"Looking for that Hollow Log."

Experiences & perceptions of Queensland Rural Medical Spouses
- NIGEL BOND

May 2003
Acknowledgements

This research project was completed with the cooperation of many people.

I would like to acknowledge those individuals who took time out from their busy schedules to take part in the interview process. Your responses and comments formed the basis of the postal survey and set the scope for this research. In addition, I would to thank all those who took the time to complete the postal survey, and those who participated in the focus groups. Without these contributions this research would not have been possible.

I would like to acknowledge the other individuals who have helped to see this project to completion. In particular the work of Anne Chater, and all other members of the Queensland Rural Medical Family Network for their contribution, and dedication to this research. Thanks also to staff of the Queensland Rural Medical Support Agency, in particular Kate Hawtin, Rosemary Burnett and Col White.

Finally I would like to also thank the many people and organisations that have assisted in the provision of data, information and advice.
Contents:

EXECUTIVE SUMMARY ......................................................................................................4

1.0 INTRODUCTION ...........................................................................................................12

Rationale for the research project: ...........................................................................16

2.0 METHODOLOGY ...........................................................................................................22

3.0 RESULTS .........................................................................................................................25

Respondent representation .......................................................................................25
Family Demographics ..............................................................................................28
Education and Qualifications ...................................................................................28
Occupations ..............................................................................................................29
Social interaction and hobbies ..................................................................................30
Expectations prior to moving to current location, social orientation and early support networks .........................................................................................................................35
Expectations prior to relocation ...............................................................................37
Early supports and orientations ................................................................................41
Settlement of children and educational issues ..........................................................44
Attitudes towards aspects of current lifestyle ............................................................47
Issues concerning access to suitable health care ......................................................52
Cultural identity and maintenance of cultural/religious practice ..............................57
Views about life as a doctor’s spouse in a country town .........................................60
Dimensions of alienation .........................................................................................66
Summative views about life as a doctors spouse in present location .......................70
General Conclusions .................................................................................................74

4.0 COMPARING THE PERSPECTIVES OF SPOUSES ACROSS GENDER AND ETHNICITY ...........................................................................................................................77

Overall gender differences .......................................................................................77
Examination of the perspectives of Overseas Trained Doctors. .........................86

5.0 QRMFN NEEDS ANALYSIS ........................................................................................90

6.0 FOCUS GROUPS ..........................................................................................................102

Roma Focus Group .................................................................................................103
Biloela Focus group .................................................................................................105
Atherton Focus Group .............................................................................................107
Charters Towers Focus Group ................................................................................108

7.0 CONCLUSION AND RECOMMENDATIONS ........................................................110

List of recommendations: .......................................................................................111

REFERENCES .....................................................................................................................116

APPENDICIS .......................................................................................................................119

Appendix One: Rural, Remote and Metropolitan Area Classification (RRMA) ..119
Appendix Two: QRMFN Postal Survey ...............................................................120
Appendix Three: Interview Consent Form ............................................................133
Appendix Four: Interview Information Sheet .......................................................135
Appendix Five: Focus Group Demographics Data Sheet ..................................137
List of Tables:
Table 3.0: Queensland distribution of partners by RRMA .....................................................25
Table 3.1: Demographic Information: Sex and Age of Spouses (%) by RRMA .................25
Table 3.2: Respondents age range grouped by Partner’s employment type and RRMA .......26
Table 3.3: Country of birth .................................................................................................26
Table 3.4: Distribution of Non-Australian born spouses by RRMA ....................................27
Table 3.5: Raised in rural environment ..............................................................................27
Table 3.6: Comparing sex and age distribution of respondent’s backgrounds, prior to age eighteen. ........................................................................................................................27
Table 3.7: A comparison of respondent’s area of upbringing with present location (indicated by RRMA). ..................................................................................................................28
Table 3.8: Frequency of children in particular age categories by parent’s age .....................28
Table 3.9: Educational Qualifications ..................................................................................29
Table 3.10: Present Occupation (N = 97) ............................................................................29
Table 3.11: Comparison of male and females working either full or part-time ...................30
Table 3.12: Involvement in organised social activities and hobbies, ranked in order of prominence (not all respondents responded to this question, many indicated several choices) ..................................................................................................................31
Table 3.13: Major supports (%) ..........................................................................................31
Table 3.14: A comparison of choice of supports between male and female respondents (%) 32
Table 3.15: Presence of close friends or confidants by personal characteristics (%) .........33
Table 3.16: Comparison between Australian born and non-Australian born respondents, levels of overall satisfaction with rural life, and presence and absence of close friends (%) ..................................................................................................................33
Table 3.17: Places where close friends socialise ..................................................................33
Table 3.18: Interaction with friends by RRMA (%) .............................................................34
Table 3.19: Reasons for moving to a rural location ................................................................36
Table 3.20: Comparison of previous rural experience and expectations prior to relocation ..........................................................................................................................39
Table 3.21: A comparison of the percentage of respondents who are employed in positions consistent with their training, and their expectations prior to relocation .................................39
Table 3.22: A comparison between respondents’ expectations and overall level of happiness .............................................................................................................................................40
Table 3.23: Accuracy of information given to respondents at time of relocation (by number of respondents).............................................................................................................................................40
Table 3.24: Examples preparations undertaken by spouses prior to relocating (N=29) .........42
Table 3.25: Percentage of respondents from each background who reported undertaking pre-move preparation .........................................................................................................................43
Table 3.26: Family size and schooling ..................................................................................44
Table 3.27: A comparison of numbers of families in each RRMA and choice of school for their children. .............................................................................................................................................45
Table 3.28: Issues impacting on rural spouses ....................................................................48
Table 3.29: Projections of overseas trained spouses length of time in Australia, and predicted duration of stay in rural Australia .........................................................................................................................59
Table 3.30: Aspects of life as the “doctors spouse” (mean score 1=strongly agree, 5=strongly disagree) .............................................................................................................................................60
Table 3.31: A comparison of level of agreement (%) and partner’s employment type .............61
Table 3.32: Rating aspects of current lifestyle (ranked in order from satisfied to most dissatisfied) .............................................................................................................................................62
Table 3.33: Projected length of stay in current location ........................................................63
Table 3.34: Comparison of predicted length of stay by RRMA ............................................64
Table 3.35: Respondent’s reasons for predicted length of stay........................................64
Table 3.36: Proportion of respondents scoring positively on Seaman’s Dimensions of Alienation..........................................................66
Table 3.37: Comparison of positive scores for social isolation and gender, across RRMA...66
Table 3.38: Comparison of positive scores for social isolation and gender across age categories........................................................................67
Table 3.39: A comparison of respondents who rated positively for feelings of powerlessness, and their initial reasons for relocating to the rural area.............................................................68
Table 3.40: Positive and negative perceptions of life as the spouse of a rural doctor (rank ordered as nominated by respondents).........................................................................................71
Table 3.41: Advice to future rural medical spouses.................................................................................................................................72
Table 4.1: A comparison of female and male respondents by projected length of stay in current location (%).....................................................84
Table 4.2: A comparison of female and male respondents by reasons for projected length of stay in current location ..................................................................................................................................................84
Table 5.1: A comparison of respondents prioritising of QRMFN services by respondent’s residing town population size..........................................................94
Table 6.1: Demographics of focus group participants........................................................................................................................................102
Table 6.2: Roma Focus Group ..............................................................................................................................................................................104
Table 6.3: Biloela Focus group................................................................................................................................................................................106
Table 6.4: Atherton Focus group............................................................................................................................................................................107
Table 6.5: Charters Towers Focus Group .........................................................................................................................................................109

List of figures:
Figure 3.1: A comparison of predicted length of stay in present location by age category....63
Figure 4.1: SSA depicting relationship between Female respondents’ responses and dimensions of alienation...............................................................................................................................................78
Figure 4.2: SSA depicting relationship between Male respondents’ responses and dimensions of alienation...............................................................................................................................................81
Figure 4.3: SSA depicting relationship between spouses of OTDs respondents’ responses and dimensions of alienation...............................................................................................................................................87

List of acronyms:
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Qld</td>
</tr>
<tr>
<td>CME</td>
<td>Continued Medical Education</td>
</tr>
<tr>
<td>OTD</td>
<td>Overseas Trained Doctor</td>
</tr>
<tr>
<td>QLD</td>
<td>Queensland</td>
</tr>
<tr>
<td>QH</td>
<td>Queensland Health</td>
</tr>
<tr>
<td>QRMFN</td>
<td>Queensland Rural Medical Family Network</td>
</tr>
<tr>
<td>QRMSA</td>
<td>Queensland Rural Medical Support Agency</td>
</tr>
<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>RDDAQ</td>
<td>Rural Doctors Association of Queensland</td>
</tr>
<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Area</td>
</tr>
<tr>
<td>RWO</td>
<td>Regional Workforce Officer</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>TRD</td>
<td>Temporary Resident Doctor</td>
</tr>
<tr>
<td>WACRRM</td>
<td>Western Australian College of Rural and Remote Medicine</td>
</tr>
</tbody>
</table>
Executive Summary

Between September 2002 and April 2003, the Queensland Rural Medical Support Agency, in conjunction with the Queensland Rural Medical Family Network undertook a research project to examine the experiences of spouses of rural medical practitioners (RMP’s) in Queensland. This project employed a range of methodologies, including face-to-face interviews, a postal survey and focus groups. Participants provided responses to both qualitative and quantitative questions, including self assessment using a clinical alienation scale designed to explore feelings of alienation across five dimensions; powerlessness, meaninglessness, normlessness, social isolation and work estrangement. Three hundred and sixty partners living across rural Queensland were surveyed, with one hundred and fourteen returning completed questionnaires (a response rate of 32 %). Focus groups were conducted upon completion of the research in rural areas to determine the validity of the results.

An examination of the respondent’s demographics suggests that they are proportionally representative of Queensland rural medical spouses in general, in that most are female, aged between 36-55 and Australian born. The majority are also likely to have at least two children. One respondent in every ten is a medical practitioner and 50 percent of all non-medical practitioner respondents work in either a health or allied health profession (one third of whom are Practice Managers). The majority of male respondents (69 percent) are employed on a full-time basis, while the majority of females (62 percent) work only part-time. While many of the respondents worked in areas that were consistent with their level of education and training, this was not the case for Practice Managers (65 percent of whom trained in other areas). Almost half of respondents over the age of 51, and 45 percent residing in RRMA 6 also reported working in areas that were not consistent with their levels of education or training. In addition, forty two percent of Non-Australian born spouses were working in occupations not consistent with their education or training.

Fifty seven percent of Australian born and fifty eight percent of Non-Australian born respondents grew up in either rural or provincial towns. The majority of male respondents (75 percent) and approximately half of all female respondents (53 percent) had either rural or semi-rural backgrounds. Results suggest that previous rural experience has some impact on determining where respondents currently reside. This is particularly evident for those raised in provincial areas, with no respondent originating from a provincial centre currently residing in a RRMA 6 or 7 locations. Interestingly, results suggest that those with little or no previous rural experience were more likely to report unrealistic pre-move expectations, and to have undertaken minimal pre-move preparation.

Even respondents that had undertaken some pre-move preparation commented on many issues they were unhappy with. This suggests that the factors that determine the overall happiness and satisfaction of spouses are issues that tend to be longer-term lifestyle factors rather than immediate environmental ones. As such social factors, such as community interaction, and social isolation (which are difficult to prepare for) have just as large an impact on overall satisfaction as do the more physical issues such as housing and employment.

The majority of respondents reported coming to the rural setting because of the work available for the doctor. Only three percent of females and 26 percent of males reported moving because of their own personal reasons. Although most respondents said that their
pre-move expectations had been met, those who did not were consistently more likely to be unhappy in their present situations. Results suggested that being provided with up to date, and accurate information prior to moving played an important part in determining whether their initial rural experiences were positive ones.

Although three quarters of respondents reported having close friends or confidants within the communities they were living in, almost 40 percent of partners of Overseas Trained Doctors (OTDs) reported they did not. This supports other results that indicate that these spouses are most in need of family and social support services. Results indicate that those with good social networks were more likely to report being happy than those who did not have access to such networks.

Most dependent children have at least one sibling, and slightly over half are of school age. Only 13 percent of respondents sent their children to boarding school, with the majority of primary and secondary school aged children attending local schools. Only a small proportion of respondents reported being dissatisfied with local schooling, although they did express concerns over the adequacy of education for children in Year 11 and Year 12. The availability of university education was also reported as being a major consideration. As many participants wanted their children to attend university, proximity to a tertiary institution was a concern. The most frequent reason for not sending a child to boarding school was reported as not wanting to separate family members. However, the most salient predictor of leaving rural practice was because of children’s higher education. Many respondents commented that they would consider moving once their child reached university age.

The results of this research indicate that the majority of respondents are reasonably content in their present circumstances, and that rural life has many positive attributes. These include the generally relaxed lifestyle, the many opportunities of the rural environment (such as outdoor pursuits) and the friendliness and safety of the rural community. Despite this, respondents indicated that there were a number of aspects of their current situation that made their lives difficult. It is these issues that have the potential to impact on how long they wish to remain in the rural environment.

Given that seventy percent of spouses moved to their present location for employment reasons (predominantly for the doctor), many female respondents felt they have little control over their present situation (a concern noted by sixty percent of partners of Queensland Health employees); this lack of control leads to feelings of powerlessness and social isolation. Furthermore, community pressures and expectations result in feelings of normlessness (having to modify one’s behaviours to conform to community norms or expectations).

Although such pressures are not as pervasive for spouses of OTDs, other issues, such as a lack of cultural and religious facilities impact on their general well being, especially in their early stages of their resettlement. Such early negative experiences greatly affect their predictions for how long they will stay in the bush. This conclusion is supported by the finding that forty-five percent of the OTD spouses who have lived in Australia for less than ten years predicted they would leave the rural area within five years, or as soon as their spouses period of bonding was over (this includes half of those who have resided in Australia for less than five years).

Responses to the alienation scale varied considerably not only across individual characteristic groupings, but also within the five dimensions of alienation. Such a result suggests that
respondents felt some degree of alienation on some dimensions but not on others (with feelings of social alienation, powerlessness and normlessness being evident in a larger number of respondents). Of some concern is the fact that 45 percent of respondents scored positively on more than one dimension, and thirty percent of respondents scored positively on four or more dimensions. Although generally there was a rejection of the dimensions of alienation statements, there was a 56 percent overall acceptance rate among Non-Australian born respondents (as opposed to 36 percent of Australian born) and an overall acceptance rate of 41 percent of female respondents opposed to only 30 percent of male respondents.

The results of this research have shown that female spouses are more likely than males to be expected to behave in certain ways, be more involved on committees and community groups. When examined by hobbies and interests, male spouses are more often involved with sporting groups or hobbies than they are with school fundraisers, or local committees. Male spouses therefore have the ability to transgress the boundary from ‘acquaintance’ to ‘close friend’ more easily than female spouses. As comments from participants have demonstrated, it is much harder for the female respondents to step outside the community-defined stereotype of the “doctors wife”.

Seventy percent of all respondents maintained that one of the hardest aspects of living in rural or remote areas is the lack of family close by, particularly in times of need. Given the costs of interstate transport, families often relied on the telephone as their major source of family contact for extend periods of time. This form of communication was not considered appropriate in some situations. Respondents frequently commented that they were concerned that their children often missed the opportunity to interact with their extended families, in particular, grandparents who were often unable to travel such large distance to visit families in the bush. In addition, given the difficulties in leaving the medical practice for extended periods, children were often unable to visit family members elsewhere without going on their own.

Other issues causing concern for medical spouses included (in order of priority):

- Social isolation, including personal loneliness, and a lack of anonymity and personal privacy. Often respondents found it difficult to make friends (particularly spouses of OTDs). Breaking the barrier between acquaintance and friend was reported to take a great deal of time. The ability of children to form friendships was also an issue of concern, particularly for the younger children of spouses of OTDs. Children of country doctors were occasionally bullied or teased in local schools. As families of Temporary Resident Doctors (TRDs) reported frequently being relocated to new areas, the socialisation of their children became particularly problematic. Constant monitoring of behaviour to avoid community gossip was noted as being a major issue faced by the majority of Australian born respondents, but not a major issue of concern for spouses of OTDs.

- The majority of rural medical spouses are concerned about the long hours that their partners are required to work, and the stress that this places on the families, and on their relationships. Respondents noted that because their partner was frequently away from the home, the tasks of parenting and running the household was often left to them. This put a great deal of strain on relationships. In addition, this also meant that socialising outside the home was difficult as often the doctor would be called away during the evening, or would have to cancel invitations at little or no notice. Interestingly, this issue was of
greatest concern to spouses of hospital-based doctors, with 86 percent reporting this issue as a major problem as opposed to only 67 percent of respondents whose spouses worked as private practitioners.

- Eighty percent of respondents reported being dissatisfied with the current availability of locum facilities and the regular on-call demands on practitioners. A lack of locums meant that it was difficult for many families to take holidays together. This added to the pressures facing many spouses, as it meant that medical spouses were often fatigued and stressed. Several respondents commented that when a locum was employed, patients often preferred to wait until the regular practitioner returned, rather than going to see an unfamiliar doctor. This additional patient workload upon return (combined with the loss of income while away) made it difficult to justify leaving the practice for any extended period. Respondents also stated that in times of illness (either the respondent’s or the doctors) it could be extremely difficult to find a replacement doctor. For the doctors, this meant having to work while unwell, and for the spouses, this occasionally meant the doctor was unable to take time off, even at the time of a family medical emergency.

- Rural medical spouses often worked long hours with little recognition. Female respondents in particular, were often expected to act as the doctor’s receptionist twenty-four hours, seven days a week. Although the majority of female spouses were in part-time paid employment, they also worked extensive hours as bookkeepers, receptionists, and business managers, despite only a small proportion having received training or qualifications in these areas. Respondents saw a greater need for professional development opportunities, and often viewed such opportunity as a substitute for the general lack of professional interaction or satisfaction.

- Lack of access to certain facilities such as religious/cultural facilities and recreational opportunities (such as theatres and cinemas, museums etc) was considered an issue for many families. Suitable entertainment and recreational facilities were more of a concern for male spouses. Spouses of OTDS were more likely to be concerned with availability of culturally appropriate foodstuffs (such as Halal meat), and suitable religious and cultural facilities. While some respondents were prepared to modify many religious/cultural practices according to facilities that were available, others were more intent on moving to a different location that had more appropriate facilities.

