

Australian Medical Workforce Advisory Committee

Australian Institute of Health and Welfare

**FEMALE PARTICIPATION IN THE
AUSTRALIAN MEDICAL WORKFORCE**

AMWAC Report 1996.7

September 1996

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AHMAC	Australian Health Ministers= Advisory Council
AIHW	Australian Institute of Health and Welfare
AMWAC	Australian Medical Workforce Advisory Committee
CME	Continuing medical education
CMO	Career Medical Officer
CPMC	Committee of Presidents of Medical Colleges
DEETYA	Department of Employment, Education and Training and Youth Affairs (Commonwealth)
DHFS	Department of Health and Family Services (Commonwealth)
DIRETFE	Department of Industrial Relations, Employment, Training and Further Education (New South Wales)
FTE	Full time equivalent
GP	General Practitioner
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
OMP	Other medical practitioner
Qld	Queensland
RACGP	Royal Australian College of General Practitioners
RMO	Resident Medical Officer
SA	South Australia
Tas	Tasmania
UK	United Kingdom
USA	United States of America
Vic	Victoria
VRGP	Vocationally registered general practitioner
WA	Western Australia

TERMS OF REFERENCE OF AMWAC AND THE AMWAC FEMALE MEDICAL WORKFORCE WORKING PARTY

The Australian Health Ministers' Advisory Council (AHMAC) established the Australian Medical Workforce Advisory Committee (AMWAC) to advise on national medical workforce matters, including workforce supply, distribution and future requirements.

AMWAC held its first meeting in April 1995.

AMWAC Terms of Reference

1. To provide advice to AHMAC on a range of medical workforce matters, including:
 - the structure, balance and geographic distribution of the medical workforce in Australia;
 - the present and required education and training needs as suggested by population health status and practice developments;
 - medical workforce supply and demand;
 - medical workforce financing; and
 - models for describing and predicting future medical workforce requirements.
2. To develop tools for describing and managing medical workforce supply and demand which can be used by employing and workforce controlling bodies including Governments, Learned Colleges and Tertiary Institutions.
3. To oversee the establishment and development of data collections concerned with the medical workforce and analyse and report on those data to assist workforce planning.

AMWAC Female Medical Workforce Working Party Terms of Reference

Part of AMWACs 1996-97 work plan was to prepare a report for AHMAC on female participation in the Australian medical workforce. As a first step in this process, the Australian Institute of Health and Welfare (AIHW) prepared a female medical workforce profile. This profile was based primarily on an analysis of the data obtained from the AIHW 1994 Medical Labour Force Survey. The AMWAC Female Medical Workforce Working Party was established as a sub-committee of AMWAC and was asked to provide an interim report to AMWAC on the policy implications of the trends that are evident in the female medical workforce profile prepared by the AIHW.

The terms of reference of the AMWAC Female Medical Workforce Working Party were to:

1. Examine the data provided by the AIHW, and other sources, and consider the implications of increasing female participation in the Australian medical workforce for the future supply and distribution of medical practitioners.
2. Develop strategy recommendations to AMWAC to deal with issues associated with an increasing proportion of female medical practitioners, including, if necessary, recommendations for more detailed work to be undertaken.

The Working Party was established in June 1996 and held its first meeting on 3 July 1996. It presented its first report to the AMWAC meeting of 9 September 1996. The report was then presented to the October 1996 meeting of AHMAC.

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The Working Party would like to acknowledge the assistance provided to it in preparing this report by Mr John Harding, Ms Anne Broadbent and Mr Warwick Conn (AIHW) and Mr Paul Gavel (AMWAC).

INTRODUCTION AND SUMMARY OF KEY ISSUES

Background

Women currently comprise 26% of medical practitioners in Australia. Current medical school enrolments are comprised of nearly 50% women, and 45% of Australian first degree graduates from medical schools in 1994 were women. The female medical workforce is growing at a much faster rate than the male medical workforce and it is projected that women will comprise 30% of the medical workforce by 2000 and 42% of the medical workforce by 2025.

In addition, female medical practitioners' work practices presently differ from their male counterparts in that they are more likely to be working part time; to be working in a capital city or major urban centre; and to be working as a general practitioner. Women also tend to leave the practice of medicine or practise at quite low activity levels for a period of time during their career.

Increasing female participation in the Australian medical workforce, combined with the different work characteristics of male and female practitioners, is likely to have a substantial impact on the future supply and distribution of medical practitioners in Australia. AHMAC asked AMWAC, as part of AMWACs 1996-97 work plan, to prepare a report to it on female participation in the Australian medical workforce.

As a first step in this process, the AIHW prepared a female medical workforce profile. The profile was based primarily on an analysis of the data obtained from the AIHW 1994 Medical Labour Force survey and this profile is included in this report.

To help prepare the report to AHMAC, AMWAC established a Female Medical Workforce Working Party, to provide advice to it on the policy implications of the trends that are evident in the data provided by the AIHW.

Approach of the Working Party

The Working Party undertook a worldwide literature review; contacted individuals and institutions; and combined its analysis of the AIHW profile with the results of other recent studies conducted in this area.

The report examines the available data and provides recommendations from two main standpoints:

1. the implications for the medical workforce in Australia, and the main segments within this workforce, of increasing female participation in the workforce; and
2. policy approaches that may need to be considered to ensure there is a more equitable distribution of male and female clinicians, and that female clinicians optimise their role in particular areas of the Australian medical workforce.

In some instances, insufficient data have necessitated a recommendation for further research; this is particularly the case with qualitative issues.

Australian Medical Workforce Benchmarks

In preparing the report, the Working Party also had to be aware of the general trends in the Australian medical workforce and the expected future scenarios. In this respect its principal source document was the AMWAC & AIHW report Australian Medical Workforce Benchmarks (AMWAC & AIHW 1996). This report estimates that there is a current oversupply of medical practitioners in Australia and projects that supply will not move into balance with estimated requirements until around the year 2019.

The benchmark report also highlights that within the Australian medical workforce there is a major maldistribution problem. It is estimated that there is:

- an oversupply of urban primary care practitioners (GPs and OMPs) of 4,356;
- an undersupply of rural primary care practitioners (GPs and OMPs) of 511;
- an undersupply of specialists of 1,838;
- an undersupply of hospital non specialists of 400; and
- an undersupply of locums of 200.

