children start school.
   c. Very hard to find the right schedule.
   d. Not an issue for full time general practice. Women should be prepared to work full time.

9. The ability to train and retrain (after time out) in a flexible part time training program in general practice that caters for the individual needs and circumstances of women general practitioners.
   a. Working part time I can barely afford the fees for life and evening courses offered. Yet I need to keep up.
<p>| 74 | 10. The current climate of uncertainty and change in general practice and its effect on women general practitioners. Changes identified include: Provider number limitation Medicare cuts Budget holding Increasing litigation Practice accreditation Differential HECS fees Vocational Registration Continuing medical education and quality assurance State and Commonwealth agreements on health care Managed care Better practice program (B.P.P.) | a. This is the issue that causes me the most stress currently. b. Widespread impact for males and females. c. I am working toward VR through the practice eligible route. I fear the rules will be changed before I succeed. I have no trust in the current climate of uncertainty. |
| 72 | 11. Having a presence, voice and share of power in decision making about political issues affecting women general practitioners and their patients. | a. Many decisions made by males working full time. b. Through which organisation? c. I often notice in a big meeting that I am &quot;invisible.&quot; It is often hard to be empowered in a mixed gender setting. d. Follows naturally from a strong sense of self-esteem and autonomy with control over professional life. |</p>
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</table>
| 67 | 12. Developing strategies for women general practitioners who work part-time and flexible work hours to provide continuing comprehensive care, home visits and after hours care to patients. | a. Working part-time I sometimes feel guilty I'm not always there for my patients.  