- Approximately forty percent of respondents were very concerned about suitable access to confidential health care, an issue of particular importance to those living in towns with populations over 5000 people. Often general practitioners in the larger country towns work in two or more doctor practices; this increases the potential for confidential medical information to be observed by a number of people. Comments from several respondents suggest that occasional breaches of confidentiality have had dramatic consequences for spouses, ranging from simple embarrassment through to the refusal to see any medical practitioner since that time. Forty five percent of all respondents were treated by their partner on a regular basis (approximately fifty percent of females and forty percent of males). Interestingly, four of the eleven respondents who were medical practitioners themselves, also preferred to use their spouse as their regular medical practitioner. While many spouses viewed being treated by your partner as being acceptable, several spouses (including many spouses of OTDs) were concerned about this situation, and would either see a doctor in another practice, or wait until they had the opportunity to see a doctor in another town.
While rural medical spouses face similar experiences, some issues have a greater effect on some spouses than on others. Individual characteristics such as gender, age, ethnicity and degree of remoteness are important factors in determining which issues will effect spouses the most and in which ways. Only by recognising that rural medical spouses are not an homogenous group and tailoring specific strategies and interventions that address such differences will support agencies such as QRMSA or the QRMFN be able to continue to provide suitable support for rural doctors and their families.

This research highlights the continued contribution that rural medical spouses make to both the medical practice and the local community in general. In 1996, research by Wise et al, coined the term “married to the practice.” Despite the recent workforce changes, this situation is still very much the rule rather than the exception. The QRMFN cannot operate in a vacuum, its members are volunteers, and therefore it is the responsibility of the Rural Workforce Agencies and Commonwealth departments to ensure that the Medical Family Networks are adequately supported; not only in terms of financial support, but also in terms of communication links, employment strategies, and medical workforce support for the doctors. In such an environment QRMFN will be able to continue to develop strategies that will have a substantial impact on the length of time spouses choose to remain in rural areas.

Queensland Rural Medical Family Network Needs Analysis

The QRMFN was established in 2000 and comprises a group of voluntary medical spouses/partners who utilise a variety of formal and informal means to provide assistance to Queensland rural medical partners and their families. The QRMFN management team comprising of seven members that determines policy and planning, and liaises with the QRMSA project officer who coordinates the QRMFN activities. The QRMFN operates from five hubs that cover specific geographical regions throughout rural Queensland.

In the three years that the QRMFN has been operating in its present form, it has developed important relationships with the Queensland Rural Divisions of General Practice and several other medical and community stakeholders. The network runs a number of programmes such as the rural bursary programme (that provides up to ten applications per year), as well as a telephone information service. In addition to these programmes, the QRMFN runs a number of activities at Continued Medical Education events and conferences including:
- Mentoring workshops
- Educational sessions (such as practice management training sessions)
- Child minding services
- QRMFN Luncheons, social outings and dinners

Slightly over half (51 percent) of the respondents to the survey reported having involvement with the family network, a significant achievement given the short period of time the QRMFN has been operating. A breakdown of these respondents shows that 81 percent were female, (51 percent of all female respondents) and 19 percent were male (representing 33 percent of all male respondents).

When analysed by age category, almost 60 percent of respondents involved with the QRMFN are aged between 36-50, slightly over one quarter (28 percent) are older than 51, while only 14 percent are between 26 and 35.
Twenty-eight percent of respondents who were from countries other than Australia are involved in the QRMFN. This figure makes up 22 percent of respondents who have had involvement with the family network in some form. The remaining 78 percent of spouses who are involved with the network are Australia born.

Of the respondents who reported involvement with the QRMFN, over half (56 percent) are located in RRMA 5 locations. Those respondents in RRMA 6 and 7 make up 11 percent and 15 percent respectively. The remaining 19 percent are made up of partners living in RRMA 4 locations.

Interestingly, 47 percent of all respondents living in RRMA 6 locations, and 50 percent of all respondents from RRMA 7 locations reported utilising the QRMFN services at some stage. This result suggests the importance of the family network to those partners in more remote areas. Nearly all of those respondents (98 percent) who have involvement with the QRMFN have children. Overall, respondents who were involved with the QRMFN reported being either satisfied or very satisfied with the services provided by the family network, only 3 percent of respondents reported that they were dissatisfied with the current services provided. In particular, spouses reported that services such as social orientations, mentoring programmes, and the provision of activities at medical education events and conferences were extremely valued, and that these services often made it possible for them to attend medical events with their partners and families. In an environment where the ability to spend time together is rare, these opportunities were considered extremely important.

In addition, a relatively high proportion of rural medical spouses (although often trained in health or allied health professions) are employed as Practice Managers or bookkeepers. Bursaries provided by the QRMFN have enabled a number of spouses to undertake book keeping, small business management or practice management courses.

As part of the survey, spouses were given a list of options for services that the QRMFN can offer, (the majority of which they currently provide) and then asked to rank them in order for priority. Overall, respondents rated all activities favourably; suggesting that respondents felt all activities discussed were valuable services that the QRMFN should provide. When responses were examined by respondent’s town size, there were some differences in priority of rankings.

**Providing children’s activities at MET events**
When ranked in order of priority, providing children’s activities was ranked the most important for respondents in smaller towns, and listed second for those in larger towns. Overall, eighty percent of respondents ranked this as either being Very important or Important.

**Social orientation upon arrival in town**
Respondents ranked this service as second most important. Providing social orientation on first arrival in a new town was ranked either Very Important or Important by 76 percent of all female respondents and 62 percent of all male respondents.

**Confidential medical services**
Almost three quarters of respondents ranked confidential medical facilities as being either Very Important or Important, indicating a strong preference for this type of service. This
option was rated as the highest priority for those respondents residing in larger towns. Over 90 percent of women with children rated this option as most important.

**Provision of counselling facilities**
Sixty-nine percent of all respondents ranked this service as either Very Important or Important. However, approximately 90 percent of those who ranked counselling as being Very Important had children.

**Provision of the QRMFN Newsletter**
The provision of the QRMFN newsletter was seen by the majority of respondents (80 percent of those with QRMFN involvement) as an important service provided by the network. A breakdown of remoteness categories suggests however, that it is seen as more important by spouses residing in more remote areas.

**Mentoring programs**
Of those respondents who reported mentoring programs as being Very Important, sixty percent were in the 36-50 age category. Over fifty percent of all respondents in the 51 and over category ranked this service as being Very Important. When these results were examined by RRMA, 85 percent of respondents in RRMA 7 locations, and 70 percent of respondents in RRMA 6 locations ranked the provision of mentoring programmes as either Very Important or Important. These percentages are slightly higher than those recorded by respondents in RRMA 5 (68 percent) and RRMA 4 locations (65 percent). These results do suggest that spouses who reside in more remote areas see a greater need for mentoring programs than spouses who live in the less remote centres.

**Work orientation and Bursaries**
The provision of work orientation and bursaries was ranked as either Very Important or Important by 67 percent of spouses. In particular, participants in the remotest areas ranked this service as being an import aspect of the QRMFN, with 80 percent of participants from RRMA 7, and 65 percent of participants from RRMA 6 ranking this option as either very Important or Important. Approximately 70 percent of respondents between the ages of 25 and 50, ranked this service as being Important, as did those aged 51 or over.

**Events just for spouses**
Support for “spouse only events” indicated that organising activities that do not include children would be supported by younger spouses. Given the number of comments concerning lack of entertainment facilitates, an occasional ‘spouses’ only social event at workshops may prove a popular addition to services provided.

**Gender specific activities**
Although several male respondents commented on the lack of services provided to male spouses by the QRMFN, only 51 percent of males ranked gender specific activities as being Very Important or Important, as opposed to Over 60 percent of females ranking this issue as being important. This may however, be due to the fact that several male respondents commented that events should be centred around “family activities” such as outings to parks, swimming and so on, as opposed to events such as golf trips or shopping excursions.

**Internet based communication with others**
Respondents ranked providing Internet communication links between spouses as the least important of all the options. Forty-six percent of respondents ranked this option as being
Very Important or Important. The majority of respondents indicated that they were not interested in this form of networking and that they preferred face-to-face interactions. Electronic communication was generally viewed as impersonal, and as well as logistical considerations (some did not have regular access to the Internet), the majority of respondents commented that they did not have the time available to spend chatting over the Internet.

Conclusions and recommendations
Results of the Needs Analysis supports the finding of the overall research results suggesting that rural medical spouses are not a homogeneous group, and there are some services that are required by some, that would not be suitable for others. Taking into account differences such as gender, age, or presence/absence of children and simply level of remoteness, will be an important aspect of the future of planning of the Queensland Rural Medical Family Network. Even though the Queensland Rural Medical Family Network is effectively addressing some of the needs of the partners of medical practitioners, workforce issues of the practitioner still remain as barriers to the recruitment and retention of doctors across rural Queensland.

It is important to note that problems and concerns vary from region to region. It is therefore imperative that any attempt at identifying solutions take regional and individual differences into consideration, and that solutions be directed at a local level, where factors individual to that specific family and their community be taken into consideration.

These results indicate that there are still a number of issues that the QRMFN needs to address in order to continue to support rural medical spouses. There is increasing empirical evidence to support anecdotal findings that decisions by medical families on whether to leave or remain in rural areas are made over the dinner table. Research conducted by the QRMFN clearly shows that social and professional isolation of spouses (and the resulting feelings of powerlessness) are major factors in any decision to leave the rural area. It is vital therefore that the QRMFN continues to develop its strategies and interventions in order to support and empower rural medical families. Furthermore, it is of major importance that continued funding be available to support programs that aid rural medical families and allow these programs to reach their desired objectives. The happiness of the medical spouse and the medical practitioner are still indelibly linked and of pivotal importance in the recruitment and retention of medical practitioners in Queensland. As one participant commented:

“A doctors spouse has to be supported and happy for the medical practitioner to firstly go to a rural town, and secondly for the doctor to stay in that town. The partner and children must be happy, it’s as simple as that.”
1.0 Introduction

A number of reports have been commissioned throughout Australia during the past decade in an attempt to understand the problem of attracting and retaining General Practitioners to rural areas (for example see; Barney, 1998; Campbell, 1995; Hays, 1993; Hoyal, 1995; Kamien, 1987; 1996; Levitt, 1999; Sevier, 1990; Veitch, 1997, 2003). 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. For the most part, however, these reports have placed spouses’ concerns on the periphery, essentially using them to bolster the financial and professional arguments of the doctors.

Only in recent years have researchers attempted to quantify the experiences of rural GP spouses/partners as research studies in their own right (for example, see Wise, Nichols, Chater and Craig 1996; Hoyal 1997; Hays 1997; Roach, 2002). Very little research specific to rural Queensland has been undertaken since this time.

Research (while not specific to Queensland) has identified a number of key issues facing the partners and spouses of rural health professionals. However, these issues tend to have been generalised across all locations, categories and individuals living in rural areas. Research addressing issues specific to particular groups of people, or location, is not yet available. For example, in order to address the shortages of health professionals in rural areas across Australia, a large number of Overseas Trained Doctors (OTDs) and Temporary Resident Doctors (TRDs) have begun practicing in rural Queensland under a number of incentive programmes. There has been little research to date on the issues faced by OTD/TRD spouses or their families. Furthermore, research examining location or community size is also lacking; for example, issues facing families in a RRMA 41 location are likely to be different from those residing RRMA 7 regions. Similarly, age, ethnicity, and gender of partners will also affect their experiences differently. Such differences between individual categories of spouses/partners is likely to influence which strategies will most likely succeed or fail in particular areas.

In 1987, Kamien described rural medical practice as “a family concern” (Kamien, 1987). Medical practitioners need a stable emotional platform from which to practise. One of the contributors to this platform is the doctor’s spouse (be this wife, husband or de-facto partner). There is a need to better understand the impact of general practice on the lives of such partners. Gaining better understanding of this may improve both personal relationships and the quality of the doctor-patient interaction. Furthermore, as Wise, Nichols, Chater and Craig (1997) discuss, an understanding of the support and training needs of spouses of rural doctors is an important component of efforts to improve recruitment and retain rural doctors.

From previous studies it is possible to identify a number of key issues and themes, which adversely affect the spouses (and families) of rural medical practitioners. These themes can be categorised under the following main headings:

- The impact on spouse and family directly
- The impact on careers (and the impact of the doctors careers on the spouse)

---

1 See Appendix One for definition and explanation of RRMA categories.
- The effect of community relationships and interactions (including expectations and stereotypes)
- The perceived inequity between private practitioners and Queensland Health employees

**Impact on spouse and family directly:**
Research has identified a number of issues that directly affect the spouse of rural medical practitioners and their families. These issues include:

**Personal health concerns.**
Previous research indicates that many spouses maintain that it is very difficult to take care of their own health (and that of their GP partner) in a rural community (For examples see Roach, 2002, Wise et al, 1996). This often means putting off consultations until visiting the city or larger regional town hundreds of kilometers away. Because of the real and perceived problems of confidentiality, many doctors’ spouses are reluctant to use services in rural areas, waiting until they can visit a major city, where their anonymity can be more assured.

**Access to suitable housing**
Access to suitable housing is a major concern for the rural medical practitioner and their families. Housing standards for doctors and for their relievers have not received much thought (Hoyal, 1995). Poor housing contributes to the lack of privacy frequently complained of by partners. Government employees in rural areas have entitlements to certain standards, but the majority of medical practitioners are not government servants (White, 2001). If housing is provided, such accommodation is unlikely to be of a high standard and invariably is designed for single persons, with no provision for spouse or family. The purchasing of a property is not often a viable alternative. Previous research suggests that the purchase price of accommodation in rural towns, if any is available, may be substantially lower than in cities, but the capital gain over time is likely to be minimal. This is a major disincentive to medical practitioners and their families remaining in rural locations for extended periods of time (Hays et al, 1997).

**Education of children**
The education of the children of rural medical spouses is also noted as being of a major concern (Wise et al, 1996, Roach, 2002). This is particularly an issue for parents of secondary or university aged children. The quality of secondary education available locally compared to the cost of sending a child to boarding is a significant factor in the decision to leave or remain in a rural practice. Hoyal’s 1995 research demonstrates that the desire of doctors to ensure that their children receive education consistent with hopes of professional careers is at odds with the lower expectations of many country secondary schools, in spite of very considerable work by rural school staff to raise academic standards. As Hoyal notes, Queensland Health figures for medical school entry confirm the bias against non-Metropolitan and State school pupils for places. South Australian studies indicate that children’s education, especially secondary, is the most potent reason for rural GP’s intention to leave the country practice.

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. Major concerns previously identified by rural doctors’ spouses about the educational system include:
• That some rural high schools do not go beyond Year 10, which forces a decision to be made as to whether to send the children to boarding school, or to leave the practice and return to the city.
• The lack of competition and subject choice stifled the child’s development, that peer group pressure urged conformity to lower standards.
• Inexperienced teachers were impediments to high academic achievement.
• Employment opportunities for the older children (once they have left school) are also a major concern.

Access to suitable relief
The ability to take time off for holidays and the poor availability of locums for their partner’s practice is cited as a major issue for some spouses, as is the quality of recreational and professional facilities for themselves and their children. As Lowe (2003) comments, these issues, combined with the long hours that the doctors are required to work make up a significant proportion of rural spouses concerns.

The impact on spouses’ careers
Suppression or realignment of the spouses’ careers and the associated conflict between their own needs and those of their families is an issue identified in the majority of research. Significant in this regard is the opportunity for employment in the spouse’s field of expertise and the inherent requirement for re-training and updating of qualifications by the provision of educational programs (Wise et al, 1996, Veitch, 1991, 2003).

Doctors’ spouses 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 (Veitch, 1991). In addition, Hoyal’s research (1995) reveals antagonism by rural communities to doctor’s partners taking paid work, especially in hospitals. Doctor’s spouses are often seconded into the role of (unpaid) secretary and nurse’s aide, which also limits or prevents the opportunity of gaining a second income. Furthermore, inadequate training in the management side of the medical practice can further exacerbate feelings of frustration and inadequacy.

There is a strong need for partners to have access to educational upgrading through distance education, both for their own sake and to avoid falling behind advancements in their chosen profession. Spouses are often at risk of being engulfed by their partners’ careers.

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 leave the rural environment. Nonetheless, financial problems do not improve the spouse’s self-image, but can increase the resentment towards the community if they feel their partner’s services are being exploited.

Interestingly, male spouses also report comparisons and contrasts between their own careers and their spouses; yet few seem to report a sense of being overwhelmed by their partners’ occupation.

Social isolation and the effect of community expectations:
Even when the town is very welcoming, the partner of a rural practitioner can still feel very isolated due to the distance from family and friends, and the lack of intellectual stimulation. Research suggests that the community tends to treat them differently because of their relationship to the doctor (Wise et al, 1996). Spouse may be more isolated than the doctor.
Being the partner of a general practitioner in itself, can be a particularly isolating feature in rural towns and can place the partner in a defensive position at social gatherings.

Research notes that many of the spouses of rural doctors are concerned about the roles imposed on them by the community in which their partners are working. In the face of strongly felt community expectations, many of the partners of rural GPs discuss a need to forge a separate identity for themselves. Frequently spouses report that their acquaintances and friends are also patients of their medical partner, and that at times this involves intimate contact: This can be an area of difficulty and/or embarrassment for those concerned.

The lack of cheap and regular transport throughout Australia reemphasises the feelings of isolation for spouses in rural and remote practices. Many rural roads are in bad repair; many country rail services have been removed. Furthermore, 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. As many medical spouses may not have regular access to their own transport (often the doctor needs to take their vehicle) a lack of regular public transport can also be an issue.

The excessive on call demands on rural doctors are putting severe mental and physical stresses on the doctor and their partner, and consequently on their relationship. During the doctor’s on call periods the partner is often required to be working also, offering receptionist facilities that often leave them feeling “chained to the phone” (Hoyal, 1995). At the same time the spouse becomes, virtually a sole parent, who must deal with the varying demands of children single handedly. The enormous influence of partners on the career paths of medical husbands has been demonstrated by a number of researchers (e.g. Lowe, 2003, Roach, 2002). Some additional perceptions of the pivotal role of doctors’ partners in local communities come from Larch and Crawford, who noted the high community expectations placed on them and the great disadvantages they felt due to their partners’ long hours of work (cited in Hoyal 1995). These factors were regarded as negating the social status conferred by being a doctor’s partner. As these are United States references, there is clearly a need for more Australian data in this area.

Inequity between the public and private sector:
Doctors providing non-specialist services to rural Queensland communities can be categorised as salaried or fee for service (White, 2002). The two largest groups are private practitioners and Queensland Health employees. Competition between ‘public’ and ‘private’ considerations presses heavily on many rural doctors.

As research from the Queensland Rural Medical Support Agency (QRMSA) indicates, Queensland Health salaried doctors (such as Medical Superintendents with Right to Private Practice, Medical Officers with Right to Private Practice) are provided with an employment package including salary and a number of fringe benefits. As many private practitioners in rural and remote areas do not have the guarantee of these provisions a dichotomy is sometimes created between Qld Health salaried and private practitioners (White 2002).

