The perceptions of rural women doctors about their work

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ABSTRACT

Background: Recruitment and retention of medical staff are important issues in rural health. The aim of this study was to describe and understand the perceptions of women doctors working in rural hospitals in South Africa about their work.
Methods: This was a descriptive study, using a qualitative methodology. Free attitude interviews were conducted with 14 women doctors. Themes were identified and tested against the data and comments from the research diary.
Results: The main theme was balance. A rural woman doctor has to juggle different issues, including running the household and responsibilities at work. Other themes that were identified included the reason for working at a rural hospital, attitudes to rural life, opportunities for personal and professional growth, the feeling of being needed in a rural hospital, advantages and disadvantages for children and family, the impact of relationships on the rural woman doctor, issues regarding the environment and security, and that the proximity of home and work gives a rural woman doctor far more connection with her family.
Conclusions: Some of the themes identified in this study agreed with international research, e.g. the importance of a job for the spouse, family considerations influencing the choice to specialise, and balancing responsibilities at home and work. The advantage of accommodation close to the hospital is a theme that has not been documented before. Based on the findings, recommendations are made to attract women doctors to rural areas.
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INTRODUCTION

The recruitment and retention of medical staff are important issues in rural health. Since about 50% of graduates at South African medical schools are female,[1] a special effort will have to be made to recruit women doctors for rural practice. The aim of this study was to describe and understand the perceptions of women doctors working in rural hospitals in South Africa about their work. Very little research has been done in South Africa on women doctors, and none specifically on rural women doctors. Issues previously identified in South African research include women's dual responsibilities at home and at work and discrimination in the workplace;[2] maternity leave arrangements and sexual harassment;[3] as well as role conflict and the fear of achievement in a field that is considered "masculine".[4] Issues examined internationally include coping with children,[5,6] role strain[7,8] and gender differences in the style of practice.[9,10] Factors affecting rural women doctors internationally include balancing multiple roles, difficulties with maternity leave[11] and opportunities for spousal employment.[12,13]

METHODS

A qualitative methodology was used because it was an exploratory study in an area that had not been researched before. The researchers wanted to find out how rural women doctors saw themselves without imposing their ideas on them. Sam-

pling was done purposefully and 14 women doctors were chosen with maximum variability sampling.[14] Doctors were chosen from different provinces and age groups, and the sample included both married and single women (see **Table I**). Doctors from six different provinces were interviewed by the first author between June 1999 and June 2000, including five from the Northern Province (now Limpopo Province), four from KwaZulu Natal, two from North West and one each from the Eastern Cape, Mpumalanga and the Western Cape. Twelve interviews were conducted face to face and two telephonically. A sample size of 14 was considered adequate because saturation was reached, i.e. no new themes emerged during the last interview. Because the study focused specifically on hospital doctors, no private practitioners were interviewed. A free attitude interview technique was used, with only one interview question: "What does it feel like to be a rural woman doctor?" The duration of the interviews varied from five to fifty minutes. The interviews were audiotaped and transcribed verbatim. The computer program *Atlas.ti*[15] was used to code the data. Themes were identified and tested against the data and comments from the research diary. A model was constructed to demonstrate the process and relationship between the themes. The analysis was posted to the respondents for verification and their comments were included in the final analysis. Ethics approval for the study was obtained from the Medunsa Research, Ethics and Publications Committee.

Table I: Demographic data of respondents

Respondent	Approx. age	Years rural experience	Race	Partner	Children
A	40+	14	White	Y	3
B	60+	27	White	N	-
C	30+	3	Black	Y	2
D	20+	1.5	White	Y	-
E	20+	0.5	Indian	Y	-
F	40+	15	White	Y	3
G	70+	49	White	N	1
H	50+	30	White	Y	4
J	40+	19	White	N	-
K	30+	5	Black	Y	3
L	40+	18	Indian	Y	4
M	50+	29	White	Y	3
N	30+	1	White	Y	-
O	20+	1.5	Black	N	1

RESULTS

As shown in the model (Figure 1), the main theme emerging from the study was *balance*. A rural woman doctor has to juggle different issues – running the household, work responsibilities and the question of specialising. In the model, the *foundation* indicates her reason for working in a rural setting. Eleven of the 14 women mentioned their reason for choosing this setting – five because of a missionary "calling", five followed their partners (husband or boyfriend) and one returned to the rural area in which she grew up. The husband's job and the children's schooling can erode the foundation. The *clouds* indicate her thoughts and attitudes, i.e. her inner world. Growth is an important theme. The *house* indicates that a rural woman doctor has a strong connection with her home, as the doctors' houses are often on the premises of rural hospitals. The *rectangles* indicate the different groups she has relationships with – patients and the community, colleagues, and urban doctors.