b. If possible |
| 67 | 13. Self-education and professional development through participation in courses, post graduate degree programs, teaching activities and evaluation. | a. I have always participated in self-education and recognised its inherent importance to me.  
b. This is where the profession should be looking at funding / tax initiatives as other professions do |
| 67 | 14. Recognition of the need to vary work practices to complement the various stages of the life cycle of a woman general practitioner. | a. Ability to work and study varies throughout the cycle.  
b. I think there is a significant need.  
c. Very hard to accomplish. |
| 65 | 15. Respectful recognition of the serious contribution and credible performance of female general practitioners. | a. There still seems to be a feeling that real medicine is full time.  
b. I feel female GPs are often belittled by colleagues especially in areas of conflict.  
c. Women are just as capable as men and have specific strengths.  
d. Many people still regard female GPs as a "joke" - the takers of pap smears not doing the real "doctoring work"  
e. I think this already exists.  
f. I disagree. I think women are well recognised in general practice. I have found preference given to women when applying for a job.  
g. This can not occur when the medical profession emphasises doctors and not patients. |
<table>
<thead>
<tr>
<th>16.</th>
<th>Appropriate communication with allied health professionals and access to facilities required for health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Not having trained in these areas “who” or “what” is available takes time to find.</td>
</tr>
<tr>
<td>b.</td>
<td>Appropriate use of resources.</td>
</tr>
<tr>
<td>57</td>
<td>17. Stereotyping of women general practitioners health service provision resulting in long, complex and difficult consultations which are emotionally and mentally exhausting and of limited financial return.</td>
</tr>
<tr>
<td>a.</td>
<td>Very true</td>
</tr>
<tr>
<td>b.</td>
<td>I disagree, an individual doctor should be able to control length of a consultation.</td>
</tr>
<tr>
<td>55</td>
<td>18. Conflicting multiple roles for women in professional and non-professional life.</td>
</tr>
<tr>
<td>a.</td>
<td>The interface between the culture of women and that of medicine needs to be acknowledged.</td>
</tr>
<tr>
<td>b.</td>
<td>I sometimes oscillate between feeling I am a bad mother and a bad doctor.</td>
</tr>
<tr>
<td>c.</td>
<td>There should be no conflict</td>
</tr>
<tr>
<td>d.</td>
<td>Applies to every working person. Should not be a key issue for female GPs.</td>
</tr>
<tr>
<td>45</td>
<td>19. Equity in professional life for female general practitioners.</td>
</tr>
<tr>
<td>a.</td>
<td>We have to earn it.</td>
</tr>
<tr>
<td>b.</td>
<td>Even if they work part time.</td>
</tr>
</tbody>
</table>
|   | 20. Time to attend and access a variety of educational programs and activities in order to satisfy quality assurance and continuing medical education (QA and CME) requirements (points) for women general practitioners in a variety of locations and situations. | a. Very important  
   b. Also quality of CME talks |   |
|---|---|---|---|
| 44 | 21. Difficulty for women general practitioners who work part time and flexible hours in becoming a partner or associate in a group practice and hence having input to decision making and practice administration | a. Since a partnership is business arrangement - this is negotiated in business terms.  
   b. Often women delay becoming partners until they have family.  
   c. Decision making is the key here. There is also readily available work without having to take on running a business this is a real plus.  
   d. I can never make our weekly doctors meeting due to lack of available child care.  
   e. Working part-time eliminates the chance of becoming a partner or associate. |   |
| 29 | 22. Competence in a broad range of skills for part time work and flexible working hours to provide a comprehensive range of quality care to patients. | a. True  
   b. I like to be able to offer a full range of services and not have to refer a lot  
   c. I think this is available.  
   d. The reason I have been a remote procedural GP.  
   e. As much for patients as our reward. |   |
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</table>
| 23. | The decision to practise in an urban or rural location. | a. I feel this should be a choice for the individual whether male or female and no one should be forced into working anywhere, especially without extra incentives.  
b. Major  
c. Becomes more important for rurals as children grow older. |
| 24. | Having support and opportunity for mentoring from partners, peers and community. | a. Women have traditionally supported the partners not the other way round. My traditional partner does not hold the medical profession in very high regard. This can be hard.  
b. I have always had support from partners, peers and community.  
c. Becomes more important for rurals as children grow older. |
| 25. | Availability of appropriate locum cover for women in general practitioners. | a. This was and still is the big problem  
b. Locums hard to get especially rural.  
c. Difficult to find female locums for all female practice.  
e. Women have traditionally supported the partners not the other way round. My traditional partner does not hold the medical profession in very high regard. This can be hard.  
f. I have always had support from partners, peers and community.  
g. Women have traditionally supported the partners not the other way round. My traditional partner does not hold the medical profession in very high regard. This can be hard.  
h. I have always had support from partners, peers and community.  
i. Difficult to find female locums for all female practice.  
| 26. | Lack of female role models in general practice and academia. | a. I feel this very strongly  
b. This is gradually improving but a long way to go in medical politics.  
c. There are no role models. I am now one of the younger female doctors and see that as myself and express it. A big responsibility to be a role model.  
d. I disagree. Plenty and increasing numbers of good female GPs.  
e. I do not consider there is such a lack  
f. Rubbish. They are there. Women are best/worst at putting others down.  
g. Not true.  
h. I do not consider there is such a lack  
i. Rubbish. They are there. Women are best/worst at putting others down.  
j. Not true.
| 24 | 27. The capacity to gain, through training, special skills available in specialist college training programs. | a. Recognise my need to obtain further skills. Often hard to negotiate.  
b. The more knowledge and expertise one has the better job one is able to do. |
| 22 | 28. The nature of part-time and flexible working hours which results in the lapsing of a wide variety of procedural skills. | a. This is particularly applicable to me.  
b. True  
c. I do not agree with this statement. |
| 17 | 29. Stereotyping by the community and the profession of women general practitioners' work by streamlining service provision in general practice and external agencies to specific areas including: prevention, counselling, health promotion, women and children's health, psychosocial issues and populations with specific health needs eg. aboriginal health. | a. Very true.  
b. Yes if this means we are being pushed into "women's medicine".  
c. I disagree. Individuals get known for what they are good at or interested in.  
d. The stereotype may be a reality for many.  
e. The stereotype does not apply to all women general practitioners. They take in all varieties of work. |
| 13 | 30. The perception of safety for women general practitioners performing evening and after hours surgery work and house calls. | a. No problem in rural practice.  
b. I have never worked in unsafe places. |
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<tbody>
<tr>
<td>1</td>
<td>31. Having a house and workplace with facilities and location appropriate to needs.</td>
<td>a. Important</td>
</tr>
</tbody>
</table>
| 4 | 32. Consideration by administrative staff of the professional work roles and practices of women general practitioners. | a. Administrative and nursing staff.  
b. I think this is easily achieved.  
c. What administrative staff are these? |
| 2 | 33. Harassment of women general practitioners by patients and colleagues. | a. I have never lost control in a patient situation. Harassment of women GPs by nursing staff and allied health professionals.  
b. I have never been harassed.  
c. Not generally experienced.  
d. This has never happened to me. |
DELPHI QUESTIONNAIRE #3 SECTION B