Qld Health employed doctors often have a set salary, a number of fringe benefits including, accommodation, a car, telephone and payment of indemnity insurance. In addition, they are entitled to paid leave which includes, study leave, long service leave, sick leave, annual leave, compassionate leave (including leave loading), parental leave etc. Rural relievers are
recruited by Queensland Health (QH) to fill in for the medical officer when they are on such leave. QH employees are also entitled to a ½ day off every 6 weeks that can accrue. Such provisions are a locus of concern for private practitioners and their families. In particular, the provision of housing, paid leave (with a reliever provided) and a guaranteed salary make it difficult for the non-QH Private practitioners to compete. It is likely that the additional stresses placed on the families of private practitioners because of their need to be self-sufficient may lead to either an increased level of stress on such families, to the extent that they leave the rural setting for the more lucrative urban environment. Exactly what influence (if any) this difference in employment makes to the rural experience has not been fully investigated.

Summary:
As several Australian researchers have commented, Australian-based research on the partners/spouses of rural medical practitioners is still limited, and based primarily on secondary data. Despite this, existing research has demonstrated that the partners of medical practitioners play a major role in any decision on whether to remain or leave the rural practice. Issues such as children’s education, professional development, employment, and the demands of rural practice have all been highlighted as needing addressing, if rural health providers are to stem the flow of doctors and their families leaving rural practice. While it is not possible to reduce the distance between rural towns, it is possible to reduce the isolation and loneliness felt by many rural medical spouses. Organisations such as the Queensland Rural Medical Family Network need to ensure that they have adequate resources to support rural medical spouses. To do this, however, they must also ensure that they have the necessary information to specifically target strategies or projects in ways that are beneficial for all its members.

Rationale for the research project:
The aim of this research project was to identify the needs of partners of rural and remote doctors in the areas the Queensland Rural Medical Family Network (QRMFN) currently offer support, as well as to suggest areas and ways the QRMFN could provide other services. It was the intention that this project would utilise and build on research previously conducted by Queensland Rural Health agencies and medical stakeholders, such as the QRMSA, ACRM and RDAQ, as well as similar national research that was undertaken by other Rural Workforce Agencies such as WACRRM.

Over the last decade, there have been numerous reports on factors that have been identified as influencing rural doctors attitudes towards the rural practice. Many of these reports, however, have assumed a certain homogeneity amongst the spouses of rural doctors, the aim of this research was to examine whether area this was case, or if, in fact, such issues are area, or people specific. Furthermore, it was the intention of this research to investigate areas which at present, there is little, robust data. This includes issues unique to Overseas Trained Doctors issues, those areas that may be gender specific, interaction of individual characteristics (e.g. age, family status) community profile, and differences (if any) between families of Queensland Health employees and private practitioners.

An important component of this research project is the analysis of the spouses’ expectations prior to entering the rural environment. Current research suggests that should an individual’s expectations or perceptions be unrealistic in some way, they will be more likely to react negatively should these expectations be challenged, than those individuals whose expectations or perceptions are more realistic.
Experience has shown that in order to gain an insight into experiences of life as the partner of a rural doctor, data collection should consider the relative influences of mediating factors, process and events, which led to both the decision to move to a rural locality and to remain in such areas. In particular, current data lacks relevant information about; the utilisation of services, who accesses what, which services are effective, which are not, and perhaps most importantly, the types of activities partners participate in and how these relate to how happy/settled they are. A behaviour-based approach to the research process enabled specific issues to be identified and targeted in a way that has not been reported so far.

Outcomes:

- Achieve detailed knowledge of the demographics of the spouses/families of rural doctors:
- Achieve detailed knowledge of the issues facing spouses/families that is specific to family structure, location, gender, community – that is unique to rural Queensland:
- Gain understanding of levels of alienation correlated with specific variables:
- Gain detailed understanding of the types of experiences of rural spouses/partners:
- Access the need to provide specific services that can be targeted to specific groups: and
- To enhance the relationship between the QRMFN and its stakeholders:
Theoretical Constructs utilised in this research:
During this development of this research a number of theoretical constructs were utilised in the construction of the research questions. By employing these constructs it was possible to develop a research questionnaire that would enable the researcher to examine participant responses at a level beyond their extrinsic motivations and environmental concerns. It was hoped that such an analysis would enable agencies such as the QRMFN and the QRMSA to gain a detailed insight into the behaviours of rural medical spouses in an attempt to develop a greater understanding into how and why decisions to either remain or vacate the rural environment are made. The questionnaire developed for this research was based on the following basis.

Expectancy value model
Individuals have attitudes towards just about everything (and everyone), from the dangers of drink driving, through to the probability of winning a major lottery. An attitude is a disposition to respond favourably or unfavourably towards some person, thing, event, or place or idea (Wortman and Loftus, 1992). Although attitudes are often dismissed as unimportant, in some instances, they can have a profound effect on an individual’s behaviour. Attitudes towards a particular situation (thing, person or environment) can also be affected by the expectations that an individual holds concerning that particular experience. For example, a rural medical spouse’s attitude towards a particular town can be greatly affected by the expectations that individual had about the experience in that town prior to moving there.

Individuals develop expectations about what their behaviours will lead to, and they attach values to receiving or avoiding certain consequences. Out of these ideas emerged ‘expectancy value’ models of motivation (Lewin, 1959, in Wortman and Loftus, 1992). These models explain attitudes and motivations by taking into account both expectancy of achieving a particular goal (or experience), and the value placed on it.

According to expectancy-value theory (Fishbein and Ajzen, 1976), a person is more likely to behave in positively to a given situation, if their expectations concerning that is experience have been realised (regardless whether these expectations were positive or negative). In terms of rural medical practitioners and their spouses, if their perceptions of rural life are realistic to the reality, then it is likely that they will have a positive attitude towards their experiences. This in turn may influence any decisions they make concerning whether remain in the rural environment.

This has particular implications for the preparation of medical practitioners and their families prior to their entry into the rural locality (for OTDs especially). If the partner or the medical practitioner have unrealistic expectations, then they will be more likely to either leave the rural location as soon as they are able (for example, as soon as their period of bonding has ended), or, if they do decide to stay, they may be less likely to seek help from appropriate sources, should they experience any difficulty. For those with realistic perceptions or expectations, they will be more likely to remain in the rural environment longer, or, seek help, should they run into difficulty.

Alienation and isolation
In one form or another, the theory of alienation dominates modern research and historical sociological thinking. Psychologists and sociologists often use the term alienation to describe the estrangement of people from themselves, and their social environment. Sociologists maintain that an alienated individual is a person who feels that they have lost control over
their own life; the individual believes that they have lost their identity, dignity, importance and meaningfulness (Weiss, 1961, in Kovacs and Cropley, 1975, p15). In such cases, individuals can no longer make sense out of events going on around them; they lose the ability to predict the outcome of events because the interrelationships of causes and effects they have previously learnt are no longer relevant. They have failed to maintain an inner state of sameness and continuity, a subjective stability that is normally matched by their observable sameness and continuity with other people. Forces beyond their control frustrate their expectations and their calculations are brought to nothing.

Because alienation has been such a pervasive topic of study of by sociologists, “alienation” became a household word with a great range of meanings. This looseness of definition has seriously limited its usefulness in general and academic discussion. Seeman (1959) attempted to provide an organised view of the uses that had been made of this concept and to reunite the historical interest scholars had in alienation with modern empirical methodologies. His theory has since become the standard model for examining alienation. Seeman identified five alternative meanings of alienation: powerlessness, meaninglessness, normlessness, social estrangement, and work estrangement.

**Powerlessness**, refers to Marx’s view of the worker’s condition in the capitalist society. The theory of alienation as powerlessness is perhaps the most frequent usage in contemporary literature. Seeman, however, defined powerlessness as “the expectancy or probability held by the individual that his or her own behaviour cannot determine the occurrence of the outcomes or reinforcements they seek”.

**Meaninglessness**, refers to the individual’s sense of understanding the events in which they are engaged. High levels of alienation of this type can occur when the “the individual is unclear as to what he ought to believe – when the individual’s minimal standards for clarity in decision making are not met”. The individual cannot predict with confidence the consequences of acting on a given belief. In other words, where powerlessness refers to the sensed ability to control outcomes, meaninglessness refers to the sensed ability to predict behavioural outcomes.

The third variant of the alienation theme, **normlessness**, originates from Durkheim’s notion of “anomie”. In its traditional usage anomie refers to the situation in which the social norms regulating an individual’s conduct are no longer effective as rules of behaviour. Following on from this, there is also a high expectancy that socially unproved behaviours are required in order to achieve given goals.

The forth type of alienation, **social estrangement**, refers to feelings of social isolation. This type of alienation can be described in terms of reward values. The alienated in the estrangement sense are those who assign a low reward value to goals or beliefs that are typically highly valued in the given society.

Last dimension of alienation is **work estrangement**. This dimension is consistent with Marx’s description of work alienation. Researchers theorise that this form of alienation results from the loss of intrinsic meaning or pride in work. For example, a worker who works simply for his/her salary lacks the ability to find self-rewarding the activities they are engaged with. Seeman’s five definitions of alienation became the basis of a short questionnaire used to determine levels of alienation in sample groups. Variations of this questionnaire are now widely used in alienation research.
Like other researchers, Seeman examined the general concept of alienation from the viewpoint of the actor, with the subject being the unit of analysis. To each of the five statements in the questionnaire the respondent is asked to choose from a selection of possible responses, ranging from “Strongly Agree”, through to “Strongly disagree”. Once completed, the subjects’ alienation scores are calculated by combining the scores of the five responses.

- Powerlessness: I can do little about today’s problems.
- Meaninglessness: My situation is so complicated, I don’t understand what is going on.
- Normlessness: To get ahead, you are forced to do things that are not right.
- Social estrangement: I often feel lonely.
- Work estrangement: I don’t enjoy the work I do.

For the purpose of this investigation into the perceptions and experiences of rural medical spouses, the writings of Kovacs, Cropley and Seeman were employed to provide a working definition and understanding of alienation, as they are more relevant to this topic than those of others researchers. Support for this theoretical foundation became obvious when a comparison of the relevant literature on alienation was undertaken to determine how they agree or disagree with the findings of Seeman and Kovacs. It was evident that the majority of researchers concurred with these findings.

**Smallest Space Analysis:**
In order to establish whether relationships existed between the concepts identified in the data, and specifically to identify patterns in the nature of the responses of particular groups of respondents, a Smallest Space Analysis (SSA) procedure was used.

Smallest Space Analysis is a multi-dimensional scaling technique used to represent correlations between variables in a statistically derived geometric space (Lundrigan, 2001). For non-dichotomous data Pearson’s Product Moment Correlation coefficient is used. SSA is particularly useful in exploratory analyses as it produces a solution of smallest dimensionality on the basis of the rank order of correlations rather than their absolute values.

Smallest Space Analysis of data results in a series of points plotted on a two or three dimensional axis. Each of these points represents a variable. The proximity of points measures the strength of the relationships between the variables they represent, with points plotted close together having a stronger association than those plotted further apart.

A Coefficient of Alienation (C of A) accompanies each Smallest Space Analysis plot. The Coefficient of Alienation indicates the fit between the geometric representation portrayed in the SSA plot and the original correlation matrix from which the associations between the points on the plot are derived. A Coefficient of Alienation can range from zero to one, with zero representing a perfect fit and coefficients of less than 0.25 indicating a good fit.

The points represented on an SSA plot are analysed according to Facet Theory² (Lundrigan, 2001). Facets are mutually exclusive concepts, comprised of mutually exclusive elements,

---
which can be used to define the constituents of a research domain. In the SSA plots shown in this report, two main types of Facet are used to divide or partition the data points. These are:

- Axial Facets – shown as lines separating the plotted points into distinct regions.
- Modulating Facets – shown as frequency contours portraying transitional distinctions between the points displayed within the plot.

Within this context, SSA theory states that centrally located points tend to represent variables with the highest associative relationships to other variables. These variables are considered significant in defining the entire “universe of observations” or area under study. In contrast, points located on the periphery of SSA plots tend to represent variables of significant value in differentiating between the various regions of the plot. Finally, it is of importance to note that because the SSA configuration is derived from the associations between the variables, any emergent frequency structure represents an empirical finding with substantive meaning.
2.0 Methodology

In order to gain the detailed knowledge needed by QRMFN, a number of research methodologies were be employed. Previous response rates to postal surveys conducted by QRMSA and other RWAs tends to vary form moderate to quite reasonable, therefore to obtain robust data the research process was divided into three stages and include a number of research strategies:

Stage 1: QRMFN data collection

Initial interviews
In order to get a detailed account of the experiences of the spouses, it was decided that a series of in-depth, face to face, qualitative interviews would be employed. Participants were selected using a snowballing selection method utilising a stratified sampling technique. After a series of discussions with project officers from the Rural Divisions of General Practice, QRMFN Regional Workforce officers, and the QRMSA Medical Family Network representative, 13 spouses, from across the five rural divisions were identified. Each participant was telephoned by the researcher, and informed of the research project; they were then invited to take part in the interview process. All participants contacted agreed to take part.

Participants for the interview process were selected if they met the following inclusion criteria or demographic characteristics:

- From across the 5 rural divisions and representative of RRMA 5-7 locations
- Representative of male and female spouses who are not GPs themselves
- From different age categories
- Representative of both Australia trained and Overseas Trained Doctor’s (OTD’s) families
- Participants who do and do not have children
- Who work in a predominantly indigenous community
- Who were from a variety of community types (including mining, agricultural, industrial)
- Of both long term and short term residence
- From different socio-economic areas
- From both QH and the private sector

The Interview schedule:
The assessment of the experiences of the spouses of rural medical practitioners was determined by a series of open-ended questions, responses were recorded on a tape recorder.

The interview questions were divided into five sections:
- Demographics, including prior rural experience, past and present employment.
- Preparation prior to relocating to the rural area, including expectations on relocating
- The relocation process, including finding a home, schools etc.
- Life in a rural area, including, community, schooling, employment, privacy, and isolation levels, maintenance of cultural, familiar ties. This section also included questions of social activity, QRMFN involvement, and health issues and concerns.
- Perceptions of settlement, expectations on duration of stay in rural area.
Rationale for the interview schedule.
After initial consultation with members of the QRMFN management team, QRMSA representatives and members from the Rural Divisions of General Practice, as well as an extensive literature review, it was decided that a qualitative approach to the research design was needed. Several interview questions were based on those asked in earlier studies undertaken in this area so that comparisons over time could be examined.

Interview procedure.
Interviews were conducted in the participants’ home as it was thought this would be the most comfortable environment for the participants. The length of the interviews varied, with the shortest being approximately 40 minutes, and the longest approximately one and a half hours. In all of the interviews a good rapport appeared to be established between the participant and the researcher. Participants answered all questions in a relaxed manner.

The participants were extremely open with their experiences, particularly so when asked questions pertaining to the access of their own health needs, the schooling of their children, and issues concerning the levels of support they have received for the medical profession and the commonwealth. The spouses of OTD’s were particularly keen that their experiences in the rural sector be recorded, and that this information is used to improve the situation of both themselves and other families in similar situations. This frankness was perceived by the researcher, and later confirmed by participants to reflect the need for this research.

This research employed a standardised open-ended interview technique. Utilising this approach insured that participants were interviewed using the same sequence and were asked the same questions using the same vocabulary. As a result, the information gathered could be examined systematically.

Data analysis and presentation.
In order to analyse the interviews, the taped conversations were transcribed in a Microsoft Access Database. Results from the interviews were then compared in order to answer the research questions. The findings from this stage of the research were then used in the development of a postal survey.

Stage 2: The postal Questionnaire.
During November/December 2002, the postal questionnaire was sent to spouses of Queensland rural medical practitioners in RRMA locations 4 to 7. A copy of the seven-page questionnaire utilised is included in Appendix Two. There were 360 spouses/partners in the QRMSA database at the time of survey and all were sent a questionnaire together with a covering letter explaining the purpose of the survey and a stamped return envelope. To encourage participation in the survey, a $1 instant scratch lotto ticket was also included.

Responses were received from 114 partners, a response rate of 31%. The responses were analysed using SPPS 11.5 (Statistical Package for Social Sciences).
Limitations of research:
It must be acknowledged that the response rate to the postal survey was less than expected, despite follow-up letters being sent to spouses. It is therefore difficult to generalise these results to other rural medical spouses in Queensland. The experiences and attitudes of respondents presented in this research may not necessarily concur with others in similar situations. However, by utilising a number of research methodologies as well as triangulation with other sources (including research conducted by other Rural Workforce Agencies) the data is considered valid and reliable. Further confirming the reliability of this research is the fact that the findings discussed are consistent with those identified by rural medical spouses presented in previous reports.
3.0 Results

Respondent representation

Table 3.0 provides a breakdown of responses by number, percentage and RRMA together with details of the state distribution for comparative purposes.

Table 3.0: Queensland distribution of partners by RRMA

<table>
<thead>
<tr>
<th>RRMA</th>
<th>Total number of spouses</th>
<th>Survey respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>RRMA4</td>
<td>76</td>
<td>12</td>
</tr>
<tr>
<td>RRMA5</td>
<td>180</td>
<td>53</td>
</tr>
<tr>
<td>RRMA6</td>
<td>44</td>
<td>13</td>
</tr>
<tr>
<td>RRMA7</td>
<td>41</td>
<td>12</td>
</tr>
<tr>
<td>Missing</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>341</td>
<td></td>
</tr>
</tbody>
</table>

The table indicates that responses received were reasonably representative of the state-wide distribution with some slight under representation in RRMA 5 and proportionally a slightly higher representation in RRMA 4.

Table 3.1: Demographic Information: Sex and Age of Spouses (%) by RRMA

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>RRMA 4 %</th>
<th>RRMA 5 %</th>
<th>RRMA 6 %</th>
<th>RRMA 7 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>30</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>Female</td>
<td>73</td>
<td>70</td>
<td>75</td>
<td>81</td>
</tr>
<tr>
<td>100% as [N]</td>
<td>[22]</td>
<td>[56]</td>
<td>[12]</td>
<td>[16]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>26 - 35</td>
<td>9</td>
<td>11</td>
<td>17</td>
<td>44</td>
</tr>
<tr>
<td>36 - 50</td>
<td>77</td>
<td>67</td>
<td>50</td>
<td>31</td>
</tr>
<tr>
<td>51 and over</td>
<td>14</td>
<td>23</td>
<td>33</td>
<td>19</td>
</tr>
<tr>
<td>100% as [N]</td>
<td>[22]</td>
<td>[54]</td>
<td>[12]</td>
<td>[16]</td>
</tr>
</tbody>
</table>

Table 3.1 shows the distribution of spouses in each RRMA, by sex and age. In all RRMA localities respondents were more likely to be female than male, and between the ages of 36 and 50. In the more remote locations, (RRMA 6 and 7) there is a greater spread across the age categories.