Themes

The various themes that emerged from the study will now be expanded upon and elucidated by quotations from the interviews.

1. The attitudes of women doctors to rural life and work

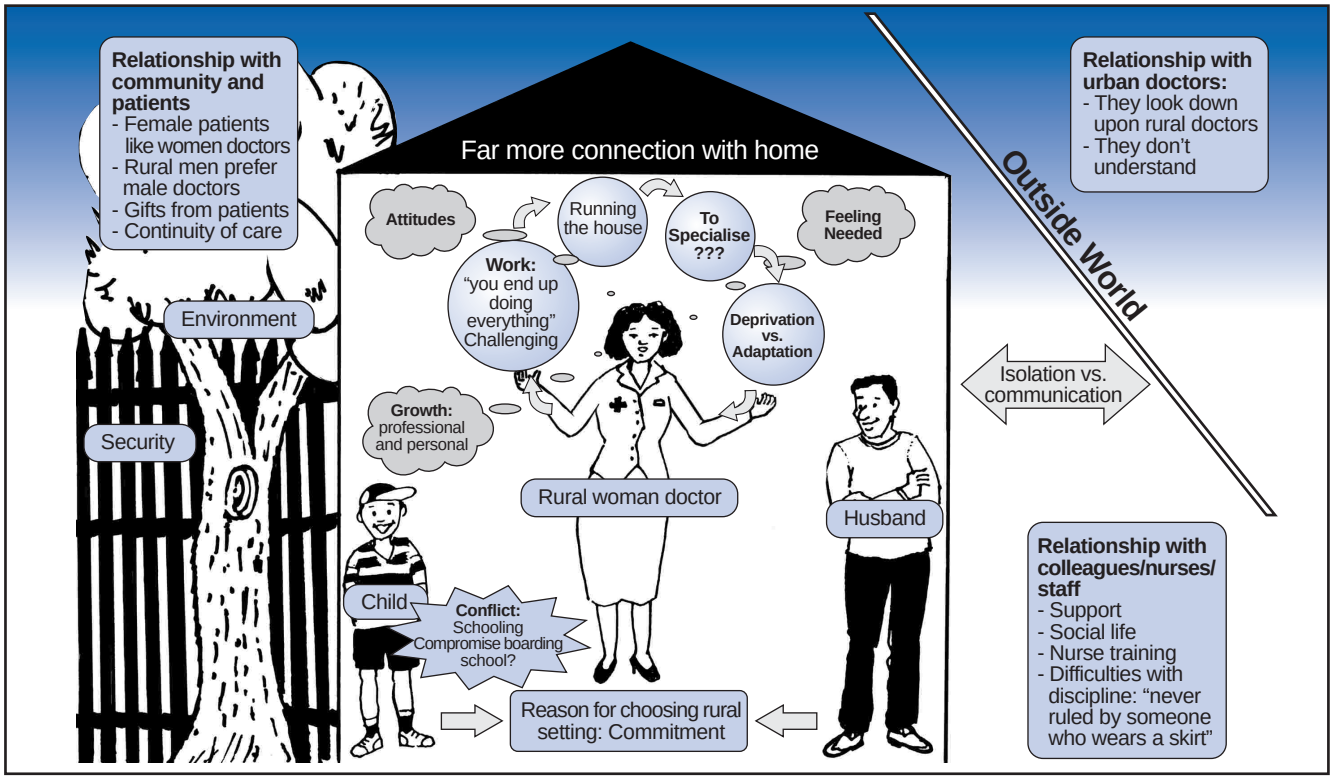
"I think it is the best work a woman can do."