Key issues for women general practitioners in their non professional life.

1. To cast your final vote choose only ten items.
2. Give weight of "10" to the most important, "9" to the second most, etc.
3. Add comments and suggestions on where to from here to address each key issue.
4. Comment on the role of further research to address key issues.
5. Add any important key issues that have been missed, including your vote for that item and argument as to why it should be included.

<table>
<thead>
<tr>
<th>Preliminary Vote Scores</th>
<th>Key issues in non professional life</th>
<th>Comments</th>
<th>Final Vote</th>
</tr>
</thead>
<tbody>
<tr>
<td>245</td>
<td>1. Having time to nurture a quality relationship with a partner.</td>
<td>a. Have to find a partner first. b. Work tends to override my private life at times. c. I feel children rather than work is the barrier here. d. Difficult when caught up with work and education. Often partners are in professional jobs too. e. An important issue that was neglected. f. This is very important. g. My current relationship with my partner is arguably the only quality relationship with a partner that I've had. It began almost as soon as I began to work part-time. I used to feel that my work was more important than any relationship. This never brought me any joy. h. My least successful issue in this time frame. My responsibility and having little to do with being a GP.</td>
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<tr>
<td></td>
<td>237</td>
<td>2. Making time for self care to avoid stress, guilt, burn out, physical and mental ill health.</td>
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<tr>
<td></td>
<td>200</td>
<td>3. Management and organisation of time to allow for successful participation in all aspects of professional and non-professional life.</td>
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<td></td>
<td>182</td>
<td>4. Having the time to keep in touch with children to provide for them and to share their life experiences.</td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>All this has happened to me. I do not want it to happen again.</td>
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<tr>
<td>b</td>
<td>I came close to breaking down earlier this year.</td>
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<tr>
<td>c</td>
<td>I have changed positions significantly three times in my life as I have been unable to protect myself from burn out time for self care was never acknowledged.</td>
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<tr>
<td>d</td>
<td>Hard because my husband is unemployed and wants my attention when I get home.</td>
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<tr>
<td>e</td>
<td>Added to by pressure of general practice and home life.</td>
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<td></td>
</tr>
<tr>
<td>f</td>
<td>I am afraid to admit I don't have any time for myself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>Goes without saying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>I am very organised.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>It is important to value that we are whole people.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>My responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>My children are the most important part of my life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>They need me more than my patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Issue for most working women.</td>
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<tr>
<td>d</td>
<td>I like to keep an active role in my children's growing up, education and being there for them when needed.</td>
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<td></td>
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<tr>
<td>e</td>
<td>Make time. If I fail as a mother my hard won self esteem would be rocked.</td>
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</table>
### 5. Time and ability to engage in social contacts and foster friendships.