The significantly higher proportion of females in each RRMA category was expected, as this is in keeping with the inverse proportion of male doctors who comprise approximately 70 percent of the Queensland rural medical practitioners. Similarly, there is a tendency for the more remote doctors to be younger than those in less isolated areas. This, in part, is because Queensland Health employed doctors tend to be younger and be located in more rural areas where there is a greater need for medical practitioners (Table 3.2).
Table 3.2: Respondents age range grouped by Partner’s employment type and RRMA

<table>
<thead>
<tr>
<th>Respondent age range</th>
<th>Partner’s employment type</th>
<th>RRMA 4</th>
<th>RRMA 5</th>
<th>RRMA 6</th>
<th>RRMA 7</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>Queensland Health employee</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Private practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 - 35</td>
<td>Queensland Health employee</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Private practitioner</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>36 - 50</td>
<td>Queensland Health Employee</td>
<td>4</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Private practitioner</td>
<td>12</td>
<td>25</td>
<td>4</td>
<td>3</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>17</td>
<td>34</td>
<td>6</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>51 and over</td>
<td>Queensland Health employee</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Private practitioner</td>
<td>3</td>
<td>9</td>
<td>4</td>
<td>2</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>3</td>
<td>12</td>
<td>4</td>
<td>3</td>
<td>22</td>
</tr>
</tbody>
</table>

Country of birth
Data indicates that sixty percent (N=68) of the respondents are Australian born. Forty (N=46) were born overseas. The largest proportion of overseas born respondents were from South Africa (13) followed by the United Kingdom (9). It also needs to be acknowledged that the majority of overseas trained spouses are Australian citizens or Permanent Residents and have lived in this country for many years (under 10% of respondents are temporary residents). Table 3.3 provides a breakdown of county of origin. Those without Australian Citizenship comprise only eight percent of respondents. Ten percent of spouses (N=10) reported English as their second language.

Table 3.3: Country of birth

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>13</td>
</tr>
<tr>
<td>UK</td>
<td>9</td>
</tr>
<tr>
<td>NZ</td>
<td>4</td>
</tr>
<tr>
<td>Scotland</td>
<td>3</td>
</tr>
<tr>
<td>Fiji</td>
<td>2</td>
</tr>
<tr>
<td>Ireland</td>
<td>2</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>2</td>
</tr>
<tr>
<td>Bahrain</td>
<td>1</td>
</tr>
<tr>
<td>Burma</td>
<td>1</td>
</tr>
<tr>
<td>Denmark</td>
<td>1</td>
</tr>
<tr>
<td>England</td>
<td>1</td>
</tr>
<tr>
<td>India</td>
<td>1</td>
</tr>
<tr>
<td>India/UK</td>
<td>1</td>
</tr>
<tr>
<td>Italy</td>
<td>1</td>
</tr>
<tr>
<td>Nigeria</td>
<td>1</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>46</td>
</tr>
</tbody>
</table>
Table 3.4 shows the distribution of spouses who are non-Australian born across the rural classifications. Results demonstrate that these respondents are located predominantly in RRMAs four and five.

**Table 3.4: Distribution of Non-Australian born spouses by RRMA**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>RRMA 4 %</th>
<th>RRMA 5 %</th>
<th>RRMA 6 %</th>
<th>RRMA 7 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>64</td>
<td>56</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Other</td>
<td>36 (n=8)</td>
<td>44 (n=23)</td>
<td>25 (n=3)</td>
<td>25 (n=4)</td>
</tr>
<tr>
<td>100% as [N]</td>
<td>[22]</td>
<td>[55]</td>
<td>[12]</td>
<td>[16]</td>
</tr>
</tbody>
</table>

**Previous Urban and/or Rural Background**

Partners were asked whether they had been raised in a rural environment, a metropolitan city or a provincial town. Over forty percent of Australian born, and almost half of overseas born respondents reported living in a rural town until the age of eighteen.

**Table 3.5: Raised in rural environment**

<table>
<thead>
<tr>
<th>Childhood upbringing (18&lt;)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural town</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>Provincial town</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Metropolitan area</td>
<td>46</td>
<td>42</td>
</tr>
<tr>
<td>Where Raised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural Australia</td>
<td>72</td>
<td>66</td>
</tr>
<tr>
<td>Rural Overseas</td>
<td>38</td>
<td>35</td>
</tr>
</tbody>
</table>

The relatively high proportion of respondents with rural origins suggests that this may be an important factor in decisions to take up a rural lifestyle.

**Table 3.6: Comparing sex and age distribution of respondent’s backgrounds, prior to age eighteen.**

<table>
<thead>
<tr>
<th>Childhood background (18&lt;)</th>
<th>Under 25 (%)</th>
<th>26 – 35 (%)</th>
<th>36 – 50 (%)</th>
<th>51 and over (%)</th>
<th>Male (%)</th>
<th>Female (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural area</td>
<td>100</td>
<td>42</td>
<td>36</td>
<td>65</td>
<td>56</td>
<td>38</td>
</tr>
<tr>
<td>Metropolitan area</td>
<td></td>
<td>42</td>
<td>45</td>
<td>26</td>
<td>26</td>
<td>48</td>
</tr>
<tr>
<td>Provincial city</td>
<td></td>
<td>15</td>
<td>19</td>
<td>9</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>100% as [N]</td>
<td>[1]</td>
<td>[19]</td>
<td>[64]</td>
<td>[23]</td>
<td>[27]</td>
<td>[82]</td>
</tr>
</tbody>
</table>

When a comparison is made of the respondents backgrounds in terms of exposure to rural and urban life, it can be seen from Table 3.6 that there were several differences between age and gender categories. Respondents over the age of 51 were more likely to have been raised in rural areas, as were males. Females were more likely to have been raised in metropolitan areas. Few respondents were raised in provincial cities.

When examined by present location, results suggest that previous upbringing has some effect on determining where respondents currently reside (Table 3.7). It is interesting to that
respondents who were raised in provincial centres are more likely to be located in less remote areas.

Table 3.7: A comparison of respondent’s area of upbringing with present location (indicated by RRMA).

<table>
<thead>
<tr>
<th>RRMA</th>
<th>Rural upbringing (%)</th>
<th>Metropolitan upbringing (%)</th>
<th>Provincial upbringing (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>12</td>
<td>21</td>
<td>38</td>
</tr>
<tr>
<td>5</td>
<td>57</td>
<td>50</td>
<td>63</td>
</tr>
<tr>
<td>6</td>
<td>19</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>11</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>100% as [N]</td>
<td>[42]</td>
<td>[44]</td>
<td>[16]</td>
</tr>
</tbody>
</table>

Family Demographics

The results indicated that 91 percent (N=90) of respondents had children and that the total number of children across all respondents was 216. Only nine respondents (9 percent) reported that they did not have children. Table 3.8 provides a breakdown of family demographics (N=205).

Table 3.8: Frequency of children in particular age categories by parent’s age.

<table>
<thead>
<tr>
<th>Child’s age</th>
<th>Under 25</th>
<th>26-35</th>
<th>36-50</th>
<th>51 and over</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5</td>
<td>1</td>
<td>17</td>
<td>23</td>
<td>3</td>
<td>44</td>
</tr>
<tr>
<td>5-10</td>
<td>2</td>
<td>41</td>
<td>0</td>
<td>0</td>
<td>43</td>
</tr>
<tr>
<td>11-15</td>
<td>0</td>
<td>44</td>
<td>1</td>
<td>1</td>
<td>45</td>
</tr>
<tr>
<td>15-20</td>
<td>1</td>
<td>26</td>
<td>7</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td>20 and older</td>
<td>0</td>
<td>19</td>
<td>47</td>
<td>6</td>
<td>66</td>
</tr>
<tr>
<td>Totals</td>
<td>1</td>
<td>20</td>
<td>153</td>
<td>58</td>
<td>232</td>
</tr>
</tbody>
</table>

Education and Qualifications

The majority of respondents held either a university or college degree (71 percent) or technical or trade certificate (13 percent). Ten percent of spouses had a secondary education up to grade twelve (or equivalent). Those with university degrees had qualifications ranging from bachelors degree through to Masters degree, with areas of speciality including, arts, medicine (including allied health qualifications), and law. It should be noted that some spouses reported more than one professional qualification. Table 3.9 provides a description of some of the qualifications listed:
Table 3.9: Educational Qualifications

<table>
<thead>
<tr>
<th>Qualifications included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Graduate Diploma (x2)</td>
</tr>
<tr>
<td>Diploma of Naturopathy, Post-Graduate Medical Herbalism, Bach of Arts (General Studies)</td>
</tr>
<tr>
<td>Master's Degree</td>
</tr>
<tr>
<td>Masters Degree</td>
</tr>
<tr>
<td>MBBS, FRACGP, FACRRM</td>
</tr>
<tr>
<td>MSCE, Cert in workplace training; Cert practice manager</td>
</tr>
<tr>
<td>Post-graduate Diploma, Masters</td>
</tr>
<tr>
<td>Postgraduate qualifications</td>
</tr>
<tr>
<td>Reg nurse, reg Midwife, Degree in Health Science; Grad Dip in Management, endorsed Immunisation RN</td>
</tr>
<tr>
<td>Registered nurse (x2)</td>
</tr>
<tr>
<td>SRN, SCM (UK)</td>
</tr>
<tr>
<td>Royal Nurse (x2)</td>
</tr>
<tr>
<td>SR nursing</td>
</tr>
<tr>
<td>South African Pharmacist</td>
</tr>
</tbody>
</table>

Although a relatively high number of respondents reported holding medical or allied health qualifications (including nursing degrees/diplomas), (21), only a small proportion of spouses (less than 3 percent) reported having qualifications pertaining to business management, practice management or secretarial work. This is in direct contrast to the proportion of respondents who listed practice manager, bookkeeping or practice receptionist as their full, or part-time occupation (refer to Table 3.10).

**Occupations**

Table 3.10 shows a breakdown of respondent’s present occupations. Responses show that over half of the respondents (52 percent) are employed in either health or allied health occupations, with almost one third of respondents working as either practice managers or practice nurses in the same clinic as their spouse.

Table 3.10: Present Occupation (N = 97)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Proportion (N=114)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Manager/nurse</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>Allied health</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Medical Practitioner</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Teaching</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Self-Employed</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other professional (law, accountant)</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Secretarial/Trade</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Farming</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Manager</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Home maker</td>
<td>16</td>
<td>13</td>
</tr>
</tbody>
</table>
Responses from spouses concerning their hours of work indicate that the majority of male spouses (65 percent) are employed on a full time basis, as opposed to only 35 percent of female respondents. This table also demonstrates that approximately seventy percent of males and sixty percent of females are working in employment that is consistent with their level of education and training. It is interesting to note that when examined by age and RRMA, almost half (47 percent) of respondents over the age of 51 are working in areas outside their area of training as opposed to approximately 35% of those in younger categories. Similarly, spouses residing in RRMA five and six are also more likely to be working in areas that are consistent with their training. One possible reason for the difference across age category is that several of the retired respondents were working as practice manager or in some other capacity in the surgery of their spouse, for either little or no salary. In addition, as several of the older respondents commented:

“It was often expected that we, as females, give up our careers to follow our husbands, it didn’t matter what you trained to do, once you were married, that was that.”

Table 3.11: Comparison of male and females working either full or part-time.

<table>
<thead>
<tr>
<th></th>
<th>Full Time</th>
<th>Part-Time</th>
<th>Employment consistent with training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>17 (68%)</td>
<td>8 (32%)</td>
<td>18 (69%)</td>
</tr>
<tr>
<td>Female</td>
<td>27 (37%)</td>
<td>47 (64%)</td>
<td>46 (62%)</td>
</tr>
</tbody>
</table>

The results of this research echo those of earlier studies examining the occupation and education of spouses of rural medical practitioners. Of those respondents who reported “Practice Manager” as their primary employment, 65 percent also stated this occupation was not in keeping with their educational training. While the majority of these respondents were trained nurses, other occupations included occupational therapists, scientists, and dietician. As Wise et al, has suggested (and was confirmed by interview participants), this indicates that training for this position appears to be predominantly on-the-job. Several participants commented, that the position of practice manager tends to be taken by necessity rather than choice. These results also support the anecdotal evidence that the medical practice is the most likely place for a spouse to be employed as managers, or in some cases receptionists. Interestingly, spouses working as either practice nurses, managers or receptionists are also more likely to be working on a part-time basis.

Social interaction and hobbies
Spouses were asked to comment on the types of hobbies and activities they were involved in outside of work, seventy-five percent of spouses reported that they were involved in some form of organised recreational activity. Some differences in participation rates for respondents of different age, sex, and RRMA, but these were not statistically significant. The high proportion of respondents involved in organised activities suggests that such activities are seen as an extremely important method of socialisation. This conclusion is supported by participant’s comments.

- We very involved with Lions and Rotary. School groups when the children were younger. It’s very important that you are seen to care about the community.
- It’s critical that you are involved in clubs/sporting activities. It’s the bottom line when you move to a country town.

---

3 For examples see Wise et al, 1996
• If you have young children it’s really good, at these playgroup outings, you meet lots of friends.

The types of hobbies and activities that respondents are involved in are listed in Table 3.12.

Table 3.12: Involvement in organised social activities and hobbies, ranked in order of prominence (not all respondents responded to this question, many indicated several choices)

<table>
<thead>
<tr>
<th>Organised Activities</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional bodies</td>
<td>21</td>
</tr>
<tr>
<td>Religion/Church</td>
<td>18</td>
</tr>
<tr>
<td>Educational</td>
<td>1</td>
</tr>
<tr>
<td><strong>Hobbies</strong></td>
<td></td>
</tr>
<tr>
<td>Sport</td>
<td>50</td>
</tr>
<tr>
<td>Children’s school activities</td>
<td>25</td>
</tr>
<tr>
<td>Craft</td>
<td>15</td>
</tr>
<tr>
<td>Social clubs (such as book clubs)</td>
<td>10</td>
</tr>
<tr>
<td>Music/dancing</td>
<td>5</td>
</tr>
<tr>
<td>Gardening</td>
<td>5</td>
</tr>
<tr>
<td>Farming</td>
<td>3</td>
</tr>
</tbody>
</table>

In terms of organised activities, membership in professional bodies such as Rotary Clubs, Lion Clubs, Meals on Wheels and local government was the most popular. Membership within the local church was also noted as being of particular importance for many spouses. The latter was reported to be particularly comforting in times of stress (see Table 3.13). Participation in church activities included bible study, lay preaching and fund-raising.

• I am involved with bible class, which we established here. My husband also teaches in the local church occasionally. The Bible-Study groups a very important part of our lives and relationship with the community.

Taking part in sport was the most popular hobby reported. Activities included, tennis and walking, local football clubs, and shooting. Several respondents noted being part of walking groups, which provided social contact as well as exercise. Being involved in children’s school activities, including sporting days, fund-raising and playgroups, was a popular activity for many respondents. Craft groups were also discussed as being important for social interaction.

When asked who provided the major supports in their lives, respondent’s answers varied. The majority, however, nominated their partner or spouse as their main confidant, (Table 3.13), (respondents could nominate more than one option, so percentage does not equal 100%).

Table 3.13: Major supports (%)

<table>
<thead>
<tr>
<th>Family</th>
<th>Friends</th>
<th>Spouse/partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>43</td>
<td>78</td>
</tr>
<tr>
<td>N=23</td>
<td>N=38</td>
<td>N=69</td>
</tr>
</tbody>
</table>
Table 3.14: A comparison of choice of supports between male and female respondents (%)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Family</th>
<th>Friends</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>30</td>
<td>35</td>
<td>74</td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>53</td>
<td>76</td>
</tr>
</tbody>
</table>

Other supports listed included, workmates (1), church (5), sporting groups (2). Several respondents commented that they had made very few friends, but these friendships were long lasting. Several spouses also commented that they relied heavily on contact with family members living in other areas (including interstate) such contact was usually made by telephone. One respondent commented that it was his role to provide support to others, and relied on “self-support” only.

No respondents mentioned community organisations or the Queensland Rural Medical Family Network as areas of support.

Friendship and Social interaction with others:
Respondents were asked to comment on whether they had close friends or confidants within the communities they were living in. Approximately three quarters (N=83) indicated that that they did. When examined by individual characteristics, however, several trends were noted. Of particular interest, is that almost forty percent of respondents who were non-Australian born reported that they had no friends or confidents. When compared against other characteristics, this was the only statistically significant result (p< 0.05). One participant described how difficult it was to form friendships in the town they are living:

- I have not been able to make friends here, I have tried, the people are not bad, and they just don’t want to make friendship with us. My husband has found it very difficult also.

One third of males, and over forty percent of respondents residing in RRMA 7 locations, also reported having no friends or confidents in the communities in which they lived (these differences were not statistically significant). The presence or absence of children may also make a difference to whether or not a respondent was able to form friendships, with half (5), of those who did not have children reporting no close friends or confidents. Given the number of participants who reported being involved in children’s activities (such as playgroups, schools, and sporting events) this result is not surprising. Anecdotal evidence and respondent comments also indicated that having children resulted in constant involvement with other people in the community, and that the rural community was generally more supportive of families with children. As one respondent who did not have children commented:

- Children are very important to people in the community, you are expected to have children, and if you don’t, people feel that it is their place and right to ask you why, or when are you going to have children. This is can be very upsetting. You are much more accepted here if you have kids at the local playgroup.

Results from Table 3.16 suggest that the presence/absence of close friends/confidents has some relationship with respondents overall level of satisfaction. Those who report having close friends are more likely to be either happy or very happy, as opposed to those who do not have strong friendships, who are consistently more likely to be unhappy.
Table 3.15: Presence of close friends or confidents by personal characteristics (%)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Born</td>
<td>83</td>
<td>17</td>
</tr>
<tr>
<td>Non-Australian</td>
<td>63</td>
<td>38</td>
</tr>
<tr>
<td>Male</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>Female</td>
<td>79</td>
<td>20</td>
</tr>
<tr>
<td>RRMA4</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td>RRMA5</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>RRMA6</td>
<td>82</td>
<td>18</td>
</tr>
<tr>
<td>RRMA7</td>
<td>58</td>
<td>42</td>
</tr>
<tr>
<td>26 – 35</td>
<td>59</td>
<td>41</td>
</tr>
<tr>
<td>36 – 50</td>
<td>82</td>
<td>17</td>
</tr>
<tr>
<td>51 and over</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>Have Children</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td>No Children</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Table 3.16: Comparison between Australian born and non-Australian born respondents, levels of overall satisfaction with rural life, and presence and absence of close friends (%).

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>Close friends or confidents</th>
<th>Very happy/happy (%)</th>
<th>Neutral/unhappy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia born</td>
<td>Yes</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Non-Australian born</td>
<td>Yes</td>
<td>85</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>42</td>
<td>58</td>
</tr>
</tbody>
</table>

Table 3.17 shows the types of places where respondents have met and formed close friendships. Clubs, places of work and school activities are reported as commonly being places where social contacts are formed.