Main Characteristics of the Female Medical Workforce in Australia

The current profile of the female medical workforce is described in considerable detail in the AIHW profile included in this report. The main characteristics of the female workforce are summarised at the beginning of the profile which commences at page 24 in this report and so they are not reproduced here; they are, however, referred to throughout the report and as a consequence, readers may wish to familiarise themselves with that summary before reading on.

Key Issues

The increasing trend towards greater female participation in the Australian medical workforce is of no overall concern to the Working Party; indeed, it is a desirable trend on equity grounds alone, and as one aspect to ensuring that Australians have adequate access to quality medical services and choice in the selection of practitioner.

There are however a number of issues within the overall trend towards greater female participation that emerge as key issues of interest and/or concern. These key issues are:

1. The current preference of female clinicians to practise in a capital city or major urban centre. Only 17% of female GPs are located in rural or remote areas, despite the fact that 27.4% of the female population lives in rural and remote Australia (compared with 22.5% of male GPs). Similarly only 7% of female specialists are located in rural and remote areas (compared with 12.7% of male specialists). Whilst maldistribution of the medical workforce is more complex than just female participation, the current preference of female clinicians for urban practice is of concern when the overall shortage in rural clinicians and the large oversupply in urban GPs is considered alongside the knowledge that 46% of Australian first degree medical graduates are now female and this will probably reach 50% in the future. Of course, this greater preference for urban practice by female clinicians may turn around, but if it does not these factors could all combine to further exacerbate the geographic maldistribution already inherent in the workforce.
2. Despite efforts from the specialist Colleges in recent years, there remains, in the majority of specialties, a comparative absence of female practitioners and female trainees. Young

female clinicians are more likely to be training to become a GP and less likely to be a specialist in training than young male clinicians. If the current preference for general practice continues to predominate, it could be expected to contribute to a continued shortage of specialists.

3. The proportion of specialists under 40 years of age who are female are much higher than for the specialist workforce as a whole. These female specialists will on average work shorter hours and therefore contribute fewer full time equivalents (FTEs) to the workforce. On current trends, female specialists will retire, on average, at least five years earlier than male specialists. When considering the establishment of additional training positions Commonwealth/State/Territory health authorities, specialist Colleges and the AMWAC specialist working parties will need to be aware of this trend and not assume that workforce contribution will be gender neutral. Increases in the number of specialist training posts may be needed to offset the decreased lifetime workforce contribution by female specialists. Again, any gender effect is likely to be compounded in rural areas where there is an ageing male workforce and a comparative reluctance of female clinicians to practise.
4. Female hospital non specialists were predominantly resident medical officers (RMOs) and interns, rather than salaried or other career non specialists. In turn, when coupled with the expected growth in female participation, this could have implications for the future supply of hospital non specialists; again particularly in rural areas.
5. The female medical workforce has a younger age structure than the male workforce. The large majority of female clinicians (75%) are under 45 years of age. Males outnumber females in all age groups and will continue to do so until the number of female graduates exceeds the number of male graduates. As the female workforce ages, the proportion of females in each age group in the workforce will continue to rise and this could create workforce shortages if the lower average hours worked by females are not considered in matching workforce provision to patient needs.
6. The sex related differences in working hours appear to be slowly diminishing but are still significant. The average hours per week worked by full time female clinicians are very similar to that of full time male clinicians, as are the average hours worked by male and female RMOs and interns, and male and female specialists in training. There is also evidence to suggest that male practitioners are choosing to work fewer hours than in the past. The difference that occurs between male and female clinicians in total hours worked is due almost entirely to the greater proportion of female clinicians who prefer to work part time (defined as less than 40 hours per week). In 1994, 46.8% of female clinicians were working part time compared with 15.3% of males. In the subgroups of the workforce, 65.5% of female GPs were working part time, 43.7% of female specialists, 20.7% of female hospital non specialists, and 10.7% of female specialists in training.
7. For females, the proportion working part time was highest in the 30 and early 40 year age groups, coinciding with the time when a large number of female clinicians have extra family commitments. Generally, however, women who leave the workforce for a period of time return to the workforce. This highlights the need to ensure that there are satisfactory arrangements in the workplace to allow women, and possibly increasingly

men, to leave the workforce for a period of time and to resume their careers at a later date; and if the return to work includes needing to manage a family and a career, that suitable structures are in place to enable this, such as retraining opportunities to enhance skills and access to child care.

8. There is a revealed preference from women patients for female clinicians which is particularly prominent in care for reproductive health. It is a trend that can be expected to continue, and as a result, a concern has to be expressed that those female clinicians practising may become overwhelmed by the demand for their services. This could be a particular problem in rural areas, where there is a shortage of female clinicians and sometimes a shortage of women's health services.

There is also the issue of access and equity for female patients. Female doctors can and do close off their books to new patients. The access and equity principle says that if demand for female clinicians in particular specialties by female patients exceeds supply, then effort should be made to increase the numbers of female specialists in training in those disciplines, including removing barriers, historical or otherwise, unless women clinicians themselves do not wish to be trained in those specialties because of the nature of the work.

9. Population census data indicates withdrawals from the workforce by male and female doctors aged in their twenties. There could be many reasons for this, such as temporary absence from the workplace for family reasons. However, these figures are especially significant if people are completing a medical degree and then choosing not to practise medicine, particularly given the cost associated with training a medical graduate. The reasons behind what seems to be a comparatively high level of non participation appear to need further study.
10. Projections and other analyses are needed on the impact of increasing female participation within various segments of the medical workforce. At present no adjustments are being made to training numbers because of the lower average lifetime FTE contribution of female medical practitioners. To facilitate these analyses, age by sex data have to be collected on new entrants to each of these segments of the workforce, and on participation rates by women in each workforce age group. The AIHW, with the assistance of AMWAC, should take action to collect and analyse the data required.
11. Women should be able to achieve more equitable representation and greater visibility across the medical profession. Current demographic projections predict that if professional development and participation by women are not achieved, then the workforce as a whole will not fulfil the needs of society for health care.
12. The effect of any changes in health structures and the regulatory environment on the medical workforce (for example increases in higher education fees and access to Medicare provider numbers) will need to be monitored to ensure there is no adverse impact on female participation in the medical workforce.

