The Spouses: A Major Support for the Rural Doctor

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A country practice is essentially a family practice. To ignore the stresses put on the spouse is to render invisible a core aspect of the doctor's decision to reject rural practice. Recognition of the implication of these stresses is urgent, if further reductions in GP services are to be averted.

"Rural practice is ultimately a matter of establishing doctors' families in the country, since rural practice is a family concern. ...Similarly, to keep a doctor in the country his wife must perceive that the advantages of country life and medical practice outweigh the disadvantages."¹

During the last 2 decades the difficulty situation of attracting medical practitioners to rural areas has developed into a crisis situation. GPs are leaving country practices after only a few years to pursue medicine in the larger population centres, where the emotional and physical demands are less, and the financial remuneration for the skills and hours worked is more realistic.

This crisis in rural health care delivery increases the pressure on the remaining GPs and their families. Because a country practice is essentially a family practice, to ignore the stresses put on the spouse is to ignore a vital component of the doctor's decision to reject rural practice.

During today's workshop I shall provide a framework for the discussion of issues affecting rural doctors' spouses in Australia. In doing so, my major challenge is to illuminate the issues and concerns influencing the spouses to support or oppose the alternative of rural medical practice.

There are a number of advantages to be enjoyed by living in country Australia, advantages freely admitted to by most rural doctors' wives, and indeed major determinants in the decision to set up rural practice.

These positives, however, are being increasingly outnumbered by a variety of educational, social, economic, vocational, and health concerns.²

Twenty or more years ago, a doctor's wife may have willingly accepted the supportative role, and enjoyed the status and recognition that flowed from her husband's position. Today, the spouse is more likely to resent her loss of identity and the inroads of the practice into family's private and social life.³
The influence of the women's movement and consequent improvement in career and educational opportunities may partially inform us of the reasons why rural doctor's wives are dissatisfied. This, however, ignores the very real personal, social and economic reasons for spouses' dissatisfaction.

The fact of the matter is that the position of many rural doctors' families vis-a-vis other professionals' families in the Australian community, has deteriorated significantly over recent times. This is largely due to governments' health policies as well as the effect generally of the downturn in the rural economy.

To remain silent and thereby maintain the invisibility of this problem, would be more destructive to rural society generally, than open and severe criticism at this stage.

Increasingly long hours, infrequent holidays, declining incomes and lack of suitable locum relief, combined with the inability to pursue a career, social and professional isolation, lack of privacy and virtual sole parenting, has meant that a disproportionate amount of the stress of rural practice has been placed on the spouse.

These stresses are adversely affecting the physical and mental well-being of the doctor's spouse, and stretching to the limit her abilities to manage the tensions between the doctor, the practice, the community and the family.

Recognition of the implications of these pressures is urgent if further reductions in the health services of rural areas are to be averted.

Recent reports concerning rural practice

A number of reports have been commissioned throughout Australia during the last five years in an attempt to understand the problem of attracting GPs to rural areas.

The main emphasis of these reports has been the financial and professional disincentives to the establishment and maintenance of rural general practices.

Social, personal and lifestyle factors, including spouse dissatisfaction are only now beginning to be realised as more significant determinants. By and large however, these reports have placed spouses' concerns on the periphery, essentially using them to bolster the financial and professional arguments of the doctors.

These reports' preoccupations with financial/vocational considerations obscure those less quantifiable, but no less important concerns of the rural doctors' wives - social isolation, personal fulfillment, family safety, cohesion and happiness, children's academic and social development and community atmosphere.

By better understanding the reasons for the spouse's decision to endorse or oppose country practice, emphasis can be given to those aspects which encourage commitment, rather than continually stressing the negatives and engraving them into the consciousness of all potential rural practitioners' wives.

Because of the doctor's wife's pivotal position between the practice, the family and the community, she is able to reflect, both consciously and intuitively on the real and perceived benefits of rural practice specifically and on country lifestyle and community generally. The issues confronting rural doctors' spouses can therefore be most effectively considered under one of the following three headings:
A. Rural Medical Practice Issues:

B. Rural Community Issues

C. Spouse Issues Specifically

Some of the major factors turning doctors' wives against rural practice include:

(i) the educational opportunities for their children;
(ii) the physical and mental stresses of a rural practice
(iii) the lack of career options for the spouses
(iv) financial difficulties and constraints
(v) social, professional and cultural isolation
(vi) difficulties with transport and communications
(vii) concerns for the rural economy, and
(viii) personal health concerns.

This is not to say that this ranking will be the same for every doctor's spouse. Priorities for individual spouses will depend on their lifestage, the ages of their children, their financial status and security, educational background and the period of residence in the country.

It would nevertheless appear that rural practice is becoming increasingly less attractive to a broad spectrum of rural doctors' spouses.