Table 3.17: Places where close friends socialise

<table>
<thead>
<tr>
<th>Meeting place</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through clubs or orgs</td>
<td>34</td>
</tr>
<tr>
<td>Through my work</td>
<td>33</td>
</tr>
<tr>
<td>Through school activities</td>
<td>30</td>
</tr>
<tr>
<td>Through my spouse's work</td>
<td>28</td>
</tr>
<tr>
<td>Through church or religion</td>
<td>14</td>
</tr>
</tbody>
</table>

* respondents could choose more than one option, there % does not equal 100.

Other places included:
- Neighbours and children’s friends
- Internet
- Local farmers
- Needlework classes
• Neighbours
• Playgroup
• Socially, mother's group
• Tennis group
• Tennis, invited people myself

It is interesting to note, that nowhere in this section is the QRMFN mentioned, either as a place where friendships have been formed, or as a regular place of networking with people.

Respondents were then asked to comment on how often they met with friends for social contact, and where such interactions took place. Results from respondents indicate that the majority (70%) meet with friends at least once per fortnight, with sixty percent of these meeting with friends at least once per week. Although there was little difference in frequency of social meeting when responses were examined by age or gender, some difference was evident when they were examined by area of remoteness. Approximately two thirds of respondents residing in RRMA 6 and 7 locations met with friends less than once per fortnight.

Table 3.18: Interaction with friends by RRMA (%)

<table>
<thead>
<tr>
<th>RRMA</th>
<th>% within RRMA</th>
<th>Once per week</th>
<th>More than once per week</th>
<th>Once per fortnight</th>
<th>Less than once per fortnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRMA 4</td>
<td></td>
<td>39</td>
<td>50</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>RRMA 5</td>
<td></td>
<td>37</td>
<td>29</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>RRMA 6</td>
<td></td>
<td>67</td>
<td>22</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>RRMA 7</td>
<td></td>
<td>11</td>
<td>22</td>
<td>33</td>
<td>33</td>
</tr>
</tbody>
</table>

Slightly over half of respondents reported that when they do meet with friends it is most likely to be either in their own home (51 percent) or in the home of their friends (49 percent). Only 16 percent of respondents reported meeting in restaurants of coffee shops. Thirty-eight percent of respondents reported meeting in both their own homes or friends homes. Other places identified as social contact points included:

• At clubs for a coffee (4)
• Church or bible study (4)
• At sports (3)
• At various activities associated with children (3)
• At work (3)
• In nearest town

• In past - not enough friends to ask to a dinner party
• Morning walks - difficult to entertain in you own home when partner likely to be called out at anytime - we leave town on 'days off'
• On holidays away
• Over the phone (3)
• We visit with them out of town
The results of this section demonstrate the importance of social interaction to the overall satisfaction of spouses with life in remote areas. Sports, clubs and organisations and the community church are important places where spouses meet friends, as well as providing places to gather. These results also suggest that meeting either in their own homes, or friends’ homes, provides important social interaction. The fact that very few respondents choose to meet friends in restaurants of coffee shops may be indicative of a lack of facilities in such towns. It is important to note that degree of remoteness seems to play a role in how often people are meeting with friends, with those in more remote areas (RRMA 7) not socialising as often as those in less remote areas. Slightly over half of the respondents choose to socialise mainly in their own homes, as comments from several participants indicate, this is likely to be because of the unpredictable nature of the time doctors get to spend away from the practice or hospital. Often doctor-spouses are called away from social engagements to attend medical emergencies, therefore it is often the spouses choice to remain close to their own homes. Likewise often friends of respondents are reluctant to invite them out to dinner, in the likelihood that the doctor-spouse will be called away (this is often bore out of experience).

A further concern for the Medical Family Network may also be the number of spouses who either have no social connections, or who choose to predominantly contact friends and/or family by the telephone. This may lead to an increase in feelings of social isolation and have ramifications on how long they are likely to remain in rural areas. This is especially likely to be the case with spouses of overseas trained doctors, who are less likely to have close friends in the areas that they are living.

**Expectations prior to moving to current location, social orientation and early support networks**

Several studies have previously demonstrated how important suitable preparation for life in rural areas can be as a factor contributing to the longer stay in the country (Wise et al, 1996). The current research sought the experiences and views of spouses about their early preparations and about their expectations of rural life, prior to their relocation. This information was complimented by a series of questions relating to the levels of support that spouses received from both their partner’s employers, and from the local community upon their arrival. The results of this section demonstrate how important it is that partners of medical practitioners are suitably prepared, prior to their resettlement into rural areas. Spouses were firstly asked to identify why they made the decision to move to a rural area. Responses were examined by gender, age and ethnicity. As Table 3.19 demonstrates, almost half of respondents reported that the primary reason for their move to the rural location was because of their doctor-spouse’s employment. Only thirteen percent of respondents chose a move to a rural location as their own personal choice, despite the fact that almost 45 percent of respondents had grown up in a rural location (only 3 percent of whom, chose this reason specifically).
Table 3.19: Reasons for moving to a rural location.

<table>
<thead>
<tr>
<th>Reason for moving</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/partners employment</td>
<td>57</td>
<td>50</td>
</tr>
<tr>
<td>Spouse bonded to a rural area</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Personal choice</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>My employment</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>For rural lifestyle</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Raised in rural area</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>113</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

When examined by gender, only three percent of female spouses relocated because of their own employment, and opposed to 28 percent of male respondents. Fourteen percent of females (as opposed to only 11 percent of males) chose “Personal Choice” as their reason for relocation. Interestingly, when compared by age, respondents in the younger age category (26-35) had a slightly greater chance of moving to a rural area because of their own reasons/employment than those in older age categories. This may be because fewer expectations are placed on them to follow their husband’s career path (as has previously been suggested by respondents). When asked if they had a choice in areas to move too, three quarters of respondents reported that they did have, and a decision to move to a rural area was made by both parties. There were no significant differences in choice, when examined by age or gender, however, over one third (35 percent) of respondents who were non-Australian born reported having no choice in the decision to move to a country area.

Typical comments on the decision to move to a rural area included the following:

- The area had to be rural, but I had a say in location
- Limited choice - given a list of 38 places and numbered them from 1 to 38 - area needed a speech pathologist for 12 hrs/week so we got first preference as I was a speech pathologist
- It was a family decision
- My husband took up private practice in his home town
- My husband chose this area to be his own boss (solo practice) and to stimulate his medical brain - so children and I just followed
- We came from overseas, where we lived in a small town, and preferred to remain in a small place in Australia
- We may have had, but we were offered a job here, out of the blue, so we didn't look further
- Came as locums to view area and job
- A position came up here - my husband's home town so we jumped at this once in a lifetime chance to be close to extended family
- My wife (the Dr) moved to [town name removed] when we married I have my own business in town
- My husband had joined practice before we married
- We discussed and made a mutual agreement to stay here after we began our relationship here
- My spouse wanted to return to his home town to start working at his father's practice as his father was retiring
- An initial teacher appointment and we decided to stay
- Husband was not bonded student - wanted to be a rural doctor - I just didn't realise how long we'd be here
These comments indicate that individuals choose to move to rural areas for a number of reasons, and for the most part, it is a decision that is made by both partners. For the participants who have no rural background, or even for those who may have, whether they have realistic expectations of what life will be like as the partner of a rural doctor, can have an effect on the type of experience they will have in these remote areas. This may particularly be apparent for spouses who have expectations pertaining to their own career paths.

**Expectations prior to relocation**

As part of the research process, spouses were asked to comment on they types of expectations they had about living in rural areas prior to their relocation to the country. They were then asked to comment on whether they believed these expectations were met, not met, or exceeded.

The kinds of expectations and perceptions that spouses held centered around five main themes. The most commonly held expectation centered on the perception of a ‘relaxed rural lifestyle’. Typical comments included:

- I wanted to have this simple life after 39 years in the concrete jungle
- I was looking forward to raising children in a rural environment
- A less hectic pace than in the city.
- I expected a relaxed lifestyle (no traffic lights) and community living

**Employment:** Comments from respondents regarding their own employment suggested that while some had the realistic expectation that finding employment could be difficult, others believed that they would have little trouble continuing their careers in their new environment.

- Employment is mainly in rural type of work, i.e. not for white-collar workers
- I had a reasonably realistic outlook regarding work. I expected it would be difficult to find a suitable job.
- I expected friendliness, a full time career and government housing.
- We tried to keep our ‘non-work’ expectations to a minimum to avoid disappointment.
- I thought I would eventually obtain employment in my chosen career but due to lack of job placements in this area this proved impossible - if a position became vacant now I would not be an acceptable candidate as it is now 23 yrs since I worked

**Housing:** Several respondents were under the impression that suitable housing would be provided by either Queensland Health, or by the local employer often this was proven not be the case. This result in particular demonstrates a lack of communication between employer and employee. Other spouses were not prepared for the poor level of housing that was sometimes offered or available. Others were aware of the problems concerning housing.

- Rural areas are sometimes limited in their accommodation, so I was prepared for this.
- I expected a house away from the surgery, as privacy was important.
- I expected to have proper housing and schooling, and to get away when needed.
- I was told that my employer would provide a home rent-free for us. This was not the case.
- I thought housing would be better, and less expensive.
• Spouses working hours: Several respondents commented that they expected the move to a rural area would hopefully mean reduced working hours for their doctor-spouses, and a more relaxed pace of life for the doctors. Other spouses seemed more prepared for the long hours their partners would be working.
• I was expecting the long hours that my husband would need to work.
• I was expecting long hours and a quiet lifestyle.
• Spouse working long hours, holidays having to be planned well in advance.
• We expected to be working long hours, and have difficulty getting locums.
• Didn’t imagine hours would be as long for spouse, I imagined I would work and contribute to the surgery; and I have.
• I expected more control over working hours for my spouse and opportunities for employment for me.
• I thought we would be working fewer hours than in the city practice we left. I was wrong.

Schooling: As with employment and housing, respondent’s expectations concerning schools for their children varied, with some respondents expecting to have difficulties finding suitable local schools, and other not anticipating any such problems.
• I expected to have a good school nearby, and some recreation around.
• I expected to be here around 5 years-now 20 years. I did not want my kids to have to go to boarding school however my son loved it.
• I expected a good, friendly school.

Comments from those who had previously lived in rural areas indicated that they were well prepared for life in a small town.
• Previous experiences provided me with expectations/perceptions that were met.
• I had lived in the same town when younger, so knew what to expect.
• I was raised in a rural area, so was prepared for what to expect. I was shocked by the long hours my husband was working.
• I knew what to expect of lifestyle, as I had experienced a rural life before moving here.

Respondents with no previous rural background, were less prepared, as these comments suggest:
• No, I just went. I was newly married and so had no choice.
• No. I didn’t know what to expect, it was all very new for me.
• I had very little expectations, not only were we moving to a rural area, but we were also moving country.
• I had no real concept of what a rural medical lifestyle would be.

Despite some inconsistencies, the majority of respondents (80 percent) reported that their expectations of rural life were either met, or exceeded. Results suggest, however, that there are some identifiable trends present in those spouses who reported that their expectations were not met. As demonstrated in Table 3.20, spouses who were raised predominantly in metropolitan cities up till age 18 were more likely to report expectations not being met. This result may be due to perceived ideas of country life not meeting the reality, or that they may not have been provided with correct or accurate information prior to their relocating. Those with previous rural experiences were more likely to have an accurate perception of rural life.
Table 3.20: Comparison of previous rural experience and expectations prior to relocation.

<table>
<thead>
<tr>
<th>Location</th>
<th>Met</th>
<th>Not met</th>
<th>Exceeded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural area</td>
<td>74</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Metropolitan area</td>
<td>56</td>
<td>36</td>
<td>8</td>
</tr>
<tr>
<td>Provincial city</td>
<td>73</td>
<td>9</td>
<td>18</td>
</tr>
</tbody>
</table>

Respondents, who were employed in positions not consistent with their educational training, were also more likely to feel their expectations were not met (p<0.05), as Table 3.21 indicates. Only a small proportion (6 percent) of spouses employed in areas consistent with their training felt that their expectations prior to moving had not been met.

Table 3.21: A comparison of the percentage of respondents who are employed in positions consistent with their training, and their expectations prior to relocation

<table>
<thead>
<tr>
<th>Employment consistent with training</th>
<th>Expectations met (%)</th>
<th>Expectations not met (%)</th>
<th>Expectations exceeded (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>78</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>No</td>
<td>54</td>
<td>39</td>
<td>7</td>
</tr>
</tbody>
</table>

Respondents reported a number of aspects of life in the rural environment that they were either not prepared for, or that failed to meet their expectations. Predominantly, these included, the long working hours of their doctor-spouses, the absence of the housing they were promised by employers, the perceived poor quality of schools in the vicinity, a lack of privacy and anonymity, and the extent of community expectations. Several respondents also commented that they were not prepared for the lack of facilities and/or entertainment in some rural areas. Comments from respondents included:

- Accommodation is not adequate for families.
- Accommodation of Queensland Health is sometimes not up to standard - to rent is difficult and to buy a house is very risky because it might not sell easily.
- There is the expectation that my spouse will work long hours, often without a break. This took us by surprise.
- It is very hard to get locums to relieve or to stay. As well the cost involved far outweighs the relief - it actually adds to stress load.
- Life became a fishbowl existence - anonymity was impossible.
- Schools were not up to the standard we wished for and had to send them away.
- Locums for off weekend and holidays are non-existent and caused long stretches of no leave or no-income holidays.
- Sometimes this was frustrating as I felt as though I needed to fit into a box that fitted community expectations that did not allow for my individuality.
- Spouse worked more hours than expected.

Fishbein’s expectancy value model predicts that behaviour, behavioural intention, and attitudes are a function of the belief that an object possesses a particular set of attributes or that particular behaviours will have particular consequences. It is likely that those spouses who had their expectations met, regardless if these expectations were positive or negative (such as the expectation that the doctor would have to work long hours, or that there would be little privacy) would be less affected by the stresses of life in remote areas, than those who
had unrealistic expectations, or whose expectations had not been met. The results of this research support this conclusion, at least in part.

Table 3.22 demonstrates that respondents whose expectations were met were more likely to be either satisfied or very satisfied with life in a rural area. Alternatively, those who reported that their expectations had not been met were more likely to view their present situation as either unhappy, or very unhappy (p< 0.05).

### Table 3.22: A comparison between respondents’ expectations and overall level of happiness

<table>
<thead>
<tr>
<th></th>
<th>Met</th>
<th>Not met</th>
<th>Exceeded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very happy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Within how happy are you</td>
<td>80</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>% Within were expectations</td>
<td>50</td>
<td>7</td>
<td>56</td>
</tr>
<tr>
<td><strong>Happy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Within how happy are you</td>
<td>69</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>% Within were expectations</td>
<td>38</td>
<td>29</td>
<td>44</td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Within how happy are you</td>
<td>60</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>% Within were expectations</td>
<td>13</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td><strong>Unhappy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Within how happy are you</td>
<td>0</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>% Within were expectations</td>
<td>0</td>
<td>29</td>
<td>0</td>
</tr>
<tr>
<td><strong>Very unhappy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Within how happy are you</td>
<td>0</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>% Within were expectations</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>

Although it is not possible to attribute overall levels of satisfaction solely to previous expectations, the fact that the above are significant differences suggests that there is some relationship between these two factors. This theory is supported by respondent’s comments concerning job and lifestyle expectations in particular. One way of aiding in reducing false expectations in particular is to ensure that information provided to individuals (both to the doctor and their partner) prior to their undertaking rural placements is relevant, practical, and up-to-date. As Table 3.23 demonstrates, this is not always the case.

### Table 3.23: Accuracy of information given to respondents at time of relocation (by number of respondents)

<table>
<thead>
<tr>
<th></th>
<th>Department of Immigration Practice</th>
<th>ACRRM</th>
<th>AMAQ</th>
<th>RACGP</th>
<th>Rural Division HIC</th>
<th>RDAQ</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very Helpful</strong></td>
<td>2 2 1 2 1 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Helpful</strong></td>
<td>3 3 3 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neutral</strong></td>
<td>1 4 3 1 2 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Not Very Helpful</strong></td>
<td>1 5 3 1 4 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Useless</strong></td>
<td>6 4 1 2 2 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Respondent’s comments concerning the information received included:

- We did not receive any information from anybody (15 respondents)
- Such organisations did not exist at the time we moved here (12 respondents)
- In those days (22 years ago) there was no information given to spouse directly - not even address of house
- QRMSA excellent, the Department of Immigration was most difficult to get information and almost impossible to speak to someone on the phone
- AMAQ gave wrong information and also HIC
- Very little or no help from anyone else
- HIC would need to get their act together - we constantly receive conflicting information from their staff.
- In 1980 when we moved to [name removed] we received no info at all!! - We had no idea what to expect.
- My partner moved a year later so I'm uncertain how he found these - some tension over getting QH to initially pay upfront for the transfer
- My wife is British - we had major problem with provider number
- No info - moved 'blind' to 1st Australian job (none offered by DIMIA) - once here AMAQ was helpful, SQRDGP employer were most helpful
- No support received even though move was while a registrar
- No organisations consulted (4)
- These organisations were not very helpful
- The only information we had we sourced ourselves
- We didn't get information from any organisation, just friends

These results indicate that for the most part, information given to spouses prior to their move to rural areas is viewed as reasonably unhelpful; there are however some exceptions. QRMSA, RDAQ, and RACGP, were frequently perceived as organisations that provided accurate, helpful information. An additional concern was that several respondents commented that they received no information from these organisations, despite repeated requests. Of note is that no respondent of recent years mentioned the QRMFN as providing any form of information prior to his or her move to a rural area. This may be an area that can be investigated by the Network in future planning.

Early supports and orientations

Research has indicated the importance of having suitable systems of support in place for new arrivals into country towns (Hoyal, 1995; Roach, 2002; Wise et al, 1996). Doctors and their families often find themselves in new environments where they have very little knowledge of the local area, people, or customs. This is particularly evident for Overseas Trained Doctors and their families. Often how they are received in this early stage can have a major effect of their overall experiences in the rural areas. In many cases, doctors and their families are initially heavily reliant on their new employer for orientation into this new environment. Comments for respondents suggest while the new doctor is often orientated to their new place of work, often the spouses and families are left to find their way on their own.

Respondent’s reports indicated that slightly over one third (34 percent) of spouses had any form of initial support from their partner’s employer. While employers are under no obligation to provide this support, often the medical practice or hospital is the first point of social contact (especially for the new doctor). This result indicates that it is often up to the spouses themselves to form their own social contacts, and this can be a difficult and at times
stressful task, particularly if the spouse is not working during this period. Interestingly, while forty-one-percent of female spouses did report receiving initial support from their spouses employer, only seventeen percent of male spouses reported that they did. Comparisons between Australian born and non-Australian respondents suggested only slightly higher levels of support for Australian born respondents (41 percent and 31 percent respectively).