It should be noted that the issues raised in this paper, particularly in relation to the need for increasing flexibility in training and employment, are relevant not only to the female medical

workforce but to all employees, males and females, in all types of work.

Options for Government and the Medical Profession

As with all issues of public policy, the options for government and the medical profession range from doing nothing at present to a detailed policy response aimed at reversing the potentially negative trends highlighted in the report.

The maldistribution within the female medical workforce is of greatest concern, particularly as this seems to again impact most on rural areas in a geographical sense, and most on the specialist and the hospital non specialist workforces in a structural sense; that is, all the areas where the current shortfalls are greatest.

The Working Party was of the view that policy responses to maldistribution need to be considered within the broader context of the medical workforce as a whole, rather than just the female aspects of the problem, and as such the AMWAC Maldistribution Working Party was considered the more appropriate forum within which decisions and recommendations on alleviating maldistribution should be made.

Health authorities, the specialist Colleges and the AMWAC specialist working parties need to be aware of the current different average lifetime workforce participation pattern of female clinicians when considering future workforce needs and, most importantly, the establishment of any additional training positions. To date, this point has not been highlighted in the AMWAC specialist working parties, probably because the specialties studied so far have mostly been surgical. However, it is an issue that must not be overlooked.

It appears to the Working Party that the majority of the other issues of concern require the monitoring of current trends and/or further research, rather than a policy response at this time. Further research is particularly necessary to obtain an understanding of why the workforce characteristics and trends described in the AIHW profile exist. The recommendations of the report reflect this view. It should be possible to complete the bulk of any additional work in a relatively short period of time.

RECOMMENDATIONS

The Working Party recommends that:

1. Any policy response to the maldistribution issues highlighted in this report should be considered within the broader context of the medical workforce as a whole, and the appropriate forum for this is the AMWAC Maldistribution Working Party.
2. Health departments, specialist Colleges and the AMWAC specialist working parties take account of the current different average lifetime workforce participation pattern of female clinicians when considering projections of workforce requirements.
3. AMWAC and the Commonwealth Department of Health and Family Services (DHFS) co-ordinate a study of clinicians to provide more detailed research on the qualitative issues associated with female participation in the medical workforce. This study should examine the attitudes of male and female clinicians, employed or not employed in medicine, and cover all major age categories, rural and urban clinicians and all the main segments of the medical workforce.
4. On behalf of AMWAC, the Committee of the Presidents of Medical Colleges (CPMC) should undertake a major review of College arrangements to facilitate female specialist training and practise, including whether new approaches to training will be required in the future, whether the current arrangements for part time/flexible training and family leave during training are sufficient benefit and encouragement to women, and why female clinicians prefer particular specialties and not others. CPMC should report to AMWAC within six to nine months. AMWAC should provide CPMC with all necessary support. The results of the review should be used by AMWAC and CPMC to develop strategies that may encourage greater female participation in specialist practice.
5. AMWAC coordinate a historical/cohort study of medical practitioners from graduation throughout their medical careers to identify factors which determine career choice and examine concerns about non participation in the workforce.
6. AMWAC to report progress and /or the results of the additional studies to the October 1997 meeting of AHMAC.

SOME IMPLICATIONS OF INCREASED FEMALE PARTICIPATION IN THE MEDICAL WORKFORCE

Geographic Distribution

On the whole, rural areas do not attract female clinicians. Female clinicians are concentrated in capital cities and other major urban areas to a greater extent than their male counterparts and at a much higher rate than would be expected based on population distribution. In 1994, 72.5% of the female population was located in capital cities and other major urban areas, but 87.9% of female clinicians were located in the same areas. Although 27.4% of the female population was located in rural and remote areas, only 12% of female clinicians were resident in these locations. In comparison, 84.4% of male clinicians were located in capital cities and other major urban areas (71.5% of the male population) and 15.8% were located in rural and remote areas (28.4% of the male population).

Similarly, 83% of female primary care practitioners and 93% of female specialists were working in capital cities and other major urban areas. In comparison, 77.5% of male primary care practitioners and 87.3% of male specialists were working in these areas.

Young females and males both had very high proportions working in capital cities and other major urban areas, associated with undertaking internships and other post university training. However, the pattern for older males and females is quite different. Female clinicians over 35 years generally have a higher proportion working in urban areas than their male counterparts. This distribution may have implications for the future distribution of the workforce, given the expected increase in overall female participation.

Considerable resources are currently being devoted to strategies to attract doctors to rural and remote areas and then retain them. To be effective, it would seem that these strategies must reflect increasing female participation in the medical workforce and the comparative reluctance of female clinicians to practise outside urban areas.

The difficulties in attracting and retaining a suitable range of health personnel to rural communities are well documented and are summarised in the report prepared by the AMWAC Rural and Remote Areas Medical Workforce Working Party (AMWAC 1996). The report details 22 key disincentives to rural and remote medical practice. These range from the image of the rural lifestyle and rural medical practice, through problems associated with postgraduate and undergraduate training, to a range of difficulties associated with actual rural medical practice, including issues surrounding the spouse and/or family. Difficulties identified as affecting rural practice include longer hours, lack of access to back up and specialist services, the need for a greater level of procedural skills, and a lack of suitable and available locum relief for continuing medical education (CME) and recreation leave.

However, it would appear that little research has been conducted in Australia to investigate the specific needs of female clinicians in rural and remote areas, as distinct from the needs of all clinicians, both male and female. Helen Tolhurst (1996) is undertaking a pilot project which aims to investigate the educational and support needs of female rural GPs and to develop strategies to address these needs in order to increase the recruitment and retention of female doctors in rural areas. As part of her work, Tolhurst conducted six focus groups of female rural GPs. These focus groups consistently identified problems relating to females working in rural areas, including:

concerns about personal safety; lack of a peer group; lack of emotional support; and lack of family support.

Rural GPs in the Tolhurst focus groups also recounted difficulty accessing health services for themselves such as gynaecological services and obstetric services; especially when the number of health professionals working in rural areas is low or limited and the female rural GP is working closely with the other health professionals. This has resulted in some female clinicians travelling long distances to obtain routine services for themselves such as pap smears.