1. Education

Education is a major worry for doctors' families as indeed it is for many rural parents generally throughout Australia. The education at the local high school is considered inadequate with Subject choice limited and staff experience in many instances, minimal.11

Boarding school often becomes the only option, offering the child or adolescent a better education and a more stimulating environment by which to gain entry into university.12,13

The major concerns expressed by rural doctors' wives about the educational system were:

(i) that some rural high schools do not go beyond Year 10, which forces a decision to be made as to whether to send the child/ren to boarding school, or to sell up the practice and return to the city;
(ii) that the lack of competition and subject choice stifled the child's development;
(iii) that peer group pressure urged conformity to lower standards; and
(iv) that inexperienced teachers were impediments to high academic achievement.

The solution to this problem has ramifications for rural Australia generally. Better trained and more experienced teachers in combination with a more flexible and comprehensive education policy, would benefit not only doctors children, but rural children at large.

Such policies in the longer term would also have the effect of increasing rural students' representations within the medical science faculties of Australian universities, where students from rural areas are currently under-represented in medical school intakes.

If what Kamien has claimed is true, that medical students of rural origin are more likely to take up rural practice, then the rural community has a double incentive for supporting their rural doctors in any lobbying for improved educational facilities and personnel in country areas.14
2. Physical and Mental Stress

Country towns are losing their best doctors because of huge strains on lifestyle. Fatigue and emotional burnout are major problems for those involved in rural practice, and are the most common reasons for leaving country areas.15,16

The excessive “on call” demands on rural GPs are putting severe mental and physical stresses on the doctor and his wife, and consequently on their marriage.

During the doctor’s “on call” periods the wife is “on call” too, offering receptionist facilities, which often leave her feeling “chained to the phone”. At the same time the wife becomes, virtually a sole parent, who must deal with the varying demands of children single-handedly. These “on call” demands can cripple any chance of pursuing a career of her own, because of the difficulty of arranging childcare for such erratic hours, and sheer physical exhaustion. The wife is therefore forced into the “home maker” role, with very little recognition of her crucial importance to the smooth and effective running of the practice. The constant interruptions to family life when “on call” put strains on the marriage and the family.

Added to these “on call” obligations are the difficulties with arranging recreational leave or time-off. Such “endless doctoring is unhealthy” leading to a chronic state of exhaustion which reduces the efficiency of rural health services.17 Recognition of the spouse’s crucial role to the smooth running of rural practice is vital if these issues of stress are to be addressed.

3. Employment for the Spouse

The economic base of most rural towns is very much simpler than that of major metropolitan centres limiting the employment options available to the spouse. Qualifications are often not given the recognition that they command in the city. In addition rural doctors’ wives must contend with the long and erratic hours that their husband’s are “on call”, and the difficulties in arranging childcare particularly outside the standard 9am to 5pm Monday to Friday.

Doctors’ wives with nursing qualifications often find they are unable to work, where their husband is the Visiting Medical Officer because Their employment is considered inappropriate by many hospital managements.18

As an alternative to paid outside employment, many wives become involved in farming and/or the rural practice management. In the current depressed state of the rural economy, farming has become more of an expensive hobby than a viable additional source of income, while Inadequate training in the management side of the medical practice can further exacerbate feelings of frustration and inadequacy.19

4. Financial Difficulties and Constraints

Financial difficulties are very real for medical practitioners in rural Australia, particularly those in remote locations. In medium sized rural towns, the doctor’s income may be better in comparison with others in the community, but when considered in terms of the hours worked, the skills required, the overheads and expenses of the practice, taxation and insurance, the income is not high.20 Reduced capital gains for rural real estate is another major financial disincentive to a doctor’s family choosing country practice.21

The financial constraints on the family are resented by many spouses although these are not considered to be the major determinant in a decision to move. Nonetheless, financial problems do not improve the spouse’s self-image, but can increase the resentment towards
the community if she feels her husband’s services are being exploited. The spouse’s inability to take on employment to assist financially increases her sense of powerlessness and frustration. To address this imbalance, suggestion like zone allowances, tax rebates, capital gains tax exemption, alternative fee structures and the tax deductability of boarding fees have been made.

5. Social Isolation

The feelings of resentment towards the community and the practice because of the inroads both make into family life, do not improve the feelings of isolation experienced by many doctors’ wives. Even when the town is very welcoming, the wife can still feel very isolated due to the distance from family and friends, and the lack of intellectual stimulation and like-mindedness in a small country town.

“Doctor bashing” is a particularly isolating feature in rural towns placing the wife in a defensive position at social gatherings.

Women’s organisations like the Country Women’s Association (CWA) have been found to be rather conservative. Many younger doctors’ wives have found the activities of the CWA to be of limited interest to them to date, although this situation is changing. I believe that one of the greatest challenges to rural society and its organisations is how they will deal with this phenomena of the increasing social, economic and political involvement of rural women.