The results indicate that despite moving to a new area, often one that is completely foreign to previous experiences, a relatively high percentage of spouses are left to form their own social connections for themselves, and their families. As previous results have demonstrated, respondents often rely on contacts through their own employment (if they are working), schools (if they have children), or clubs and organisations to develop these connections. As male spouses in particular receive little social support from their partner’s place of work, these other forms of contact become extremely important.

Approximately eighty percent of respondents indicated that the local community had an important role in their settlement into the new community. When examined by personal characteristics such as age, gender, ethnicity and presence of children, results suggest these attributes had little effect on community involvement. Of those respondents who reported very little involvement with their local community, 76 percent were located in agricultural communities, 17 percent were from industrial communities, and approximately 6 percent were from predominantly indigenous communities. This result is likely to be explained, however, by the large proportion of respondents who were residing in agricultural areas (87 percent of all respondents).

Overall, these results demonstrate that the majority of spouses feel supported and encouraged by members of the local community, and, in part, by their spouse’s employer. There were however, a very small proportion (N=11, (ten percent),) of respondents who reported receiving no support from employers, or any aid from community members. When examined by demographics and personal characteristics, no significant similarities between these respondents were discernable except they all resided in agricultural communities in RRMA 5.

Respondents were asked to comment on whether or not they and their families underwent any pre-move preparations (such as investigating schools, employment options or housing conditions) prior to moving to their new location. Approximately 70 percent of respondents reported that they made no such preparation, and went into this situation “completely blind”. Of those respondents who did undertake some form of pre-move preparation, the majority (87 percent) were female.

The following table presents the types of pre-move preparation undertaken by these respondents:

<table>
<thead>
<tr>
<th>Pre move preparation</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Came from a previous rural area so knew what to prepare for</td>
<td>13</td>
</tr>
<tr>
<td>Visited town prior to relocating permanently, investigated job, schools and housing first</td>
<td>10</td>
</tr>
<tr>
<td>Spoke to other rural doctors and families</td>
<td>2</td>
</tr>
<tr>
<td>Partner came first as a locum</td>
<td>2</td>
</tr>
</tbody>
</table>
Comments from respondents regarding the types of preparation included:
- Brought hobbies and decided to take up bridge again
- Completed my diploma in piano teaching, so to have employment appropriate to the country and the family we were about to start
- Did a locum for 3 months prior to moving here. Came from a rural area
- Did pre-reg, locums in rural areas previously
- Enquired about employment opportunities and many visits to the area
- Investigated the curriculum at the high school, spent some time looking for a house that suited everybody's needs
- Looked at schools available and recreational opportunities

Although a number of spouses (11) commented that they had previously worked in a rural town prior to their present location, respondents from metropolitan or provincial centres were slightly more likely to have undertaken some form of pre-move preparation than those with rural backgrounds as would be expected, given their unfamiliarity with the rural environment).

Table 3.25: Percentage of respondents from each background who reported undertaking pre-move preparation.

<table>
<thead>
<tr>
<th>Area raised (≤18)</th>
<th>Yes (n=10)</th>
<th>No (n=33)</th>
<th>NA (n=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural area</td>
<td>22 (n=10)</td>
<td>64 (n=30)</td>
<td>17 (n=8)</td>
</tr>
<tr>
<td>Metropolitan area</td>
<td>30 (n=5)</td>
<td>70 (n=12)</td>
<td></td>
</tr>
<tr>
<td>Provincial city</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is interesting to note there whether or not respondents made any pre-move preparations made little impact on either overall happiness ratings, or whether expectations were met or not. This result suggests that the factors that determine the overall happiness and satisfaction of spouses are issues that tend to be longer-term lifestyle factors rather than immediate environmental ones. As such, social factors such as community interaction, and social isolation (which are difficult to prepare for) have just as large an impact on overall satisfaction as do the more physical issues such as housing and employment.
Settlement of children and educational issues

Table 3.26 provides a description of the family profiles and the type of schools respondent’s children are currently attending. The “Not applicable” category applies to those who are either too young to attend any form of schooling, or have left school.

Table 3.26: Family size and schooling

<table>
<thead>
<tr>
<th>Number of children per family</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>&gt;3</td>
<td>36</td>
</tr>
<tr>
<td>100% as [N]</td>
<td>[113]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of families with children of*</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
</tr>
<tr>
<td>6-10 years</td>
</tr>
<tr>
<td>11-15 years</td>
</tr>
<tr>
<td>16-20 years</td>
</tr>
<tr>
<td>&gt;20 years</td>
</tr>
<tr>
<td>100% [N]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of families with children in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local school</td>
</tr>
<tr>
<td>Boarding school</td>
</tr>
<tr>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

* Since respondent could nominate more than one category in this set of data, the percentages do not total 100%.

Spouses were asked to comment on their levels of satisfaction with the schools that their children attended, slightly over half (52 percent) of respondents with children reported that they were either satisfied, or very satisfied with the schools in their area. Only 12 percent of respondents reported being dissatisfied with local schools. Of note is that several respondents (44 percent) residing in RRMA 7 locations reported a rating of neutral, or were dissatisfied with local schools. This result must be viewed with caution, however, since actual respondent numbers were very small, and therefore not necessarily indicative of schools in this area.
Table 3.27: A comparison of numbers of families in each RRMA and choice of school for their children.

<table>
<thead>
<tr>
<th>RRMA</th>
<th>RRMA 4</th>
<th>RRMA 5</th>
<th>RRMA 6</th>
<th>RRMA 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boarding school</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Local School</td>
<td>15</td>
<td>27</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>34</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Decisions concerning choice of schools

When asked to comment on the factors that influenced decisions about their children’s schooling, only six respondents commented that they believed the cost of schooling was the major factor in deciding between local schools and boarding schools. This was of particular concern for respondents with several children. As this comment indicates:

- Boarding school is too expensive to consider, especially when we have three children to send through college.

For several respondents (six of the 23 that supplied comments), not wanting to “send their children” away was reported to be an important factor in the decision to educate the children locally. Only one respondent commented that they had no choice, and that their local school went to year ten only, therefore boarding school was their only alternative. One respondent also commented that they did not wish their children to be perceived to “be above local schooling” and therefore choose to send their children to schools in the area.

Several spouses did comment that their children had received some “gentle jibing” for being the children of the local doctor. For the majority of respondents, this did not deter them from sending them locally. For one respondent, bullying and continual “peer pressure” from local school kids did result in the decision to remove the children, and send them to boarding school.

- They are now at school in Brisbane. They had a very hard time at the local high school, so we sent them to boarding school. There was a lot of bullying, and peer group pressure from the local Aboriginal community. Other kids picked on them for being the doctor’s children.

Only two respondents commented that they believed the standard of education in local community high schools was not up to standard or that their children would be disadvantaged in some way if they did not attend boarding school.

- My children wanted to do agricultural science and vet science at university, we both felt that they would not have achieved better results if they stayed at local school, so they went to boarding school in the city. We decided we would pay what we had to so they would have a good education.

- Schooling was very difficult. Organising ourselves during primary school years was extremely stressful, the long hours, we had some one who could step in the breach for us, but it was very difficult dropping kids off at school, picking them up and so on, addressing issues of visiting the school, or taking part in things at the school. The oldest now goes to boarding school, and the youngest will follow,
but it was very difficult during the younger years. A choice of schooling is limited in a small town.

Despite these responses, respondent’s comments combined with their satisfactions ratings suggest that they are reasonably satisfied with access to, and the standard of local community schools. However, as the previous section discusses, there are instances when given the decision between sending a child away to university or remaining in the rural environment, several families have opted to leave the rural practice to be closer to suitable universities for their children.

**Socialisation of children:**
To assess levels of socialisation and happiness of children, respondents were asked to comment of whether their children had formed close friendships since arriving in their new environment. Five respondents reported that their children were unable to form friendships since arriving in a country town. One of these (previously discussed) was reported to have had difficulties with the local children, a further child was at boarding school in Brisbane, and two respondents gave no further information. The remaining respondents indicated that their children were happy in their present schools. Several of spouses the also indicated that they were very impressed with the facilities of local schools and the extra-curricular activities the schools provided for their children.

- They (the children) are involved in lots of outside activities, with the school, it depends on the child as to what they want to do but the schools are always accommodating. It’s really important that the children are involved in either sports or other activities as it helps them make friends.

An issue that was raised by several Non-Australian born respondents was the fact that because their spouses were contracted to work in areas of need, often this meant relocating into several different areas over a short periods of time. This constant upheaval was particularly difficult for the schooling of young children. Although the majority of non-Australian born spouses reported no difficulty adjusting to life in Australia, several did report that their children had difficulties settling in to school life and making friends. As these comments indicate:

- We were already settled in [name removed], but then we had to move again, my child found it very hard. Was told the school was only from years nine to eleven at that school. In addition, for my small child, the day care never really took off. I couldn’t really get the child to day care as it was so far away. By the time you got them there, it was time to go home again. For the youngest child it was very hard. She did not want to go at all. I just had to keep encouraging her, and it was a bit traumatic for her. She didn’t really enjoy it, until after some time she just gave up.

- I am concerned for my son, he needs some friendship, and to do activities, it is a concern, he is so lonely and he is always with me. He likes to play with other children the same age group (five years), but there is no one I can bring home for him.
• My children have friends now, but it was not very easy for them. They come from a different culture. They should have a lot more friends than they do. When I was their age I had a lot more friendships, it is much harder for them here.

Results from this study indicate that several children of overseas trained doctors find it difficult to form friendships in local schools, this is particularly the case for younger children. The fact that on occasion, the family is required to relocate in several different areas adds to this problem. One respondent described their feelings on the constant state of flux they have found themselves in:

• It’s scary because you don’t know what’s happening tomorrow. They could ring you tomorrow and say they don’t want you any more, but somewhere else does. That’s the truth. It feels like you are just left in the middle of nowhere. They decide where to send you and to hell with you and your family.

**Attitudes towards aspects of current lifestyle.**

Respondents were asked what they saw as the major issues affecting their experiences in the rural environment. They were asked to rank order a number of issues that have been identified as causing concern among rural spouses, and also among the rural doctors themselves. Quantitative and qualitative responses were recoded into major categories/themes and are presented in descending order in Table 3.28 together with examples of the issues raised (ranging from the most difficult, to the least). The categories are not mutually exclusive.
Table 3.28: Issues impacting on rural spouses

<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Comments from participants</th>
<th>Statistics: Mean /5: 1 = no problem, 5 = major problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of family close by. For friendship and support. Missing the growing up of children.</td>
<td>Our parents have been quite ill this past 12 months, and they are young (60) - it causes anguish when their daughter and son can't be with them at these times. My father had a stroke and 4 periodical epileptic seizures - at those times it is very hard.</td>
<td>Approximately 70 percent of respondents reported this issue presenting some difficulty. Twenty percent reported this as being a major problem.</td>
</tr>
<tr>
<td>2. Access to entertainment and facilities. Availability of certain familiar foodstuffs, religious and cultural needs.</td>
<td>I missed the shops, quality coffee shops and good restaurants, also the ability to have a coffee at 9pm in a nice coffee shop - found friends but not many are like-minded and enjoy similar interests. Basic household goods more expensive to buy locally eg white goods, furniture. Having had to travel 30 kms to my bank.</td>
<td>68 percent rated this issue as causing some problem; with almost 20% rating lack of facilities a major issue.</td>
</tr>
<tr>
<td>3. Social Isolation: Including - Personal Loneliness, isolation; Lack of anonymity and privacy/space;</td>
<td>Making new friends - I have many acquaintances - very few real friends - not that you need many - I continue to gain support from my brothers and sisters over the phone from South Australia.</td>
<td>Forty percent reported loneliness as a problem for them (including almost 20 percent who described as a large problem).</td>
</tr>
<tr>
<td>4. Employment issues (self) Including: remuneration, lack of suitable opportunities, lack of training. Long hours for little recognition</td>
<td>There was very little work for someone in my profession, so did what-ever I could. I work part-time, but even then, people look as me as to say &quot;you’re the doctors wife, why do You need to work.</td>
<td>Approximately one third of respondents rated this an issue of major concern</td>
</tr>
</tbody>
</table>
| 5. Finding suitable schooling and day-care. Issues included, access, cost, travel/distance. - Quality Education; - Health needs; - Recreational facilities | Finding secondary school is a problem as not all schools go up to year 12.  
For additional comments see Section above. | Less than 15 percent of respondents reported this as an issue of some/major concern |
| 6. Adjusting to life in a new environment | Moving to the country was a major cultural shock to me and my children but we are adjusting well now. | Less than one third of respondents reported this as a cause for concern. |
| 6. Partner's Issues/employment. After hours/on call; Role of partner; Support socially and professionally; | The employment issue worrying - rural Drs work so hard, they work very long hours, and spend very little time with partner/family. | Only 12 percent of respondents reported that issues concerning the doctor-spouse’s employment to be a major cause for. Time away from family was the main issue, and will be discussed in greater detail. |

Again the issues raised by spouses in this sample were not dissimilar to issues raised in previous research, although some of the priorities differed. Issues pertaining to isolation, role conflict and childcare were high priorities for many. An issue that was identified as being of particular concern to many respondents and affected both themselves and their families.
centred on community expectations. Respondents were therefore asked to comment on a number of community expectations that were identified by interview participants as causing some degree of discomfort or concern.

Spouses were asked to choose from a five-point scale (ranging from a score of one - ‘Strongly Agree’ to a score of five - ‘Strongly disagree’) whether or not they agreed with a series of statements concerning community expectations. Of the options present, having to ‘act in certain ways’ in order to avoid community gossip was reported as causing the most concern among spouses (with 60 percent of respondents either strongly agreeing or agreeing). As these examples indicate:

- Doctors spouse and family very easily become the subject of gossip (with no regard to the element of truth)
- Both my children and myself have to be beyond reproach, if we put a step wrong, the whole town knows about it. It all becomes the subject of gossip
- Everything I buy or do or say is gossip. I found this high profile difficult at first especially when people use you to get to the doctor

The expectation to behave in a manner “that was appropriate for a doctors spouse” was one experienced by seventy percent of females, as opposed to only 43 percent of male spouses. In addition, it was more likely to be experienced by those in the younger age category (72 percent of those between the ages of 26 – 35). This expectation was an issue of concern for almost seventy percent of Australian-born spouses, while slightly less than half (48 percent) of Non-Australian born respondents believed it was a problem.

Many respondents also agreed that as the spouses of a rural doctor, they were expected to be aware of community events and happenings, and that there was a great deal of pressure to serve on numerous local boards and committees.

- There is a feeling that as a Doctors spouse I must prove that I am willing to be a part of the community and ‘like everybody else’ before acceptance by some others. I am expected to be on all school committees, and community boards, even though I have little time myself. I am also expected to know the how the local football team did at the weekend.
- I am expected constantly to be giving or providing my time, free professional services and work on most community school projects with the expectations that ‘we can afford it’
- I should work for ‘free’ or ‘cheap rate’ because my wife is a Dr (I have my own welding business)

These particular expectations were more likely to be experienced by female than male respondents. This may however, be due to the fact that the majority of male spouses were working full-time. As only just over one third of female respondents work full-time, there may be the perception that they have more time to dedicate to community projects. Of note is the fact that those respondents residing in RRMA 7 locations more frequently agreed that these were issues of concern, with 40 percent of respondents agreeing that this was an issue for them (as opposed to 15 percent of RRMA 5, 25 percent of RRMA 5, and 9 percent of RRMA 6). Those in the older age category (over 51 years) were also more likely than the younger spouses to be expected to donate large amounts of free time to community services.
Many respondents indicated their concern over the expectation that they provide “receptionist” duties for their doctor-partners, both in, and out of the medical practice. With several citing examples of being approached in the street by locals and being asked to provide appointment times to see the doctor. In addition, several respondents commented that many community locals either expected spouses to be aware of patient medical conditions and to provide advice, or alternatively, were accused of knowing personal information concerning patient, that they had no knowledge of.

- Patients indicated that they expect me to know all about their illnesses or consultations with my partner (I don't work in the practice), patients come to me with complaints of not able to get an appointment immediately
- I am expected to be an expert on everybody's medical condition, competency of other doctors etc
- I am expected to be able to make appointment for people when at Supermarket and to know if Dr has received test results etc back
- People think Dr tells spouses every persons medical problems at home - they think you know every patients business

Like many of the other expectations placed on spouses, acting as receptionist was more frequently a concern of female rather than male respondents (50 percent of females as opposed to only 30 percent of males). This was also reported more frequently in those respondents over the age of 51 years; with 60 percent agreeing that this was an expectation on them (as opposed to only 17 percent of those in the 26-35 category, and 20 percent of those between 36 and 50).

Respondents commented on several other pressures they felt placed on them by the communities in which they lived, although the majority of these were not experienced as frequently as the one previously discussed. Approximately half of the female respondents did, however, report that community members often feel it is appropriate to ask personal questions, that perhaps, they would not ask other people. For example, one respondent commented that if her partner were away, people would often ask where he was, or when he would be returning to the practice “as if he had no right to leave them without a doctor”. This respondent often felt she had to justify both her, and her doctor-partners actions, particularly if it inconvenienced them at the time. Other expectations included, the expectation that because they were the doctor’s spouse, people wanted to socialise with them outside of work and that as the spouse of a doctor, you were wealthy, and did not need to work.

This final issue was more likely to be experienced by females rather males (36 percent and 26 percent respectively). The expectation that doctors partners should not work seemed to be more prevalent in less remote areas, with approximately 45 percent of respondents from RRMA 4 and 40 percent of RRMA 5 respondents agreeing that this was an issue they faced.

The results of this section support other research findings that comment on the nature of community expectations on the spouses of rural doctors (such as Roach, 2002, Veitch 2001). It is evident that the expectations that the local community have on these spouses are varied according to a number of factors such as gender, age, ethnicity, and area of remoteness. In addition, many respondents reported feeling no form of community pressure at all.

A number of the expectations discussed by respondents may be simply part of life in a rural town, experienced by all community members and not related to their perceived position in
the community. However, several of the pressures placed upon spouses by the local community centre around the often-held stereotypes of the “doctors wife”. This includes the perception that they are wealthy, therefore should not work, and that it is their ‘duty’ as the doctors wife to be involved with organisations and committees. The fact that many spouses commented that they are expected to behave in certain ways, and that they become the focus of community gossip should their behaviour not conform, supports this conclusion.