The Australian Bureau of Statistics (ABS) 1991 population census data suggest that part of the reason for lower female participation in rural and remote areas is that women's careers may be restricted by geographic mobility as they tend to live where their partners work. Women who are tied by their husbands' jobs yet wish to pursue their careers are in a comparatively weak negotiating position, and they will often take up positions that are convenient but which may lack professional satisfaction.

One area that can be identified as being of immediate concern is the number of female medical school students of rural origin. All available evidence suggests that there is a correlation between medical graduates from rural areas returning to rural practice. This is the rationale behind much of the Rural Undergraduate Steering Committee's work and its work on affirmative entry arrangements to medical schools for students of rural origin and greater exposure to rural medicine in the medical schools' curriculum.

Yet, despite the arrangements that have been put in place to ensure there is a greater proportion of students of rural origin in medical schools, there remains a considerable maldistribution in the origin of medical students, with a heavy bias towards students from capital cities and other major urban areas. Over recent years there has only been a slight increase in the proportion of students from rural and remote areas, rising from 7.5% of students in 1989 to 7.9% of students in 1995. Significantly, the proportion of female students from rural areas was lower in 1995 than it was in 1989 (8.7% and 8.4% respectively), despite the bulk of the increase in total medical student numbers being female. This would suggest that, from the standpoint of this indicator, there may be little turnaround in the number of female rural practitioners in the short term.

It would appear that any policy response on maldistribution must consider issues surrounding the needs of female clinicians in rural areas as well as what factors might be inhibiting a greater movement of female clinicians to rural and remote areas.

Overall it would seem that there needs to be some more research to determine reasons why female clinicians do, and do not, take up rural practice and, from this work, consideration given to some specifically female orientated policy response. In this respect some of the first clues are provided by the Tolhurst work and further evidence should come out of the Centre for Rural Health's National Survey of Rural General Practitioners which will be conducted later this year.

General Practice

General practice is the preferred segment of the workforce for the majority of female clinicians. Female clinicians represent 30.9% of the primary care workforce, which is a higher level of participation than across the medical workforce as a whole. This level of participation is fairly similar across each State and slightly higher in the Territories.

In 1994, 54.4% of female clinicians were working as primary care practitioners; 83% of these clinicians were working in a capital city or major urban centre and 65.5% of female primary care practitioners were working part time. For comparison, 41.9% of male clinicians were working in primary care, 77.5% of them in an urban location and 23.3% of them working part time.

The strong preference of female clinicians for general practice suggests, as Susan Rogers (DHFS 1995) has indicated previously, that general practice offers female clinicians the most accommodating environment. Presumably this is because women can combine their career with the raising of a family. In order to attract female clinicians into other segments of the medical workforce, these areas may have to work to become more flexible and more responsive to women's needs, offering some, or all, of the attractions of general practice.

There are other aspects to the preference by female clinicians for general practice which relate to urban general practice being the segment of the workforce that is oversupplied. Two concerns need to be expressed. First, if future female clinicians continue to exhibit the current preference for urban general practice then the oversupply problem could grow, although no definitive conclusion would be possible without more specific analysis and projection modelling.

Similarly, any attempts to reduce the urban oversupply or make urban general practice less attractive to future clinicians could impact adversely on female participation in the workforce; although again with no specific proposals to examine there is no definitive conclusion available on this possibility.

Specialist Practice

In 1994, only 14% of specialists were female. The level of participation was similar across each State/Territory. The female share varied considerably across the main specialist groups, with only 3.1% of surgeons and 13% of internal medicine specialists being female compared with 22.3% of pathology specialists.

Individual specialties with comparatively high female participation included dermatology (29.9%), psychiatry (25.1%), geriatric medicine (19.6%), rheumatology (18.9%), paediatric medicine (18.6%), public health medicine (18.5%), infectious diseases (18.4%) and anaesthesia (18.3%). Those with the lowest levels of participation were vascular surgery, urology, orthopaedic surgery, neurosurgery and general surgery.

Perhaps the more important indicator, however, is the proportion of female specialist trainees. Female specialists in training were well represented in the internal medicine and other specialties, but poorly represented in the surgery specialties, compared with males. Females made up 36.3% of internal medicine trainees, 30.3% of pathology trainees, 37.5% of dermatology trainees, 40.2% of psychiatry trainees, 33.3% of public health medicine trainees, 33.3% of medical administration trainees and 33% of obstetric and gynaecology trainees, but only 8.9% of trainees in surgery. The higher levels of female trainees would indicate that there will be a gradual trend towards greater female participation.

Specialist practice is comparatively more demanding of the clinicians' time, especially in the surgical specialties. In 1994, 56.3% of female specialists worked full time, compared with only 34.5% of female GPs; 80.4% of female surgeons worked full time, which probably indicates

immediately one of the clear reasons why female clinicians are not well represented in the surgical specialties.

Specialist training programs already incorporate part time/flexible schedules to provide opportunities for a career in a specialty without the need to sacrifice the desire of women to have children. However, males or females that choose to train part time may be disadvantaged when it comes to career advancement. These problems not only disadvantage women, but men also continue to be excluded from more active participation in family life or, if they choose to work less, may face career difficulties.

It may also be difficult for trainees to find part time employment which would meet with College requirements, in spite of the efforts which have already been made by the Colleges to make provision for them. Public hospitals also have difficulty funding part time employment in times of financial stringency. Even if trainees do find part time employment, they continue to face considerable problems. They may have to forego training opportunities which may impinge excessively on a part time job. Some will work part time and undertake training in their own time; they are then effectively working almost full time on part time pay. Ultimately, it may be useful to shift the focus of the training programs to competencies and skills rather than time spent in training.

The proportion of specialists under 40 years of age who are female is much higher than for the specialist workforce as a whole. These female specialists will, on average, work shorter hours and therefore contribute fewer FTEs to the workforce. On current trends female specialists will retire, on average, at least five years earlier than male specialists. The AIHW analyses estimated that the lifetime contribution in hours worked by a female specialist is around 75% of a male specialist across the specialties. As a result, shortages in specialties could be exacerbated in the future as the specialist Colleges increase the proportion of female trainees.

When considering the establishment of training positions the Commonwealth/State/Territory health authorities, specialist Colleges and the AMWAC specialist working parties will need to be aware of this trend and not assume that workforce contribution will be gender neutral. Increases in the number of specialist training posts may be needed to offset the decreased lifetime workforce contribution by female specialists. Again, any gender effect is likely to be compounded in rural areas where there is an ageing male workforce and a comparative reluctance of female clinicians to practise.