- a. The girlfriend network is essential to me.
- b. My friends have always been important to me. I still do not have enough time to spend with them.
- c. I can't find the time.
- d. Relationships and friends become much more important as one matures.
- e. Time to develop oneself as a person as well as a doctor.
- f. Long hours has meant it is hard to have enough time for this.
- g. Between work and children my husband and I are losing contact with friends.
- h. My responsibility.

### 6. Finding the balance between your own career and that of your partner.

- a. Have to find a partner first.
- b. e.g. going overseas for further experience and rural terms.
- c. Especially in a remote areas where employment opportunities are few.
- d. Particularly as I am planning to work in a rural setting.
- e. Important.
- f. Ongoing source of fights in my marriage.
- g. My husband is a general practitioner so we don’t have a conflict of interests.

### 7. Providing a focus for family life and all the requirements and activities of the family.

- a. The family includes immediate and extended family.
- b. My family is very important to me and I find it necessary to spend quality time with them.
- c. After myself this is my key personal issue.
- d. The balance is very delicate.
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<th>Page</th>
<th>Column 1</th>
<th>Column 2</th>
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</table>
| 119  | 8. Time for non medical interests that allow for a range of life experiences. | a. There is a life after medicine and other experiences are important.  
     b. Definitely more of an issue now we have children.  
     c. Time to develop oneself as a person as well as a doctor.  
     d. Have to get out of the medical world to appreciate the real world of patients.  
     e. My responsibility.  
     f. I can't find the time. |
| 98   | 9. Balancing non-professional and professional life leading through the drawing of boundaries to protect yourself, family and interests. | a. Family comes first. Some patients don't realise that you have a life outside work.  
     b. It is hard to switch off especially when on call which I am for approximately 140 hours a week.  
     c. This is based on a series of white lies - that one's children learn to tell early - "Mum's on a house call". |
| 88   | 10. Sufficient income to pay for private expenses e.g. childcare, children's education, mortgage and personal requirements. | a. It is very essential.  
     b. As I think through this it seems that if the income were higher, that a lot of the issues would be easier to attain.  
     c. Being a single mother this is very important - value for work put in - more remuneration for the difficult job that we do.  
     d. With children there are more expenses but less time to work.  
     e. Includes accessible affordable child care. |
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| **11. Deciding if and when to have children.** | a. Have to find partner first.  
   b. I keep putting it off because I love my job too much.  
   c. Never the right time.  
   d. This is a very important issue for me. I have not resolved it.  
   e. Often based on career advances and commitments.  
   f. Something I was not aware of but regret the most.  
   g. My responsibility unrelated to being a GP.  
   h. I passed this stage but know it is very important.  
   i. This was never a question for me. |   |
| **12. Responsibility for the organisation or performance of domestic duties.** | a. Better since I have been working part time.  
   b. We share those responsibilities.  
   c. This is often sorted out early and is an expense. A fairer tax system would recognise this.  
   d. Expected to work all day, keep the house tidy and then entertain your partner because he has had a busy day.  
   e. My pet hate. I bring in half the money so why doesn't he do half the house work.  
   f. Paid cleaning/ironing/gardening makes life bearable. |   |
| **13. Juggling the complexities of competing priorities in professional and non professional life and activities.** | a. This issue must be the main contributor to "burnout".  
   b. I always try.  
   c. Recognise early - that as a doctor at the local pre school committee you are never an ordinary mum. |   |
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| **14. Availability and access to appropriate child-care at reasonable cost.** | a. Actually very important.  
   b. All working women want this.  
   c. My children were born overseas and looked after by my family.  
   d. This is an issue that should be a professional and political issue. All working women need more cost effective child care. This is a community political issue. Suggest taking the lead at the highest level for tax reforms.  
   e. Childcare is very expensive and often doesn't cover the hours.  
   f. I need to feel that my working is not compromising my children's development.  
   g. Working part-time.  
   15 - 20% of my salary goes to childcare. |   |
|   |   |   |
| **15. Conflicting multiple roles for women in professional and non-professional life.** | a. Women are expected to work, be a wife, mother and cleaner.  
   b. I resent greatly some of the roles I've been given because I'm a woman.  
   c. Especially as relates to family relationships.  
   d. Not just female GPs. This is about any working adult. |   |
|   |   |   |
| **16. Recognition of non-professional life and respect for individual privacy by colleagues and patients.** | a. Do your patients really care about you?  
   b. In a remote community you are often asked for results when out and people seem surprised when you relax and have a good time. I do belly dancing performances. It shocks some people in the community. |   |
<table>
<thead>
<tr>
<th>17. Having support and opportunity for mentoring from partners, peers and community.</th>
<th>a. Support is very important.</th>
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</table>
| 18. Having a house and workplace with facilities and location appropriate to needs. | a. Patients expect you to be there 24 hours a day.  
  b. My responsibility. |
| 19. Accessibility of appropriate health care services for consumers who are women general practitioners. | a. Particularly the need for mental health.  
  b. I have had a female GP for just over a year. It is a relationship I value deeply. |
Dear Doctor ..........................................