Respondents who were non-Australian born, reported consistently less experiences of these expectations than did Australian-born spouses, except for the expectation that they delay their own career for the sake of their partners, (42 percent in agreement, as opposed to 30 percent of Australian born spouses). While not statistically significant, these differences may indicate that there is less pressure for overseas-born partners to undertake the community “role” of the doctor’s spouse. Whether these differences are due to ethnicity, it not possible to determine, however, it may indicate a lack of acceptance on the part of the community, given the lack of social networks amongst Non-Australian born spouses.
Issues concerning access to suitable health care

There has been very little written about the health care of a medical practitioner’s female partner, and even less concerning the treatment of male spouses, Schneck (1998). In both instances, research suggests that while the medical care received may by optimal, often the emotional care of the patient is less than adequate. As Dearlove (1994) stated:

It was clear that the essential ingredient to getting poor care was to be a doctor’s wife. How these women’s treatments became substandard was relatively straightforward. The doctors marginalised their colleagues’ wives by making them “special” patients. But what had to happen before a disaster occurred was for all the attending medical staff to ignore clinical clues that things were going wrong. This became clinically important when the wives’ emotional care was being dealt with.4

Spouses of medical practitioners (male or female) have an increased risk of drug dependence and suicide,5 medical staff often feel apprehensive treating a physician’s spouse. Treatment by the doctor-spouse may compromise good care. As Schneck commented, often it is difficult for the partner of a medical practitioner to accept recommendations from a consultant when this differs from what their partner has told them.

Schneck maintained that the difficulties of treatment when a patient is a medical family member are similar to those pertaining to the treatment of a medical practitioner themselves. Often the practitioner-relative may consider the illness of a family member as a sign of weakness. It is not unusual for a relative-patient to be reluctant to admit to any substance abuse, or psychological problem for a fear of embarrassing either himself or herself, or their doctor relative. Likewise, an adolescent relative may feel uncomfortable discussing issues such as sexual health with their general practitioner, if this person is also a parent or other immediate family member.

Several countries (such as the United States of America, Canada, and the United Kingdom) have policies that discourage medical practitioners from treating immediate family members. The American College of Physicians for example suggests that practitioners limit treatments to short-term care of “minor problems” and cautions that patients be transferred to the care of other practitioners as soon as possible.6 The American Medical Association also adds that physicians should only write prescriptions for controlled substances for immediate family members only in emergencies.7 The Canadian Medical Association says that treatment of family members should be limited to minor or emergency care, or instances when another physician is not available.8 The New Zealand Medical Association passed a similar resolution in October 2002, stating:

The NZMA advise members that it is not good clinical practice for members to treat themselves or members of their families unless there is no other available and appropriately qualified medical practitioner. Medical practitioners should exercise great discretion in carrying out any such treatment(s).9

---

4 BMJ 1994;309:1443 (26 November)
5 Murray, 1974
9 Draft policy, personal communication, Jan 15, 2003. NZAMA
As with other countries, the Australian Medical Association does not prohibit medical practitioners from treating immediate family members. The AMA does, however, suggest that medical practitioners should only treat family members for minor illness and emergency treatment, and even in this instance, care should be handed over to other medical professional as soon as possible.

For the majority of families of doctors residing in metropolitan areas, finding a practitioner to care for them presents little obstacle. However, for families in rural and remote areas finding suitable confidential health care can be a major problem, particularly if they reside on one of the many town in rural Queensland that only have either one doctor, or one medical practice. Comments from many rural spouses suggest a situation where it is very difficult for them to take care of their own health, with many of them opting to delay attending consultations until visiting a city or larger regional town sometimes hundreds of kilometres away.10

Several reports have indicated that spouses/partners of rural medical practitioners are extremely concerned about the ability for them to access confidential health care. Often concerns regarding their personal health records being present on the practice database and being accessed by practice staff make it difficult for spouses to attend the same clinic as a patient, where their partners work as doctors. Furthermore, often spouses do not wish to be treated by their partners. Unfortunately, in small, rural towns, where there is only one doctor, or one medical practice, it is not always possible, or practical, for spouses to see other medical practitioners.

**Usual Medical Practitioner.**

Results indicate that 45 percent of respondents are treated by their own spouses. Included in this grouping were all of those respondents who were residing in either one-doctor, or one-practice towns. Forty one percent of respondents, who resided in towns with more than one doctor, also used their spouse as their usual medical practitioner.

Almost one quarter of respondents (22 percent) see a doctor in another town (that is not their spouse), 16 percent see a doctor in the same practice as their spouse, and 13 percent of respondents visit a doctor in the same town, but in another medical practice.

In general, respondents who reported their primary physician as their spouse indicated this was primarily due to either little choice, or concerns over confidentiality. As one participated confirmed:

- We treat ourselves. Thankfully, I haven’t been sick yet. The doctor we used to see used to come here. Occasionally if we have to go see another doctor, we call them. It’s not easy, in a one-man practice. You simply have no choice.

Of those respondents who reported that their usual doctor was their spouse, 77 percent were female. This figure represents half (50 percent) of all female respondents. The proportion of males who have their spouse as their usual practitioner was lower at 41 percent. The remaining male respondents prefer to see either another doctor in the same practice (24 percent) or a doctor in another town (24 percent). Only a small proportion of male spouses (10 percent) chose to see a doctor in the same town, but a different practice.

When examined by ethnicity, only 30 percent of respondents who reported their spouse as their usual GP were overseas born. While given the relatively small number of overseas born spouses, this figure is not surprising. However, only 42 percent all of none Australian born respondents reported their spouse as being their usual doctor as opposed to 50 percent of all Australian born respondents. Spouses of overseas doctors are just as likely to choose another doctor in the same practice as their spouse (20 percent), a doctor in another town (26 percent), or a doctor in the same town, but different practice (13 percent).

Results of this survey suggest there are a number of factors that may determine whether an individual will choose their spouse or another doctor as their usual medical practitioner. One of the most significant factors in this choice appears to be level of remoteness (indicated by RRMA category). Seventy one percent of respondents residing a RRMA 7 location reported their spouse as their usual medical practitioner, 50 percent of respondents living in a RRMA 6 location, 40 percent of respondents living in a RRMA 5 location, and 60 percent of respondents living in RRMA 4 locations choose to see their spouse as their usual practitioner. The high proportion of respondents in RRMA 4, may be accounted by the fact that over 70 percent of all spouses living in this RRMA are female, who also are more likely to choose their spouse as their preferred medical practitioner. A further reason why spouses in RRMA 4 locations utilise their partner may be due to reasons of confidentiality or embarrassment. As several respondents noted, they did not wish to be treated by their partner’s colleagues (who more often than not also close friends).

Interestingly, the presence or absence of children made little difference in the preference of doctor, with half of respondents who did have children, and half of respondents who did not have children reporting their spouse as being their usual doctor.

Comments from several participants who were not treated by their spouses indicated that they did not feel it fair to their partner to be responsible for the healthcare of their family. Unfortunately, many spouses acknowledged that in isolated areas, in times of emergency, there was often little choice.

- It’s been a bit difficult, but [town name removed] isn’t that far away. It’s difficult on my husband having to treat me, when I had an emergency, we were just lucky there was also a lady doctor here at the time and we called her in for me. That was very difficult for him. Normally I would see another doctor.

- We don’t expect [name removed] to treat us. We would always go see somebody else at the practice. That also takes the pressure off the doctor. We have had no problems with privacy or confidentiality.

When last visited a doctor
Respondents were then asked to comment on when they last visited a medical practitioner. Results indicate that the majority of spouses (90 percent) reported visiting a doctor in the previous twelve months. This result suggests that despite concerns over confidentiality, most spouses do access medical health care when needed. This is supported by the fact that almost two thirds of respondents reported that they did not feel that accessing health care for themselves or their families was a major concern. Comments did, however, indicate that a number of spouses felt the ability to see certain specialists (particularly related to gynaecological health) was of concern for them. This was due to both availability of specialists and reasons of confidentiality. Comments from participants included:
Generally seeing a doctor is no problem. I could imagine how people could have a problem, but I don't. I do need to go to [town name removed] to see a specialist.

I have no real problems seeing a doctor, but for specialist treatment, you have to fly down to Brisbane, some services you can't access in a small town. That also requires time off work. Another problem is that because the bills or results come through work, then all staff know about it. You only have to tell one or two people.

Seeing a specialist is very difficult. In some areas where you want to be discrete, it’s difficult to do that. Especially being a health professional there’s a tendency to ignore your own health. The cost of being so concerned with other people, you don’t look at yourself. For a female it’s very difficult to see a doctor in your own town.

If I have a health issue I go out of town, I don’t want people here to know about it because they are all gossips. Having a doctor especially for doctors and their families, will make it much easier for us, knowing that your details won’t get passed on round the community. Privacy is a major issue. The other day a lady came up to us in the park and remarked about a health issue (for us) on a level of detail we weren’t aware of. It was her employer’s wife that was telling people. Some doctors’ wives generally don’t respect people’s privacy. Doctor’s wives don’t get taught about it, but they should.

Very few respondents reported that they had not visited a doctor in the previous five years. One respondent, however, reported not visiting a doctor for the past twenty years. It is important to note that for this respondent, a breach in patient confidentiality, leading to community gossip was cited as the main reason for this.

I don't (see a doctor) as I had a very bad experience with a confidentiality issue and I have not seen a Dr since (20 years). I don’t feel I can see a doctor here. People here because there was an instance where a staff member read my notes. I can’t go locally, as I know all the other doctors in this town also, even in [town name removed]. Results usually get sent over the work computers, and all staff can see it. You tend not to look after yourself because you don't want everybody knowing what’s going on. Its not so bad in a large practice, but not in a small. If I knew it would be confidential, I would do it.

A further issue of concern was for the many spouses who worked in the same medical practice as their spouse/partner, either as practice manager or nurse. In many small towns with only the one practice (or doctor) taking time off to recuperate is simply not an option. In addition, as the above comments demonstrate, privacy issues are even more of a concern. Adding to this concern is the inability of the doctor-spouse being able to take time from their practice either for their own health concerns, or to tend for a sick spouse. As these comments demonstrate:

I don’t have any strategies. It can be very difficult; there is simply no relief here if you’re sick. We were lucky I was sick for a week or so once, a doctor from another town volunteered to help out. Queensland Health couldn’t give damm. We can never have a day off sick. It gets to the point where you want to see your
patients from your bedroom. Having to go away for the treatments is a problem. You work for the government, in small town, you can’t get time off so your wife can have a baby. [Name removed] delivered my last babies himself. Your husband can’t take time off, if any mishap happened health wise, it would be disastrous, and I wouldn’t know what to do. We would just close the doors, but you cant, you have a business to run.

- When I had a miscarriage, they [name removed] would not send my husband a reliever, he had to work the whole time. I was in hospital, we had the two children to take care of, and he had to work. I felt like, what am I doing here, he had to do everything at the same time. One of the nurses was going to help. She called the pastor in church. They made an announcement in the church the following morning we were surrounded by people. My husband was expected to work while his own family was dying.

**Spouses who are themselves, medical practitioners or allied health professionals**

Eleven of the respondents who replied to this survey, were medical practitioners in their own right, three male, eight female.

Three female practitioners reported their usual doctor was their spouse, as opposed to only one male respondent. One male respondent reported going to a doctor in another town, and one reported seeing a doctor in the same town as their spouse, but in a different medical practice.

Of the respondents who were employed in either health or allied health professions, over 68 percent stated their spouse was their usual medical practitioner. Of those respondents employed in non-allied health professions (including home makers) only one third reported their spouse as their usual medical professional.

Anecdotal evidence suggests that the majority of medical practitioner periodically provide medical advice to their family and friends, and occasionally even to themselves. In many instances, good reasons account for this practice, and in the majority of cases, no difficulties arise. There is however, the possibility that difficulties will occur, especially in the event of substandard care being received.

The results of this section clearly indicate that those respondents who work in either health or allied health professions are more likely than others to be treated by their spouses. This is particularly the case for respondents working as practice managers. While Australian medical bodies do not prohibit doctors treating their family members, this practice is not encouraged. Unfortunately, as these results demonstrate, those respondents who live in more remote areas have little choice but to be treated by their partners. This situation is surely one of concern, and is an issue that needs to be addressed more closely. Although a number of respondents commented that they do not believe being treated by your spouse is a problem for them or their family, as research as shown, it is a situation that has the potential to result in individuals receiving sub-standard health care, albeit unintentional.

---

Cultural identity and maintenance of cultural/religious practice

In order to address the shortfall in rural medical practitioners in rural areas, Queensland Health employs a number of Overseas Trained Doctors (OTDs) and Temporary Resident Doctors (TRDs) to work in areas of need (often these areas are located in rural locations). Approximately 30 percent of doctors in rural Queensland are OTDs, although many of these have been residing in Australia for many years. Thirty-eight respondents with spouses who are OTDs responded to this survey. These respondents have resided in Australia from three months to 52 years, with an average length of residence of 21 years.

In order to assess any issues relating to cultural identity or religious practice, spouses were asked to identify whether they had experienced any difficulties pertaining to their continuation of either cultural or religious practice since living in rural areas.

Twenty-eight (74 percent) of non-Australian born spouses reported having no difficulty with cultural or ethnic difference, and that they believed that they were not treated any differently from other doctors spouses. Typical comments from spouses included:

- I have found people only interested and not judgmental.
- Coming from [name removed], we have the same culture. It is easy. We learn English in schools. We adapted easily. There are some words that are different and I make some of our own food and so on and so on. But we fit in really easily. We used to have maid to help in the house, that’s a bit of a difference. We do speak our own language at home we don't speak English. It makes it easier for us and the children to keep in touch with our culture. We celebrate our culture, but we came here to become Australians, not to cling to our histories.
- The town are a bit curious, but have not experienced any aggressiveness or indifferent attitudes. I don’t believe such things should be an issue. The children interact very well at school even though they are the only dark skinned people in there.

Responses from the majority of spouses of OTDs/TRDs indicate that apart from occasional curiosity, or questions, most do not experience major difficulties adjusting to life in rural Australia. No respondent reported experiencing any form of racism or discrimination because of ethnicity.

Nine respondents reported feeling some concern over the maintenance of religious practices, although none reported this as being major obstacle to their settlement in Australia. Coming from a range of countries, four of the nine were originally from South Africa, the remaining respondents were from India, Fiji, Scotland, Ireland and Zimbabwe. Seven of the nine respondents were female.

Of those who had reported difficulties in this area, seven had lived in Australia only a short period of time (ranging from one year to six years). The remaining two respondents have resided in Australia for 16 years and fifty years, both commented that these difficulties were predominantly in the early period of their settlement into Australia.

Comments from participants indicate that it is the period of initial settlement where they face the most difficulties, and suggest that once over this ‘settling in period’ concerns over cultural difference are usual small. Typical comments include:
• On arrival it did seem that people considered us strange - we had a different English accent, and different skin colour - however that gap is slowly closing
• Initially some community resistance to my husband being Asian but that was 30 years ago
• Minor 'language' or cultural issues, usually good for a laugh
• People’s misplaced perception of our religion and culture

Difficulties maintaining religious practice was an issue experienced by Christian, Hindu and Muslim respondents. For Christian respondents, it was often due to differences in denomination of Christianity. For Muslim and Hindu participants, difficulties centred on access to religious services/clerics, and availability of specific dietary requirements (such as Halal meat products). A lack interaction with others of similar faith was also noted. The significance of religion in the role of the resettlement process in often is overlooked, however, several researchers have demonstrated that it can have a significant impact on the integration process of migrants into a new community.\textsuperscript{12}

Comments from respondents concerning the maintenance of religious practice suggest that religious beliefs play an important role in their overall well-being, and that if religious needs are not catered for in a community, it may lead to increased levels of dissatisfaction with their current situation, as the following responses indicate:

• We don't have a proper pastor - I don't get any message on Sundays and get depressed and empty
• We are currently going to the Uniting Church - use to a Dutch Reformed religion - makes it hard - different totally
• I find it hard to find the ideal church set up the way we were used to specially for the children's sake
• The church is very small here, but there are churches here, the Catholic church lets us use their building, to maintain a church life is more difficult, you have to do it with your own seeking, which is not enough at times.

• The people here do not seem to be involved in the church, it is not that important to them, they seem more agnostic. They don’t want to hear about the future, they are happy to deal with those themselves, until they meet a crisis that is, then God becomes very important to them.

• It is difficult at times to maintain our culture and religion here; there is no mosque here so we pray at home. That is OK, but my husband would like to go to the mosque. There is no facilities, but it is ok we manage. We used to fly in Halal meat from Brisbane, but that became too expensive, there is still plenty for us to eat however. If we have to, we eat non-Halal meat, it's all about adapting to your circumstances. We know it will not be like this for much longer, we only came here for one year, and then we will move to a city.
• My children are converted to Christianity at school (State School), and expected to give the Lord’s Prayer. That is not acceptable for a Muslim. It is difficult for the children especially. We try to teach our children what is right for us as Muslims, but they don’t understand.

As these comments indicate, non-Australian born respondents have adopted various strategies to help them adjust to life in Australia. These strategies include, foregoing some traditional practices completely, continuing cultural/religious traditions both in the home and in the community with little alteration, or observing cultural traditions in the home only:

- It has not been too difficult to balance traditional culture and our life here. We maintain our own cultural background at home, but when we are mixing with other people, we don’t show much of our cultural background, we are friends with people here, and we like to join with their own culture. Although I am a Muslim, I don’t wear a headscarf when I am out on the street. Only those people who know me well, or are invited to our home know I am Muslim.

Access to suitable religious services was also raised by several Australian born residents as an area of concern. It is one aspect of the rural experience that has received little attention, yet, as has been highlighted in previous sections on social interaction, a number of respondents rely on religious activities as one of their major sources of both social contact, and support. It is often not possible (or practical) for small rural communities to cater for all the religious and cultural needs of its residents. However, as these results suggest, being able to maintain one’s religious and cultural practices may factor into decisions regarding families length of stay in rural areas; particularly the case for new OTDs and their families.

Comments from several respondents indicate that religious support is an important component of their coping strategy; if this service is unavailable to them the number of substitute services are limited. Thirty percent of spouses of OTDs, reported having no friends or confidants, thirty percent reported no involvement with the local community, sixty percent reported no involvement with the QRMFN, and a small number (6) reported having either no close friends or outside community involvement. Over three quarters of Non-Australian born respondents reported their main confident was their doctor-partner and only 15 percent reported other family members as close confidants.

These results suggest that there are a proportion of spouses of OTD’s who are socially isolated, and who may benefit from closer contact with services such as the QRMFN. Of the seventeen Non-Australian born respondents who have resided in Australia for under six years, ten have reported that they will leave their present location within the next six years, the remaining six respondents commented that they will leave the rural environment within the next ten years, or as soon as their period of bonding has finished. In contrast, as Table 3.29 suggests, those who remain past the initial five to ten years, are more likely to remain in the rural environment.