It is clear that the Colleges' efforts to increase female participation will need to continue if the imbalances in supply of male and female specialists are to be redressed to any significant extent. In doing so, the Colleges should not allow any pressure to alleviate the current shortfall in the supply of specialists to dominate to the point of excluding any efforts to amend training arrangements which would facilitate a greater proportion of female trainees.

Another concern of the Working Party is that until recent years medicine has remained a male-dominated field. Men have traditionally defined the norm in the academic curriculum and there is a perception that women are poorly represented on the decision making bodies. Thus, professionally active women are less likely to be involved in policy making for the profession or even to have their views and needs expressed, heard and acted upon.

Both male and female specialists in training should have adequate exposure to female role models, and access to mentors who can relate to their particular needs and difficulties. During the past decade, the number of women pursuing academic careers has increased. However, women are still under represented in senior leadership positions. Role models are important in encouraging young medical students to pursue a surgical or academic career, and, therefore, females should be better represented as teachers at senior levels. An increase in the number of women appointed to prominent educational positions to act as role models will also help men to become accustomed to dealing with women outside stereotypic roles. The Working Party agreed that mentoring schemes play an important role in the support of individuals within the profession and encourage their establishment by all responsible bodies.

The Working Party believes that the surgical environment should gradually become more supportive for women trainees. A greater number of role models in positions of influence in the surgical world will make surgery a more inviting environment for aspiring female surgeons.

The Working Party does not recommend, at this time, the introduction of quotas to increase the number of women in the specialist training programs. The Working Party agreed that the present merit based system of selection to training programs should be continued.

Significantly, many of the factors cited as discouraging to women in taking up specialist training are also now increasingly aired by their male counterparts, notably, long hours and length of training.

Working Hours

In general, female clinicians work lower average hours per week in total and in direct patient care than males. In 1994, female clinicians worked an average of 39 hours per week compared with 51.4 hours for male clinicians. However, this is not a result of the fact that all female clinicians work fewer hours than their male counterparts. Rather it is a result of the fact that a considerably larger number of females work part time. For the purpose of this paper, part time is defined as less than 40 hours but it should be noted that hours of work vary considerably above and below the 40 hour cut off point. The average total hours worked per week by age group by female clinicians ranged between 23.3 hours (70 years and over) and 55.4 hours (under 25 years). In 1994, 46.8% of female clinicians worked part time compared with only 15.3% of male clinicians; 65.5% of female primary care practitioners and 43.7% of female specialists worked part time. The comparative figures for males were 18.1% of primary care practitioners and 14.5% of specialists.

Analysis of the female medical workforce hours of work, with future contribution expressed as person years of service, suggests that the female GP lifetime contribution is 63% of the male contribution.

In terms of the average hours worked per week by full time clinicians, there are very little differences between female and male clinicians. Similarly, the hours worked by female RMOs or interns and specialists in training were very similar.

The issue surrounding working hours of greatest concern to the Working Party is the perception that part time work is not approved of, or is not valued. For example, it is suggested that part time work means less involvement in research which affects women's rate of promotion in

salaried positions. Focus groups of GPs have identified other problems associated with part time work: guilt about working part time in areas of doctor shortage; the perception that colleagues regard part time work as inferior; and pressure to work full time when they have family commitments and would prefer to work part time (Tolhurst 1996). Loss of skills, quality of care, quality of continuing education and maintenance of experience also become issues for clinicians who choose to work part time. Concern was also expressed by the Working Party that long lengths of time away from the workforce can also decrease clinicians' confidence to return to work and this needs to be examined by the Colleges.

Retirement Patterns

Females in the workforce tend to retire at an earlier age than males; on average, at least five years earlier than males. As the female workforce ages, the proportion of females in each age group in the workforce will continue to rise. The early female retirement age must be taken into account in projecting workforce requirements.

Work Practices

Women are major users of health care services. In 1995, 12.5 Medicare services were processed per female Australian resident compared with 8.4 services per male Australian resident (Health Insurance Commission 1995).

Recent analysis by Britt et al (1996) indicates that female primary care practitioners have a greater proportion of encounters with female patients than do male primary care practitioners. It also indicated that the type of problems managed by female and male primary care practitioners may be different, regardless of the mix of patient characteristics.

Female primary care practitioners have fewer patient encounters per week, longer consultations (particularly with female patients) and deal with more clinical problems per encounter than their male counterparts.

Britt et al concluded that male and female GPs manage very different types of morbidity, and that while some differences are due to their patient mix and to patient selectivity, others are inherent in the gender of the GP. It suggests that female GPs and male GPs could become semi-specialised in the future.

The work of Tolhurst indicates that female GPs in rural areas, particularly lone female practitioners, can feel pressured to provide women's health services to the exclusion of other services and to provide gynaecological, sexual assault counselling, and other counselling services even though they were not particularly interested or skilled in these areas. This may be a greater problem for female rural GPs than female urban GPs because of the small number of female GPs in rural areas and because there can be a lack of other health professionals to provide these services in rural areas (Tolhurst 1996). In the specialty areas, preference for a female gynaecologist is stated more often than a preference for a female clinician in any other specialty (Waller 1988).

There is a perception among Working Party members that clinician gender has an effect through the clinician-patient relationship and its outcomes; patients perceive male and female doctors differently; and women patients believe women doctors to have the good qualities of both male and female clinicians, such as assertiveness and initiative, but also tenderness and nurturing.

The Working Party believes that, in the future, if the enlarging pool of women doctors is tapped by patients seeking health care providers of their own gender, several factors could combine to place an increasing workload on female clinicians. In particular, the fact that women use more health care services; that the ageing female population is increasing at a higher rate than the ageing male population; and that women, on the whole, are choosing to see female practitioners. These factors could place a particular burden on female clinicians in the rural areas and on female specialists.

There is also an issue of access and equity for female patients. Female doctors can and do close off their books to new patients. The access and equity principle says that if demand for female clinicians in particular specialties by female patients exceeds supply, then effort should be made to increase the numbers of female specialists in training in those disciplines, including removing barriers, historical or otherwise, unless women doctors themselves do not wish to be trained in those specialties because of the nature of the work, such as would seem to be the case with most of the surgery disciplines.