During 1996 you took part in a research Delphi study. Thank you for your contributions to this Delphi study and the cooperation that you extended during the study. Thirty nine out of the forty women general practitioners who commenced the study completed all of the three questionnaires that that were sent to them.

All responses have been analysed and the individual response of any participant will not be able to be identified and confidentiality has been maintained. The respondents represented women general practitioners from all States in Australia and from geographic locations including, urban, rural and remote. The participants taking part in the study were from all stages of their career and life cycle including: General Practice registrars, women GPs working part-time and full-time, women GPs who had recently retired and women GPs who have other professional work such as public health or academic General Practice. A reference group of six women general practitioners from various states in Australia has overseen the project and provided wise counsel throughout the project.

The most significant key issues identified by the GPs in the professional and non-professional lives were job satisfaction and time for self-care respectively.

Other issues considered to the important in their professional lives were: achieving a balance, time management, juggling professional and non-professional commitments, flexibility in training and work, fair remuneration, sufficient income, high self-esteem and autonomy and having a presence, a voice and share of power in decision making about issues concerning women GPs.

In their non-professional life other important issues were: time to nurture a quality relationship with a partner and find a balance between his/her career, time for children, family life, social contacts and friendship, sufficient income, achieving a balance by drawing protective boundaries and time management.

A review of the study is being prepared for publication in a peer review journal. The study has been invaluable in achieving a consensus of the key issues in the
professional and non-professional lives of women GPs in Australia and also providing me with ideas for further research concerning these issues of concern. I will be continuing research regarding these issues for women general practitioners during 1998.

I acknowledge the invaluable help and assistance of the following people during the study: Dr J Walker; Dr C Newell; the Reference Group of women general practitioners and Mr E Rock. I also acknowledge the funding received from the RACGP. My sincere thanks for your assistance, patience and invaluable contributions to this study.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
INTERVIEW GUIDE

Questions for the Semi-structured Interviews

1. Which professional bodies or Colleges are you a member of?

2. Do you have an active role in any of these organisations?

   **Prompt:** If not, why? If yes, please tell me about this role or how you see your role.

3. What do you think are the key issues for women GPs?

   **Prompt:** In their professional lives and non-professional lives.

4. How do the professional bodies and Colleges that you belong to identify and consider the key issues that exist for women GPs?

   **Prompt:** When and where - give examples - tell me that story.

5. Why is that?

6. How could these issues be better tackled and addressed?

   **Prompt:** Can you give me an example? I wonder if you would like to see these issues change? Regarding these issues how could it be different?