"In a rural set-up, a doctor can either become positive or become very dejected."

2. Professional growth opportunities in a rural hospital and the desire to specialise

Several doctors felt that a rural hospital is a good place to learn new skills. One, however, was frustrated, since she felt that she did not get the opportunity to learn new techniques. The issue of whether or not to specialise was raised by five doctors. It proved to be a difficult decision, as the needs of the practitioner's family were often juxta-

Figure 1: The rural woman doctor balancing her world



posed by her desire to specialise. One said:

"When I'm faced with this and I know I can't just wait to get the training, I feel the need is now."

One respondent seemingly had to work hard to stop feeling somewhat "inferior" to her urban colleagues and to start feeling a sense of pride in what she was doing. She mentioned her studies in Family Medicine, saying this had really helped her to realise that being a primary care doctor was important. "When I did MFamMed, I gained a new perspective on what I do, I saw that it is important. It is as important as the guys that specialise. And then I did not feel inferior anymore about what I do. I feel now that what I do is important."

3. Personal growth in a rural area

A rural environment can be conducive to personal growth.

"You see the endless challenges of working in a rural area and also the way in which you can be creative in developing yourself ..."

4. The feeling of being needed in a rural hospital

Working at a rural hospital met some doctors' need for significance.

"Here you have an opportunity to do what you can, contribute, and you are needed, so you automatically have to try."

"There is a great need here, because there are not enough doctors, most of the doctors go to the cities"

5. The advantages and disadvantages for children and family

Eight of the doctors interviewed mentioned children. Most felt that it was a good place to raise children, because of the relative safety and the beautiful environment. The major problem was schooling for the older children. The husband's job was an important factor, influencing whether a rural doctor would stay where she was or not.

6. The challenge and great diversity of the work at a rural hospital

"When you are doing rural medicine, it does not matter what speciality you have, you have to do pretty much general things."

"You end up doing everything."

Being a rural doctor is about more than just clinical medicine. Some interviewees mentioned having to supervise the building of new hospital wards, one helped with a winter school for matric pupils, and three were involved in nurse training.

7. Deprivation in a rural area when compared with urban settings, but also adaptation to the situation

Most of the women viewed shopping as a problem. They managed to adapt, however. "And everything gets shaken around, and you have

to pack your eggs carefully, because they will break sometimes." Old equipment and shortages of drugs were also mentioned. "You can't do all the wonderful tests, but I saw that one can practise good medicine without all the wonderful tests."

8. Rural areas are isolated – effective communication may help

The bad roads were frequently mentioned. One said that the distance she had to travel on dirt roads to get anywhere made even going away for a weekend a "major undertaking". Adequate telephone and e-mail connections were mentioned as ways of decreasing the isolation.

9. The impact of relationships on the rural woman doctor

a) Relationships with patients and the community

The interviewees generally had good relationships with the local people and experienced them as friendly and warm. Continuity of care was seen as a positive aspect of rural medicine when compared to large urban academic hospitals. Some doctors focused on the gender of their patients and said that female patients felt more at ease with a female doctor, while older rural men still preferred to be seen by a male doctor. In contrast to other studies on women doctors, no gender differences were mentioned in the way rural doctors practise, while two interviewees specifically indicated that the gender of the doctor makes no difference. One said: "…and there's not much time for thinking about I'm doing this as a woman, or as a doctor, you know."

b) Relationships with colleagues, nurses and staff

Most doctors reported good relationships with and solid support from their colleagues. There was one exception, who said: "There is no intimacy between doctors, they just say hallo and that's it." Two doctors said that some men found it difficult to have a woman as a boss, "the male employees said that they will never be ruled by someone (who) wears a skirt".

c) Relationships with urban doctors

Urban doctors in referral hospitals were described as being ignorant of the rural setting. Mention was often made of the difficulty of referring patients. Urban doctors seemed not to take rural doctors seriously and appeared to look down upon them. "You are becoming an oddity, you don't speak the same language anymore, the perception of your environment is just so strange to them…" Most rural doctors did not see themselves as inferior. One doctor remarked: "You also know that you are a better doctor than your urban counterparts, because here you definitely have to do things, instead of just relying on specialists". Another said: "You also develop pride when you develop skills, they give you a sort of pride and confidence in that you can manage a lot of things".