Conversely, the validity of the feminine influence in medicine was questioned by the Working Party. The so-called feminine qualities: nurturance, concern for other persons, sensitivity, and the like are found in both sexes. If male doctors are, on average, more detached and impersonal, as is popularly believed, it is equally true that a number of women doctors outdistance men on those dimensions. If female physicians are on average more nurturant, quite a few male physicians are more caring than the majority of women (Eisenberg 1989).

The Working Party does believe, however, that the increasing number of females in the medical profession will bring about transformations in professional attitudes and styles of medical practice. In particular, women will bring into medicine a greater emphasis on the importance of the clinician's family life.

Career Choices

When looking at female participation in a workforce it is sometimes characteristic to suggest that targets for workforce participation rates and training rates be established to provide a framework within which monitoring and policy development could be maintained. However, the Working Party believes that with nearly 50% of medical students being female and the female workforce being comparatively younger, female representation in the workforce will increase best through natural growth, without the need for any specific target setting. Any problems that may arise in the future will occur in specific segments of the workforce and so any policy responses should aim to help female clinicians overcome any barriers to career choices within these segments.

At present, females clinicians are far more likely to be working as primary care practitioners and hospital non specialists (mainly RMOs and interns), and far less likely to be working as a specialist than their male counterparts.

Young female clinicians were more likely to be training to become primary care practitioners (through RACGP traineeships) and less likely to be specialists in training than young male clinicians. While 25.2% of female clinicians aged under 35 were RACGP trainees, and 24.2% were specialists in training, the proportions for males were 13.8% and 37.9% respectively.

It would seem that the current preference for general practice among female clinicians can be expected to continue, especially in the medium term.

Female hospital non specialists were predominantly RMOs and interns, rather than salaried or other career non specialists. If this continues to be the case, there could be implications for the future supply of salaried hospital non specialists. This could be a particular problem for rural and remote areas where 67.5% of female hospital non specialists were RMOs and interns, compared with 36.7% of males.

Although the proportion of women in medicine has risen, there is a perception that women continue to be clustered in the junior ranks of the profession.

A 1988 survey of medical graduates of the University of Melbourne found that women were less often involved in areas outside clinical practice, such as teaching and lecturing, committees of medical organisations, medical administration, research and publication (Dennerstein et al 1989). The survey also found that female doctors earned significantly less than did male doctors and were more likely to be employees or locums, and to work in sessional employment or community health centres. The study highlighted a concern that women in traditionally masculine departments found themselves not fully incorporated into the social and work life of these departments, thereby compounding any general feelings of isolation and alienation. The paucity of women in the upper echelons of the medical profession represents a career underachievement of a population who, at entry to medical school, undoubtedly were of a similar calibre to that of their male colleagues (Lefford 1987).

Quadrio (1991), in Australian and overseas studies, found that women in medicine and science have more conservative attitudes than those in the arts and the humanities; are less likely to perceive discrimination; and when they do perceive it, such as lack of success or lack of promotion, they are more prone to global attrition and to perceive their problems as due to personal inadequacy rather than to perceive any disadvantaged position. Male clinicians hold more conservative views than female clinicians on issues of female professional participation and are less sensitive to the problems of female clinicians.

It has been suggested that an effective remedy requires affirmative action; for example, medical schools should increase the number of women in senior academic ranks and should do so explicitly. The lack of women in academe and other positions of high prestige is likely to continue in spite of the changing career aspirations of women unless considerable restructuring and flexibility are introduced into career training and work patterns (Dennerstein et al 1989).

Family Commitments

Data from the ABS survey of labour force status and family characteristics indicate that there has been a considerable increase in the labour force participation of females with dependent children. Labour force participation rates for mothers with a child aged 0 to 4 years increased from 33.3% in 1984 to 46.1% in 1994. For those with a child aged 5 to 9 years the labour force participation rate rose from 54.1% to 64.9%, and for those with a child aged 10 to 14 years it rose from 56.5% to 70.5% over the same period (Moyle et al 1995).

The New South Wales Women's Employment and Training Taskforce (DIRETFE 1995), found that pregnancy was often directly connected with denial of employment, deterioration in employment conditions, harassment in the workplace, loss of training and career advancement opportunities, and enforced early departure on maternity leave.

Women continue to make a considerably larger investment in child rearing than men do. This disparity may change, as evidenced in the increasing number of men taking paternity leave, but there is little likelihood that it will change very much in the near future.

The majority of females in medicine do choose to have children and grapple with the decision of when to start a family. Female doctors have to decide between the biological advantages of having children early and the strong career pressures encouraging women to delay childbearing. The female clinician therefore has to identify her personal and professional priorities. Sometimes this may mean that she may not achieve her professional potential or may choose her profession over raising a family.

There can also be pressure for women to return to work as soon as possible after delivering a child for various reasons: in order to maintain patient workload and consistency, to meet financial needs, or because they are in a salaried position or group practice and wish to avoid placing strain on their colleagues. If a female clinician chooses to breastfeed, further demands can be placed on her time.

Working Party members perceive that, in the clinical institution, a negative value is attached to family roles as they may conflict with the immediate priorities of the institution. The obstetric experience of medical women and the consequent paediatric care is anecdotally of enormous value in the practice of medicine. Not only does it provide the ability to empathise, it also provides a wealth of knowledge which cannot be gained from a textbook. The importance of early childhood and infant development is stressed in medical training, but when students or doctors undertake part time work to spend time with their own infants they can be perceived by their peers as 'slacking'.

All females who have chosen to partner and/or parent find they have conflicts between their multiple roles of doctor, wife and mother. Work detracts from personal life or personal commitments detract from work; attempts to meet all demands result in severe tiredness (Tolhurst 1996).

Finding adequate child care when returning to work presents another challenge to female clinicians and the various options have advantages and disadvantages. A responsible care-giver who comes into the home provides the greatest flexibility, but appropriate care-givers are often hard to find and they may be expensive. Other options, including day-care centres, provide responsible care but lack flexibility, because they have defined hours that cannot be extended in an emergency. Furthermore, day-care centres cannot accommodate children when they become ill. For older children, finding suitable after school care can also be a problem. There can also be difficulties associated with finding flexible child care especially for after hours and on call work.