7. Can you suggest anyone else or anything else that could assist with this research?
Dear Doctor,

I am seeking your agreement to be interviewed as part of a study on the key issues in the professional and non-professional lives of women general practitioners in Australia. This study has received ethical approval from the Research and Evaluation Ethics Committee of the RACGP and funding has been granted by the College Foundation of the RACGP. The objectives of the study are:

- To identify the key issues in the professional and non-professional lives of women general practitioners in Australia and how these issues are being considered by professional organisations and Colleges.
- To analyse the discourse and knowledge used in professional bodies and Colleges in identifying and tackling these key issues.
- To identify strategies that will address these key issues.

The outcome of the study will form part of my PhD thesis supervised by Dr Christopher Newell, University of Tasmania and will also be used for publications in peer reviewed medical journals.

An ethical permission slip will be available for signing prior to the interview. The outcome of the study will use de-identified data so that it will not be possible to recognise individuals who have participated in the study. Confidentiality is assured.

Throughout the interview the responses of the participants should reflect their personal view on the subject and not the official policy of any organisation. The interview (approximately one hour in length) will be taped, and a transcript of the interview will be sent to the participants for confirmation. I am enclosing for your perusal a copy of the outcomes of a Delphi study. This study was conducted in 1996 as part of my thesis.

I look forward to you agreeing to be interviewed by myself in the near future.

Arrangements including a time for the interview can be made by replying to me at the

University of Tasmania
Division of Community and Rural Health

GPO Box 2233
Hobart
Tasmania 7001
Australia
Telephone 03 6228 7734
Facsimile 03 6228 7730
Mobile 0418 399 694
E-mail M.Kilmartin@utas.edu.au
Division of Community and Rural Health, University of Tasmania on contacts phone (03) 6226 7746, fax (03) 6226 7730, email M.Kilmarling@utas.edu.au. Please do not hesitate to contact me for further information regarding this study.

Yours sincerely,

Margaret Kilmarling
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
Dear Doctor

Thank you for allowing me the privilege of interviewing you for my research topic regarding the professional and non-professional lives of women general practitioners in Australia. I have enclosed a transcript of your interview for your reference. Please read the transcript and if you have any concerns or corrections to make to this transcript, please forward them to me. Confidentiality is assured and the contents of the transcript will be used as de-identified data so it will not be possible to recognise any individual who has taken part in the study.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
Protocol for Interviewees of the Semi-structured Interviews

Thank you for agreeing to be interviewed as part of a study regarding the professional and non-professional lives of women general practitioners in Australia and the socio-political place they occupy in the medical profession, and professional organisations and Colleges concerned with General Practice. This study has received ethical approval from the Research and Evaluation Ethics Committee of the RACGP. Funding for the study has been granted by the College Foundation of the RACGP. The outcome of the study will form part of my PhD thesis and also be used for publication in a peer reviewed medical journal.

Attached is an ethical permission slip for signing prior to the interview. The outcome of the study will use de-identified data so that it will not be possible to recognise individuals who have participated in the study. Confidentiality is assured and you may withdraw from the study at any time. Throughout the interview your responses should reflect your personal view of the subjects and not the official policy of any organisation. The interview (approximately one hour in length) will be taped and a transcript of the interview will be sent to you for confirmation. If you do not wish to have the tape recorder running please tell me so it can be turned off. Thank you for your assistance with this study.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania
# Appendix 16: Initial Coding Framework for Semi-Structured Interviews

<table>
<thead>
<tr>
<th>Non-Professional Life</th>
<th>Private Life Issues for WGPs:</th>
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<td></td>
<td>Relationships¹</td>
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<th>Professional Life</th>
<th>Professional Work Issues for WGPs:</th>
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<td>Practice Details⁶</td>
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### Power & Patriarchy in:
- General Practice¹⁰
- Politics¹¹
- Cultural Change¹²
- Organisations & Colleges¹³
- WGP’s Socio-political Space in Organisations & Colleges¹⁴
- Rural General Practice¹⁵

### Acknowledging the Difference in:
- Women’s Characteristics¹⁶
- Men’s Characteristics¹⁷
- Undergraduate & Postgraduate Doctors’ Characteristics¹⁹
- Medical, Hospital & Organisational Culture¹⁸