10. Issues regarding the environment and security

Several doctors commented on the beautiful rural environment and that it was a good place to raise children. Security was an issue for some, but rural areas are still considered safer than urban environments.

11. The proximity of home and work gives a rural woman doctor far more connection with her family

The fact that doctors' houses are close to the hospital was considered to be a definite advantage. "You are [so] close to home, that you can pop down at lunchtime and have your lunch, and clean up the washing if you want …"

"I can attend to hospital problems and still be able to attend to my family."

"It was close to home, one could come home during tea and lunchtime, you could breastfeed your children, it was good."

DISCUSSION

The issues that were raised in this study differed from published research about South African women doctors. Gender discrimination was not a major issue for the doctors interviewed. It has been said that the expectations of women entering medicine have changed and that they no longer anticipate discrimination in the workplace.[16] Maternity leave was not mentioned at all, presumably because the sample only included doctors who are government employees. Sexual harassment was another issue identified in previous research[3] that was not mentioned by any respondent, possibly due to the small sample size.

Certain findings from previous research were confirmed. The issue of family considerations influencing the choice to specialise is an important one,[17] and was mentioned by five of the respondents in this study. The theme of balancing responsibilities at home and work has been described before, both in South Africa[4] and internationally.[5,6,7] It is something that affects all women doctors, and in fact all working women.

There are several studies that found that women doctors practise differently from their male colleagues.[9,10] The respondents in this study did not mention it. However, it was postulated that it influenced the way patients respond to them, with female patients preferring women doctors. This has also been found to be the case in the Netherlands.[18]

Couper has discussed the reasons for choosing to work in rural hospitals.[19] The most frequent reason that he encountered was "a calling" or a sense of vocation – as was mentioned by five of the respondents in this study. He did not mention following a partner as a reason, although this aspect was mentioned by five respondents. In Australia it was found that women doctors were more concerned about job opportunities for their partners in rural areas than their male colleagues were.[13] Couper mentioned that "going back home" is a reason seldom seen in the South African public service,[19] but internationally it has been found to be important in recruiting and retaining rural doctors.[20,21] One doctor in this study mentioned how happy she was returning to the area in which she grew up.

The advantage of accommodation close to the hospital is a theme that has not been documented before. Four respondents commented on the advantages and found that it made the task of balancing work and family responsibilities easier.

The doctors seemed to find the rural hospital setting a good place to learn new skills. The learning was often self-directed. In a recent South African study on the procedural skills of rural hospital doctors, two scenarios were described.[22] The doctors in this study mostly fall into the first scenario, in which they were coping and learning from the work they were doing. The opportunity for postgraduate studies was considered very important: "There are two things needed to keep a doctor in a rural area, and the first thing is that there should be opportunities to get further training over a distance, and the second is a job for the spouse". One respondent was one of the first M Prax Med graduates at the University of Pretoria, which offers a distance learning course. Two of the respondents left rural practice to specialise, and then returned.

Very few of the doctors interviewed deliberately chose a career in rural medicine. They came to work at rural hospitals because of a missionary "calling", or because their husbands worked in a rural area. Still, they seemed to make the most of their rural experience. They managed to adapt to the challenges of working in a rural hospital and to successfully balance all the different demands made on them. With the exception of one respondent, the attitude towards rural practice was positive.

The fact that the researcher who did the interviews (EMdV) is also a woman doctor and was working in a rural hospital at the time the research was done, could have introduced some bias, but in qualitative research the researcher is the research instrument and therefore cannot be completely objective.

It would have been preferable to find respondents from all the provinces in order to make the research findings more diverse. Unfortunately, the researchers could not find any rural women doctors willing to be interviewed in the Northern Cape and Free State. Because only civil servants were included in the sample, the results may not apply to rural women doctors in the private sector. The purpose of qualitative research is primarily to identify new themes – as shown in this research.

Based on the research findings, the following recommendations are made:

- To retain the services of rural women doctors, and rural doctors in general, requires commitment from more than just the Department of Health. Important issues that need to be addressed are jobs for partners, schooling for children and better roads.