There is also a requirement for flexibility in annual leave arrangements to allow for time off during school holidays, particularly for those clinicians who are unable to find adequate child care in school holidays.

Current work arrangements for female doctors are often too inflexible to allow them to meet their family responsibilities. Employment practices which enhance the ability of men and women with family responsibilities to participate fully in the labour force are an important contribution to increased equality of opportunity.

Job share arrangements may be considered as an option but this requires two clinicians in the same area having complementary and unchanging needs. The New South Wales branch of the Australian Medical Association tried to set up a job share register which proved unsuccessful due to a combination of factors, including the need for two people to work in the same medical area and the same geographic area.

With the increasing number of women entering medicine, there are more clinicians who will have the dual responsibility of motherhood and career and, as a result, employment and workplace arrangements will have to cater for this trend. Parental leave and child care must become part of the standard package of employment conditions available to women and men from the time they enter medical school, through their residency training and during employment in any large medical group or institution. Parental leave policies should address length of leave, job security, and coverage of teaching and patient care responsibilities. Restructuring medical careers to recognise the legitimate needs of the clinicians' families will be to the advantage of all. Men and women should be offered a career compatible with both a rewarding family life and professional success.

Retaining trained practitioners through having a workplace that can also sustain the fulfilling of family roles is preferable to clinicians abandoning their training or taking up options by default because there is nothing more constructive available.

Continuing Medical Education

Difficulty with access to CME is commonly identified as a problem in rural and remote areas. However, it was also identified for female clinicians in any area because of family commitments and the difficulty of arranging child care to attend CME courses.

There are also difficulties for medical couples who wish to attend conferences together as child care is often provided for the CME social program but not for the educational program.

There can also be problems with course content and the availability of courses. In particular, female clinicians appear to be identifying the need for CME in particular subject areas and finding that this is not always available. For example, Tolhurst found that rural female GPs have identified a need for continuing education in women's health and sexual assault which is not always readily accessible (Tolhurst 1996).

Other Leave From the Workforce

Not all graduates stay in the medical practitioner workforce, due to other commitments such as family, travel, job alternatives and so on. AIHW analysis of Census data indicates that in 1991, 27.1% of females and 20.2% of males that were qualified in medicine were not practising medicine. This varied considerably with age, with the under 30 years age group of males and females having almost the same non-participation rate of roughly 16%. For females this was a substantial change from 1981 when the proportion of females aged less than 30 years who were

qualified in medicine and not working in medicine was 29.5%.

The Working Party believes that life experiences, including overseas voluntary work and maternity leave, should be considered as broadening a clinician's experience which is then available to patients and should not be considered of no value to the workforce. For example, the experience of raising young children can be invaluable to doctors caring for other mothers and children. Research is needed to determine other reasons for non participation by female doctors in the medical workforce.

The Single Female Clinician

In 1991, single female GPs were more likely to be working full time than their married counterparts - 67.9% of single female GPs compared with 37.6% of married female GPs. The same trend is observable for single female specialists.

Quadrio (1991) discusses the special problems of the single professional woman and how single women in all professions frequently experience loneliness and isolation. Those in their thirties consider themselves different from other women of the same age, including women in their own profession, because of the absence of marriage and children and the lack of support of a family. Overall, women are less competitive than men, which emphasises the dilemma of female professionals who may forego marriage and children to focus upon their careers, only to find themselves misplaced by more aggressive and competitive male colleagues.

Country of Origin/Culture

Of Australian permanent resident medical students, 40% are not born in Australia. It has been suggested that female students from particular ethnic backgrounds marry younger and withdraw from the workforce permanently on marriage; have a strong preference for working in capital cities where they have family and cultural ties; and will have career preferences and career goals different from Australian born students. Further research is required to determine the effects of country of origin or culture on career choice.

CONCLUSIONS

As indicated in the Introduction, the increasing female participation in the medical workforce is of no overall concern to the Working Party. What is of concern to the Working Party are the implications for some of the segments of the medical workforce.

The maldistribution within the current female medical workforce is a key concern, particularly as this impacts where the workforce shortages are greatest, that is, in rural areas and in specialist practice, and where the oversupply of clinicians is greatest, that is, urban general practice. The maldistribution issues need to be considered within the broader context of the medical workforce as a whole, however, rather than just the female aspects of the problem.

Ongoing projections and other analyses are needed of the impact of increasing female participation within the various segments of the medical workforce. At present, no adjustments are being made to training numbers because of the lower average lifetime FTE contribution of female medical practitioners. To facilitate these analyses, age by sex data have to be collected on new entrants to each of these segments of the workforce, and on participation rates by women in each workforce age group. The AIHW, with the assistance of AMWAC, should take action to collect and analyse the data required.

Presently, in medicine there are female clinicians who have made the choice to share their male colleagues' work pattern, and there are female clinicians who have made the choice not to match the male work pattern, and those who have chosen not to match this work pattern are in the majority. There is nothing inherently wrong with making this choice. However, the issue that still needs examination is whether those female clinicians who have opted for the comparatively less demanding career have done so based on the desire for a better lifestyle and not for reasons associated with bad experiences in medical practice. Examples of potentially negative experiences are: finding the barriers to specialist practice too great; finding the demands of full time hospital work incompatible with family commitments; or, when a career is combined with a family, finding the necessary support is not available, either in terms of infrastructure like child care, or from colleagues.

If bad experiences are the dominating reasons behind the preference of female clinicians for general practice, an urban location and part time work, then the causes of those experiences have to be changed or these workforce trends will just continue and presumably grow as more women enter the medical workforce.

The Working Party believes that family responsibilities should not be a barrier to a career. Yet many of the issues highlighted in the report revolve around having to balance a family and a career, including doing this while undertaking postgraduate training, and the absence of satisfactory support to enable this to occur easily.

Another major concern of the Working Party is that attitudes within the workforce may not be changing rapidly enough to match the growth in female participation and it should be viewed as an important role of AMWAC to examine where the attitudes of the workforce are changing, or have changed, and highlight these.

The age divide within the workforce is considered significant and any additional research needs

to be aware of the need to study the differences in issues and attitudes among the different age groups. Similarly, the attitudes of male clinicians, especially younger male clinicians, are likely to be changing and different from those of older male clinicians. Indeed, many of the key issues that are cited as impacting on women can just as easily be a problem for male clinicians, such as long hours and needing to balance a career with family responsibilities.