### Generational Change Issues For:
- Women²⁰
- Men²¹
- Male & Female Junior Doctors²²

### Medical Organisation & College Issues:
- Identity and Characteristics²³
- WGP’s Socio-political Space²⁴
- Culture²⁵
- WGPs in Leadership²⁶
Appendix 16: Key themes that emerged from the Semi-Structured interviews, grouped by initial coding categories

**Private Life Issues for WGs**
2. Home: Domestic Duties.
5. Self-Care: Exhaustion (physical & mental), Mental Health (stress, depression, burn out, guilt, not coping).

**Professional Work Issues for WGs**
6. Practice Details: Ownership, Business practices, Management, Models of practice, Finance, Human resources, Safety (violence), Location.
7. Work Practices: Working conditions, Contracts, Hours of work, After-hours work, Part-time work, Job sharing, Home visits, Leave (sick, parental, maternity, recreational, study, long service, compassionate), Remuneration (salary, percentage of Medicare schedule fee, PIP, superannuation, legal & insurance reports), Flexibility, Job satisfaction, Patient continuity, Self-education (QA & PD), Style of work.
8. Type of Work: Teaching (students & registrars), Counselling, Community work, Team work, Research, Clinical work (procedural & long consultations), Holistic care, Work in organisations & Colleges, Diversity of work, Specialised working areas (women's health, mental health & indigenous health).
9. Perceptions of WGs: Low (status, standards, pay, political activity), Biased perception, Life-style, Working mode, Adoption of masculine ways, Decision-making process, Knowledge & experience.

**Power and Patriarchy in:**
14. Socio-Political Space in Organisations & Colleges for WGs: Glass ceiling, Barriers to advancement, Women adopting the guise of men, Flexibility, Having voice, Devaluing WGs, Women's contributions, Meetings (times & structures), Addressing women's needs.
15. **Rural General Practice:** Male dominated, Hostile, Hairy-chested, Competitive, Ego (bound individuals), Clinical procedures (distinguishes rural & urban), Lack of WGP's (voice, importance, needs).

**Acknowledging the Difference in:**

16. **Women's Characteristics:** Networks, Communications, Social skills, Person focused, Different (emphasis, understanding, biology, socialisation, social roles), Agents for change, Introspective.

17. **Men's Characteristics:** Problem focused, Structural approach, Functional approach, Success driven, Interests (object things, & organisations), Lack introspection, Patriarchal, Employ a masculine mode, Clinical skills equivalent to WGP's clinical skills.

18. **Medical, Hospital, & Organisational Culture:** Masculine culture, Hierarchical, Callous, Conservative, Negative perception of females, Biomedically oriented.

19. **Undergraduate & Postgraduate Doctors' Characteristics:** Women's Characteristics: Women fear (litigation, General Practice environment, after-hours work, emergency), Women suffer (anguish, uncertainty, anxiety), Low self-confidence, Verbalise their fears, React differently to hospital environment. Men's Characteristics: Success driven, Better coping skills, Get on with the job, Carry feelings internally, High morbidities outside hospitals (e.g. marriages).

**Generational Change Issues:**

20. **Women:** Part-time work, Women are assertive, active & intelligent.

21. **Men:** Have wives who (work, are in leadership positions & organisational roles), Job share with wives, Share child-care, Increasingly work part-time.

22. **Junior Doctors (Male & Female):** Less willing to (self-sacrifice, make family sacrifices), Have different attitudes, Fear (limitation of numbers of women in medicine & devaluing of WGP's work).