The initiatives of the RDA Spouses Groups should provide a positive incentive for other rural women’s interest groups and organisations to address the social, political and economic issues which affect them. By assuming an active and visible role in relation to issues of general concern to rural women, doctors’ spouses may be able to dissolve some of the barriers which have caused their social isolation.

6. Transport and Communications Difficulties

The lack of cheap and regular transport throughout Australia reemphasises the feelings of isolation for spouses in rural and remote practices. Rural roads are in bad repair; Many country rail services have been axed; The prices of petrol and freight in rural Australia are very high; and Country air services are very expensive when compared to fares on the major trunk routes.

Federal, State and local governments need to be pressured into addressing these issues rather than allowing them to pass the buck from one level of government to another without resolution.

7. Concern for the Rural Economy

The plight of the rural economy must act as a tempering factor in any decision by a doctor and his spouse to locate in a country area. Smaller towns in particular, have been hard hit, with businesses closing and people drifting to the larger population centres. Towns of less than 2000 people are likely to lose schools, hospitals, police stations, post offices and banks if this trend continues.

All this economic gloom does not assist in the attraction of doctors to smaller rural towns. Nor does it encourage their spouses to support the concept of rural general practice. The decline in the population and industries in rural towns reduces significantly the spouse’s employment options, as well as creating additional problems for the children’s education.
should local schools close.

Hospital closure or rationalisation is seen as threatening the presence of the resident medical practitioner in the community as well as the employment of ancillary staff and other health professionals. This in turn prompts a further decline in population size and a loss in the number and range of services. In short the existence of medical services is crucial to the economic viability of many small communities and their ability to maintain and attract population.

What does need to be addressed by Governments is that during such times of economic and personal stress the need for additional medical support services has become more acute. The traditional image of the self-reliant and independent country person should not be used as an excuse by Governments to maintain a lesser standard of health service to rural people.25

Suicide and the incidence of domestic violence in rural areas are increasing. With the decline in the numbers of rural GPs, these cases of stress and violence are either not addressed which often leads to tragedy, or become yet another demand on an already exhausted rural doctor and by association his spouse and family.

Services need to be provided to rural areas which do not compete for the "bread and butter" work of the rural GP, but rather complement his/her efforts by paying greater attention to the whole person’s needs. The governments’ emphasis on a “quick fix” reductionist approach means that the longer, more difficult and out-of-hours consultations are left to the rural GP. This approach neither assists with the concept of whole patient care, nor does it reduce the stress on the rural GP.26

More appropriately trained medical practitioners in rural areas would mean a more equitable distribution of hours and income, and a more even split between routine and complicated cases. This would considerably reduce the stresses on the rural doctor and his family.

8. Health Concerns

At the Spouse Discussion Group at Coffs Harbour in may most spouses agreed that it was very difficult to take care of one’s own health in a rural community. This often meant putting off consultations until visiting the city or larger regional town hundreds of kilometres away.

Because of the real and perceived problems of confidentiality, many doctors’ wives are reluctant to use services in country areas, waiting until they can visit a major city, where their anonymity can be more assured.

The health situation of rural doctors’ wives was aptly summed up by one of the spouses at the RDA Conference: “Pray you don’t get sick!”

Conclusion

From the above it is apparent that not one single issue either convinces a doctor’s family to remain in country practice or to set up initially. Nor is one factor going to make a family leave. Any combination of the above can tip the scales against rural practice. Good educational facilities, good health and a stable and adequate income favour continued country practice. However the stress of isolation, feelings of inadequacy on the part of the doctor, lack of spouse employment and long and erratic hours, will eventually take its toll on the most hardy of families.
Governments at all levels and the teaching faculties of medicine must take note of these factors if a disaster in rural medicine is to be avoided. Motherhood statements and treating rural GPs and their families as the ‘Florence Nightingales of the twentieth century Australian health care system’ is to place at risk the health of millions of our rural population.

References

2. ibid. p. 48
3. From interviews with and submissions by rural doctors’ spouses to the National Rural Health Conference 1991. The “loss of identity” is a very strong theme and a point of delineation between the older and the younger spouses.
12. The Medical Observer 28/9/90
13. The Land “Supplement” 31/1/91 p.10.
17. Sevier, Kate Spouse Discussion Group RDA (NSW) March 1990.
18. from interviews and submissions to the National Rural Health Conference.

19. Several submissions stress the need for spouse training in the area of practice management by way of short courses and videos.


22. from the submissions from Rural Doctors' Spouses to Conference.

23. Kamien Recommendations 10, 14, and 17 of Report pp.ix-x.

24. The Bulletin 31/7/90.