Whilst the Working Party is cognisant of the improvements the specialist Colleges have introduced to accommodate female specialists in training such as the availability of part time/flexible training and deferred training, the Working Party recommends that CPMC should undertake a major study of female participation in the specialties, with the aim of examining whether additional strategies need to be considered. Mature age entry into specialist training, part time work accreditation, and shorter training should be considered. In both its form and its content, postgraduate education must do more to promote the development of women. There is scope for more provision for the special needs of women in training, particularly to shift the focus of the training programs to competencies and skills rather than time spent in training.

Overall, it appears to the Working Party that there is sufficient quantitative evidence of trends emerging from increased female participation; however, what is still lacking is qualitative information that is broad ranging enough to enable effective policy responses to some of the potential problems to be considered. Hence the recommendation for AMWAC to co-ordinate a major qualitative study to examine the factors that affect and shape female participation in the Australian medical workforce and to assess the magnitude of these factors.

The Working Party recognises that any changes to current employment and workplace arrangements aimed at facilitating greater female participation could have substantial financial implications for government. It is outside the brief of the Working Party to attempt to quantify any potential financial implications.

Full justice for women requires that they have an equal opportunity for professional success after acceptance to medical school. Women should be able to achieve more equitable representation and greater visibility across the medical profession. Current demographic projections predict that if professional development and participation by women are not achieved, the workforce as a whole will not fulfil the needs of a well resourced health service.

It is hoped that a changing profession, particularly in the younger age groups, more broadly representative of Australian society will be in a better position to meet Australia's health needs in the next century.

APPENDIX A - INTERNATIONAL COMPARISONS

Women now represent just over 50% of entrants to United Kingdom (UK) medical schools and it is expected that women will comprise 50% of the practising UK workforce by the year 2020.

For complex reasons, male and female doctors tend to express different patterns of career preference and to make different career choices in terms of both fields of medicine entered and posts held. Since 1948, women have been consistently more likely to enter general practice than their male counterparts (Elston and Lee 1996). In UK surveys of doctors= early career preferences since the 1970s, female medical students and newly qualified women tend to give general practice as their first preference compared with men and are more likely to opt for those fields which are widely seen as the most compatible with family and domestic commitments and more likely to avoid those with reputations for inflexible and demanding hours during training, that is surgery.

A 1992 survey was undertaken of female students of the Oxford University Medical School (Clarke 1992). The survey inquired whether they had considered a career in surgery or one of the specialties, and, if so, what positive or negative influences had been instrumental in their decision. A surgical career had been considered by 70%, 17% of students felt that they had received positive encouragement from medical staff to specialise in surgery, but the remainder felt that they had been actively discouraged. There was uniform agreement that structured career advice, realistic part time training schemes, and more role models would be welcomed.

Maran et al (1993) also found that all female house officers that they surveyed perceived discrimination in specialties they might enter but it was understood to be a deeply embedded problem of the medical profession as a whole. The discrimination that seemed to exist in most specialties was very much covert. It included women not being taken seriously, belief that women would not progress as far in their career, women not being seen as equal to their colleagues and subtle negative views on marriage. Some of the respondents quoted sexist questions that were asked of them at interview: 'Are you likely to get married?', and 'When you have children how will you cope with being a surgeon?' Jibes and humiliating comments aimed at women served merely to add to the pressure of proving themselves capable and demonstrated the perfunctory attitudes of many of the male staff. A few women surgeons felt that discrimination was a problem solely for those women who allowed themselves to be discriminated against.

In a 1992 study of female surgeons in Scotland, Maran et al found that anticipated hours of work had influenced career choices in 29.8% of those surveyed. Four out of ten house officers remarked that expected work hours, including on-call commitments, were important considerations in choosing a specialty.

Elston and Lee (1996) found that there was a perceived shortfall in part time opportunities, especially in hospital medicine. Even if available, Allen (1994) found widespread concern among young doctors that part time hospital training was not regarded seriously by seniors in some specialties.

Allen=s (1988, 1994) surveys identified strong support among doctors of both sexes for more opportunities for part time training and mainstream career posts. Equal difficulty was reported finding posts in hospital medicine and general practice, although more posts were sought and found in the latter (Bolton-Maggs et al 1988). Although job sharing has been specifically promoted within medicine in the UK and job share registers have been established, it is felt that there are too many obstacles to job sharing, particularly in specialist training, and there is some opposition to promotion of the concept as being unrealistic (for example British Medical Journal 29 June 1991, 302, p 1609).

In purely quantitative terms, the average contribution of women doctors over a working life and at particular points in time may be less than men and this could lead to fewer FTE doctors available in the UK (Elston and Lee 1996).

A national UK survey found women consultants less likely to have children than men although women consultants were, on average, younger (Tait & Platt 1995). Women doctors who have children report difficulties in finding child care (Baker, Williams and Petchey 1995). Most of them, and some of their male colleagues, consider more assistance should be provided (Allen 1988, 1994). All doctors face special problems with child care because of their long hours or on call commitments. Elston and Lee (1996) concluded that assistance with child care might make differences at the margin and reduce stress but is unlikely in itself to lead to large numbers of mothers to enter hard - pressed specialties, even on a part time basis. Moreover, the emphasis in the literature on children and childcare as 'constraints' on careers risks overlooking the extent to which women may positively prefer a limited commitment when their children are young.

It has been estimated that there are more adult women below retirement age out of the labour market because they are caring for a dependent adult than because of caring for dependent children. Increased dependency among elderly parents may have a greater impact on retirement rates and mobility patterns among older doctors of both sexes in the future but may not affect male and female doctors in the same ways (Brannen et al 1994; Arber & Ginn 1991). Allen (1988) found 4% of respondents reported care of a relative other than a child had been a constraint on their careers.

Relman (1989) suggests that medicine in the United States of America (USA) is now viewed by white male college graduates as a much less attractive career than before. Relman believes that the most important reason for this is the rising cost of medical education and a growing concern about future autonomy and economic opportunity. In the USA, women have shown a greater preference for salaried practice and the less remunerative specialties, so the latter is likely to weigh less heavily with them than with men. If women do choose the less remunerative careers and salaried practice, there will be further avoidance of the surgical specialties.

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