**Medical Organisations & College Issues:**

23. **Identity & Characteristics:**

   **General:** (AMA, RACGP, ADGP, AAGP, AAAGP, ACRRM), WGP's Under-represented in (decision making, financial planning, leadership positions), Organisations & Colleges lack (appeal for WGP's, understanding of WGP's, support of WGP's, encouragement of WGP's, mentorship of WGP's, networking for WGP's, convenient meeting times for WGP's, significant membership numbers of WGP's), Equal opportunity issues, Negativity, Tokenism, Power, Patriarchy, Member services, Public perception, Individual organisational roles (standards, education, training, research, politics, industrial issues, advocacy, issues for rural GPs), Why WGP's don't join organisations (costs, lack of time, child-care), WGP's contributions (broaden thinking & approach).
Academic: Organisations lack (support for part-time work, adequate staff; structural change, WGPs in senior positions, selection & promotion of WGPs, cultural change), Requirements for selection & promotion (clinical experience, overseas experience, publications, success in attracting grants, community experience & a higher degree), Power, Patriarchy, Discrimination, Medical Education, Teaching, Research, Administration.

Medical Women's Society: Social, Networking, Advocacy for medical women, Discussion forum, Medical women's voice, Information exchange, Support for WGPs.

24. Socio-Political Space for WGPs: Care givers, WGPs limited by personal lives, gender, lack of experience, organisation culture & structures.

25. Culture: Slow to change, Narrow understanding of health, Gender issues, Tokenism, Confrontational, Validation of Women's ways, Equity issues, Absence of (women's voice, women in decision-making roles, equal opportunity), Power, Patriarchy, Masculine domination, Narrow focus, Discrimination.

26. WGPs In Leadership: Difficulties for WGPs (criticism, glass ceiling, structural & organisational characteristics), Lack of (response to ideas, legitimising parenting roles in part-time work), Clumping of WGPs at a low levels, Age, Time, Organisational culture, Presidential issues.
This Appendix has been removed for copyright or proprietary reasons
Appendix 17

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

Published in:

https://www.mja.com.au/journal/2002/177/2/balancing-act-key-issues-lives-women-general-practitioners-australia?0=ip_login_no_cache%3D0ea1c8228335715b3f6fe804b566e9da

The balancing act: key issues in the lives of women general practitioners in Australia, Margaret Kilmartin, Christopher J Newell, Marin A Line: The Medical Journal of Australia: 2002, 177 (2) 87-89
Dear Doctor

Thank you for joining my Reference Group to oversee the Delphi study.

I have enclosed the following documents for your perusal:

- A copy of the position paper.
- The selection criteria of the participant experts. Prior to the first teleconference the reference group members should consider the selection criteria for the study’s participant group and have considered the names of potential women general practitioners throughout Australia that could be invited to join the study. Many of the participants will fill more than one of the criteria. Approximately 40 women general practitioners geographically spread throughout Australia will need to be recruited.
- A draft copy of Delphi Questionnaire #1. In order to pre-test the questionnaire, each member of the reference group should fill in this questionnaire prior to the first teleconference. The questionnaire will be discussed and refined at the first teleconference.
- A copy of the form for collecting the details of the potential study participants who you will contact after the first teleconference. This form together with the recorded details of the participants who have agreed to receive an invitation from me to join the study should be returned to me by fax after the first teleconference.
- A form to detail phone calls (for reimbursement) to the participants. This form is to be returned to me by fax or post at the end of the project.
- A copy of the demographic questionnaire will be sent to the participants with the first questionnaire. Members of the reference group should also fill in this questionnaire and return it to me in the pre-paid envelope. The data collected will remain de-identified and is required to complete the demography of the reference group.
I would like to hold the first teleconference on Tuesday 3/10/1996 to:

- Review and endorse the study aim, the objectives, and criteria for selecting the study participants.
- Review the pre-tested (by the individual reference group members) the Delphi Questionnaire #1.
- Discuss the process for contacting women general practitioners who may wish to take part in the Delphi study.

I look forward to working with you during this study. Please contact me at any time if you have any questions.

Yours sincerely,

Margaret Kilmartin
Senior Lecturer
Division of Rural and Community Health
University of Tasmania


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