- The Department of Health needs to be aware that women doctors have special needs, e.g. the option to work part time or not do overtime when they have young children. Accommodation close to work is seen as an advantage and rural hospitals who wish to attract more doctors need to pay attention to housing for doctors.

- Few female medical students are told about the realities of combining work and family. Medical students, both female and male, need to be made aware of gender issues relating to rural medicine. It is important to stimulate thinking around these issues early in the medical curriculum. There should be discussion about the choices that women doctors have to make in their careers, and the need to balance different roles.

- Distance learning is a very important and practical way of im-

proving one's skills and qualifications while remaining in rural practice. The current distance learning MFamMed programmes are very valuable for rural doctors, and this example should be followed by other disciplines. There is a need to accredit rural hospitals for diplomas.

CPD Questionnaire p.45

References

1. Colborn RP, Kent AP, Leon B. The changing medical student population at the University of Cape Town. *S Afr Med J* 1995;4:256-61.
2. Brink AJ, Bradshaw D, Benade MMM, Heath S. Women doctors in South Africa. *S Afr Med J* 1991;80:561-6.
3. Moodley K, Barnes JM, De Villiers PJT. Constraints facing the female medical practitioner in private family practice in the Western Cape. *S Afr Med J* 1999;89:165-9.
4. Nash ES. Depression in medical women. *JAMWA* 1998;43:176-80.
5. Woodward CA, Williams AP, Ferrier B, Cohen M. Time spent on professional activities and unwaged domestic work. *Can Fam Physician* 1996;42:1928-35.
6. Rout U. Stress among general practitioners and their spouses: a qualitative study. *Brit J Gen Pract* 1996;46:157-60.
7. Hammond JMS. Mother, Doctor, Wife. *Can Fam Physician* 1993;39:1591-6.
8. Cartwright LK. Occupational stress in woman physicians. In: Payne R, Firth-Cozens J, editors. Stress in Health Professionals. Chichester: Wiley; 1987. p. 71-87.
9. Hojat M, Gonnella JS, Xu G. Gender comparisons of young physicians' perceptions of their medical education, professional life and practice: a follow-up study of Jefferson Medical College Graduates. *Academic Medicine* 1995;70:305-12.
10. Woodward CA, Hutchison BG, Abelson J, Norman G. Do female primary care physicians practise preventative care differently from their male colleagues? *Can Fam Physician* 1996;42:2370-9.
11. Rourke LL, Rourke J, Brown JB. Women family physicians and rural medicine. *Can Fam Physician* 1996;42:1063-7.
12. Ogle KS, Henry RC, Durda K, Zivick JD. Gender-specific differences in family practice graduates. *J Fam Pract* 1986;23(4):357-60.
13. Wainer J, Carson D, Strasser RP. Women and rural medical practice. *SA Fam Pract* 2000;22(6):19-23.
14. Patton MQ. Qualitative Evaluation and Research Methods. Newbury Park: Sage Publications; 1990.
15. Muhr T. ATLAS.ti for Windows. Berlin: Scientific Software Development; 1997.
16. Hudson CP, Kane-Berman J, Hickman R. Women in medicine – A literature review 1985-1996. *S Afr Med J* 1997; 87:1512-16.
17. Unterhalter B. Discrimination against women in the South African medical profession. *Soc Sci Med* 1985;20: 1253-8.
18. Bensing JM, Van den Brink-Muinen A, De Bakker DH. Gender differences in practice style: a Dutch study of general practitioners. *Medical Care* 1993;31:219-29.
19. Couper I. Why doctors choose to work in rural hospitals. *S Afr Med J* 1999;89:736-8.
20. Rabinowitz HK. Evaluation of a selective medical school admissions policy to increase the number of family physicians in rural and underserved areas. *N Engl J Med* 1998;319:480-6.
21. Magnus JH, Tollan A. Rural doctor recruitment: does medical education in rural districts recruit doctors to rural areas? *Med Education* 1993;27:250-3.
22. Reid SJ, Chabikuli N, Jaques PH, Fehrsen GS. The procedural skills of rural hospital doctors. *S Afr Med J* 1999;89:769-73.