Table 3.29: Projections of overseas trained spouses length of time in Australia, and predicted duration of stay in rural Australia.

<table>
<thead>
<tr>
<th>Length of time in Australia</th>
<th>Predicted length of stay</th>
<th>&lt;5 years</th>
<th>6-10 years</th>
<th>11&lt; years</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td></td>
<td>10</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>10-15 years</td>
<td></td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>15 years or more</td>
<td></td>
<td>6</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Despite concerns over social isolation and satisfaction, the majority of overseas born respondents reported being happy with their present circumstances. The results do indicate however, that those who are relatively new to Australia do not intend to remain in the rural environment indefinitely. As following sections will discuss, there are a number of factors that effect the decision to either stay or leave rural practice. By helping to facilitate an improvement in both the social and support networks of these spouses, the QRMFN will, in part, help foster a reduction in the number of Overseas Trained Doctors and their families leaving the rural sector for city practices.

Views about life as a doctor’s spouse in a country town

Research and anecdotal evidence suggests that there are a number of facets of life as the spouse of a doctor in a country that are particularly difficult to accept (Roach, 2002; Wise et al, 1996). These include issues concerning lack of privacy and confidentiality, the long hours that the doctor-partner is required to work (and the subsequent pressure this places of family life) and issues centred on the spouse own career options. Such issues have been demonstrated to have an important impact on the decisions concerning length of stay in the rural areas. Spouses were asked to rate on a scale of one through five (1 = strongly agree, 5 = strongly disagree), as to whether they agreed or disagreed with a number of statements that centred on issues of privacy, socialisation and professional development.

Table 3.30: Aspects of life as the “doctors spouse” (mean score 1=strongly agree, 5=strongly disagree)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean score</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long hours worked by partner affect family</td>
<td>102</td>
<td>2.06</td>
<td>1.19</td>
</tr>
<tr>
<td>It is difficult to remain anonymous</td>
<td>104</td>
<td>2.08</td>
<td>1.22</td>
</tr>
<tr>
<td>It is difficult to maintain levels of privacy</td>
<td>105</td>
<td>2.84</td>
<td>1.39</td>
</tr>
<tr>
<td>Long hours affect ability to make friends</td>
<td>103</td>
<td>2.84</td>
<td>1.33</td>
</tr>
<tr>
<td>Concerned for personal/professional development</td>
<td>103</td>
<td>2.97</td>
<td>1.40</td>
</tr>
<tr>
<td>Concerned about access confidential health care</td>
<td>105</td>
<td>3.11</td>
<td>1.45</td>
</tr>
</tbody>
</table>

As indicated by Table 3.30, the majority of respondents clearly identified with the concern that the long hours worked by their partners affected the doctor’s ability to spend suitable time with their family (73 percent of respondents either agreed or strongly agreed with this statement). The following statement highlights the concerns of many of the respondents concerning this issue.

- I never realised the sacrifice we had to make, the long hours. It’s very hard on the family, friends and so on. Even when you expect the long hours, you can’t get used to it
- Sometimes he is away from home so long, and when he comes home there is confrontation, it is not easy.
- The hours she worked were hard on all of us, especially when she was at the hospital. She changed her hours since going private, that’s made things easier. I just stay home and look after the kids; I’ve brought up the kids from basically day
one. I’m the main caregiver; I am super-mum. I do everything you expect your wife to do, but she won’t do because she is working. I do all the housework, then go and start my own work. I can even have the washing going at the same time.

As the comments above indicate, those respondents whose partner worked in a hospital were much more likely than doctors in other types of employment to be working longer hours, and therefore spend even less time with their family. As Table 3.31 demonstrates, those respondents who had partners also working in the hospital system were more likely to be concerned about the time spent away from families.

Table 3.31: A comparison of level of agreement (%) and partner’s employment type

<table>
<thead>
<tr>
<th>Partners employer</th>
<th>Strongly agree/Agree</th>
<th>Neutral</th>
<th>Strongly disagree/disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>86</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Solo practice</td>
<td>65</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>Group practice</td>
<td>72</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Other</td>
<td>33</td>
<td>33</td>
<td>4</td>
</tr>
</tbody>
</table>

In addition to the disruption to family life that is incurred by the excessive hours rural doctors are often required to work, is the report that these long hours also make it difficult for the partner to form lasting friendships (40 percent of respondents agreed that this was an area of concern). As has previously been discussed, the frequency of 60-hour working weeks, coupled with on-call work, makes it difficult to plan social outings. If outings have been arranged, it is not uncommon for a doctor to be called away, as these comments indicate:

- After a while friends stopped asking us out to dinner since [name removed] was often being called away. Sometimes I would stay, but on other occasions I would leave with him. It’s simply easier to stay at home. I started to see life as if I was a single person in the end.

- The long hours affect us very much. The phone rings all night. You can’t go out and have a couple of drinks. You can’t have a normal social life.

In addition to the long hours worked by partners, a further issue that concerned many respondents centred on confidentiality and privacy. Seventy-three percent of respondents reported that they either agreed or strongly agreed that they found this a major issue. Respondents frequently referred to local people commenting on their, or their children’s actions, is if it was a matter of public concern. Respondents described these occurrences as very upsetting for them. This result is further supported by the fact that the majority of respondents (65 percent) rated their level of personal anonymity as either unsatisfactory or poor. The following examples are typical of many respondents’ experiences reported in this research:

- The lack of anonymity is a real problem for me. If I lived in the middle of Brisbane, and no one would know me, it wouldn’t matter if you ran into one of the husband’s patients. They wouldn’t run up to you and say, hey, I have this
thing on my finger. It happens everywhere, [name removed] got out of the habit of going into town, if we go to the bank, he’ll just sit in the car, I would come out and they’re talking to him through the window about their ailment. I can’t walk down the street without everyone knowing you.

- There is always a lack of anonymity, you cannot be invisible in a small town, you do get used to it. But it can be very difficult when everybody knows what you are doing all the time, sometimes, even before you do it.

In conjunction with the inability to remain anonymous, was the lack of personal privacy many respondents felt. When spouses were asked whether they agreed with the following statement: “As the spouse of a medical practitioner I find it difficult to maintain levels of privacy” one third of respondents either agreed or strongly agreed. In addition, when asked to rate their perceived level of privacy, almost half (49 percent) or respondents described it as either poor or unsatisfactory.

- There is no real privacy, people tell you about their needs, that they’ve seen other doctors now they will see your husband and expect them to be better than everybody else.

Respondents were asked to rank a number of other aspects of their current lifestyle that have been associated (to varying degrees) with problems of living in rural areas as the partner of a rural doctor. The scale ranged from a score of one (excellent) through to a score of five (poor). As Table 3.32 indicates, the majority of spouses were somewhat unsatisfied with these at present, with no aspect receiving an overall rating above the neutral-satisfactory grade. The availability of locums, and issues concerning personal privacy were both rated as unsatisfactory. With a standard deviation of 3.4, ‘professional interaction’ had the greatest variation among respondents, however, possible reasons for this variation have been discussed in previous sections. Only ‘personal income’ had an overall rating of ‘satisfactory’ that the majority of spouses are working in either some form of professional or allied health capacity most likely accounts for this rating.

Table 3.32: Rating aspects of current lifestyle (ranked in order from satisfied to most dissatisfied).

<table>
<thead>
<tr>
<th>Aspect of lifestyle</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal income</td>
<td>2.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Professional satisfaction</td>
<td>2.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Social life</td>
<td>2.7</td>
<td>1.1</td>
</tr>
<tr>
<td>Recreational opportunities</td>
<td>2.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Professional interaction</td>
<td>2.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Personal privacy</td>
<td>3.4</td>
<td>1.2</td>
</tr>
<tr>
<td>Availability of locums</td>
<td>3.8</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Eighty percent of respondents were dissatisfied with the level of locum provision for their spouses. Many commented on the long-term effects this issue was having on both the doctor, and the families. Respondents felt that all family members were “tied to the practice”, and
that it was difficult to be able to find time during the course of a year when they could all take holidays together.

**Projected length of stay in present location and the specified reasons for this.**
Respondents were asked to predict, given current circumstances, how long they would like to remain in their current locations. Results were compared on the basis of age, gender and RRMA. It is important to note, however, that only 72 of the 114 respondents replied to this question therefore one must be cautious in interpreting these results in terms of trends that may be present.

An examination of overall results indicate that half of respondents to this question have reported that they intend to leave their current location within the next five years, and a further thirty-five percent have indicated that they will leave the rural practice within ten years (Table 3.33)

**Table 3.33: Projected length of stay in current location**

<table>
<thead>
<tr>
<th></th>
<th>Within 0-5 years</th>
<th>Within 6-10 years</th>
<th>11 years or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Of respondents</td>
<td>36</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>% Of N [72]</td>
<td>50</td>
<td>35</td>
<td>15</td>
</tr>
</tbody>
</table>

When examined by age and RRMA, as Figure 3.1 indicates, those in the younger age categories (25-35), are more likely to leave their present location within five years, while those in the mid age category (36-50) are likely to remain for at least ten years. These results also demonstrate that over 50 percent of respondents over the age of 51 are also likely to remain in their present location for more than ten years indefinitely.

**Figure 3.1: A comparison of predicted length of stay in present location by age category.**

![Figure 3.1: A comparison of predicted length of stay in present location by age category.](image-url)
Table 3.34: Comparison of predicted length of stay by RRMA

<table>
<thead>
<tr>
<th>Predicted length of stay</th>
<th>RRMA 4</th>
<th>RRMA 5</th>
<th>RRMA 6</th>
<th>RRMA 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years</td>
<td>5 (29%)</td>
<td>18 (56%)</td>
<td>3 (50%)</td>
<td>5 (60%)</td>
</tr>
<tr>
<td>6-10 years</td>
<td>8 (47%)</td>
<td>9 (28%)</td>
<td>2 (33%)</td>
<td>2 (33%)</td>
</tr>
<tr>
<td>11 years plus</td>
<td>4 (24%)</td>
<td>5 (16%)</td>
<td>1 (17%)</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>N=17</td>
<td></td>
<td>N=32</td>
<td>N=6</td>
<td>N=8</td>
</tr>
</tbody>
</table>

When respondents predictions of their length of stay is compared by RRMA (table 3.34) it is evident that proportionately twice as many respondents living in RRMA 7 (60%) as living in RRMA 4(29%) indicated that they planned to stay five years or less in their present location. This result, although it may not be representative of all RRMA 7 respondents suggests a worsening scenario for health care in these areas. While these figures are only predictions, they do represent the desire of a relatively large proportion of spouses who wish to leave their current location within the next ten years. As Wise et al (1996) demonstrated, spouses played a major role in the decision to locate to the rural area, and they are just as likely to have an important influence in any plan to leave the rural environment. It is therefore imperative that organisations such as the QRMFN, medical agencies such as the QRMSA, and Government bodies such as Queensland Health address the concerns of both the doctors and their spouses should they wish to stem the exodus of rural doctors and their families. As these results clearly indicate, as older doctors retire, those with the potential to succeed them will not remain long enough in their present environment, under their present conditions to be able to do so.

Table 3.35: Respondent’s reasons for predicted length of stay

<table>
<thead>
<tr>
<th>Reasons for prediction</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>To complete child’s education</td>
<td>15</td>
</tr>
<tr>
<td>Once family has finished education</td>
<td>11</td>
</tr>
<tr>
<td>Retirement</td>
<td>12</td>
</tr>
<tr>
<td>Social/family</td>
<td>9</td>
</tr>
<tr>
<td>Doctors career</td>
<td>11</td>
</tr>
<tr>
<td>Economic</td>
<td>7</td>
</tr>
<tr>
<td>Unsure</td>
<td>6</td>
</tr>
<tr>
<td>Had enough/exhausted</td>
<td>6</td>
</tr>
<tr>
<td>Period of bonding complete</td>
<td>4</td>
</tr>
</tbody>
</table>

When asked to explain their reasons for their predicted length of stay in their present location, education was most commonly noted as the reason they would relocate. Fifteen respondents commented that they would leave the rural area once their children reached secondary education, or university. As discussed in previous sections, a high proportion of respondents did not wish to send their children to boarding school, but did desire to give them the best possible education. While reasonably satisfied with junior level schooling, respondents felt there were greater educational opportunities available to their children if they were schooled elsewhere, as the following comments indicate:

- We will probably leave when our first child reaches high school; we are not really interested in boarding.
- My youngest child will have finished school and we can then plan a change. We need to move after that for the education of our children and better urban opportunities.
In contrast to a lack of suitable higher education, was the fact that a number of spouses (11) commented that they would leave the rural area after their children had finished secondary school, as they did not wish to remove their child from what they thought was adequate education.

After schooling, the second most frequent reason for leaving their present location was retirement. Given the proportion of respondents over the age of 51, this result is not surprising. It will, however, leave a serious gap in the medical workforce, even if the doctor is not the individual retiring, the community will loose their services once they move.

Four respondents commented that they were would leave their present situation because they “completely exhausted”, with one respondent commenting that were leaving within two years because of they felt the experience was “emotionally and physically draining on their family”. No respondent reported that they would leave their present location because they were “unhappy” in their present situation, while relatively high number (24) reported their overall satisfaction with their present situation and expressed their desire to remain as long as possible. These responses are summed up in the following respondent’s comments:

* I love it here, so I would like to stay for the rest of my days.*
**Dimensions of alienation**

Spouses were asked to rate on a scale of 1 to 5 their level of agreement or disagreement with a series of five questions designed to specifically test levels of alienation (1 = “Strongly Agree” to 5 = “Strongly Disagree”). These five questions relate to Seamen’s dimensions of alienation (refer to introduction for information).

As Table 3.36 indicates, slightly over half of the respondents reported a positive result on the ‘Social isolation’ dimension of alienation (a score of 3 or less). Respondents also scored highly on the ‘Powerlessness’ and ‘Normlessness’ (they often feel they are required to behave in ways that they disagree with in order to gain some form of control in their lives). Approximately one quarter of all respondents scored positively on dimensions of Meaninglessness (indicating that they find it difficult to extract any important meaning from their lives) and work alienation (indicating they extract little intrinsic job satisfaction from the work they are doing).

Table 3.36: Proportion of respondents scoring positively on Seaman’s Dimensions of Alienation

<table>
<thead>
<tr>
<th>Dimension of Alienation</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social isolation</td>
<td>51</td>
<td>49</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>46</td>
<td>54</td>
</tr>
<tr>
<td>Normlessness</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>Meaninglessness</td>
<td>26</td>
<td>74</td>
</tr>
<tr>
<td>Work alienation</td>
<td>23</td>
<td>77</td>
</tr>
<tr>
<td>As 100% of [N]</td>
<td>[110]</td>
<td>[110]</td>
</tr>
</tbody>
</table>

Of some concern is the fact that 45 percent of respondents (49) scored positively on more than one dimension, and thirty percent of respondents (32) scored positively on four or more dimensions.

When these results are examined according to individual characteristics, it is evident that several trends are present. Of particular interest is the fact almost 60 percent of women reported feeling socially isolated in their present location, as opposed to only 27 percent of male respondents (these results are statically significantly different, p<0.05). As Table 3.37 suggests, this finding is common across all RRMA's and not just in the more remote areas.

Table 3.37: Comparison of positive scores for social isolation and gender, across RRMA.

<table>
<thead>
<tr>
<th>RRMA</th>
<th>% Of gender scoring positive for social isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (%)</td>
</tr>
<tr>
<td>RRMA 4</td>
<td>20</td>
</tr>
<tr>
<td>RRMA 5</td>
<td>33</td>
</tr>
<tr>
<td>RRMA 6</td>
<td>0</td>
</tr>
<tr>
<td>RRMA 7</td>
<td>33</td>
</tr>
</tbody>
</table>
Table 3.38: Comparison of positive scores for social isolation and gender across age categories.

<table>
<thead>
<tr>
<th>Age range</th>
<th>Positive score for social alienation</th>
<th>Count</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% Within gender</td>
<td>Male</td>
</tr>
<tr>
<td>Under 25</td>
<td>Social alienation</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>26 - 35</td>
<td>Social alienation</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>36 - 50</td>
<td>Social alienation</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>51 and over</td>
<td>Social alienation</td>
<td>0</td>
<td>12</td>
</tr>
</tbody>
</table>

Tables 3.37 and 3.38 depict positive scores for social alienation examined by gender, RRMA and age category. Both tables indicate that women are more likely to feel socially alienated in their present situations than men are. Interestingly, levels of alienation tend to polarise at each end of the age range, with those in the youngest categories and those in the oldest categories reporting feeling lonely or socially isolated.

There are several reasons that may account for these differences across age and gender. As previous results have demonstrated, females are much more likely to be working in areas outside their area of qualifications, and they are also more likely to be working with their spouses than male respondents are. Female spouses are also much more likely to be responsible for running the household. Given this additional pressure, there is less opportunity for females to socialise as frequently as the male spouses (it is interesting to note that 85 percent of respondents who did not feel socially isolated were involved with clubs or hobbies of some type).

The results of this research have shown that female spouses are more likely than males to be expected to behave in certain ways, be more involved on committees and community groups, and therefore have less time to form close friendships. When examined by hobbies and interests, male spouses are more often involved with sporting groups or hobbies than they are school fundraisers, or local committees. They therefore have the ability to transgress the boundary from ‘acquaintance’ to ‘close friend’ more easily than female spouses. As comments from participants have demonstrated, it is much harder for the female respondents to step outside the community-defined stereotype of the “doctors wife”.

Given that only a relatively small proportion of respondents relocated to rural Queensland for their own reasons, it is not surprising that almost half of all respondents (46%) score positively for feelings of powerlessness. Although comments from respondents suggest a number of reasons why they feel powerless in their current situation, (including social isolation, employment issues, community pressure and expectations), as Table 3.39 indicates, when responses are examined by reasons for initial relocation, an interesting trend is apparent.
Table 3.39: A comparison of respondents who rated positively for feelings of powerlessness, and their initial reasons for relocating to the rural area.

<table>
<thead>
<tr>
<th>Reasons for moving</th>
<th>Feelings of Powerlessness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partners rural scholarship holders</td>
<td>60.00%</td>
</tr>
<tr>
<td>Spouse/partners employment</td>
<td>55.60%</td>
</tr>
<tr>
<td>Bonded to a rural area</td>
<td>50.00%</td>
</tr>
<tr>
<td>My employment</td>
<td>40.00%</td>
</tr>
<tr>
<td>Personal choice</td>
<td>26.70%</td>
</tr>
<tr>
<td>Partner selected for Drs for the Bush</td>
<td>25.00%</td>
</tr>
<tr>
<td>For rural lifestyle</td>
<td>12.50%</td>
</tr>
</tbody>
</table>

As the above table suggests, those respondents who moved to their present location predominantly because of their spouse’s employment, are more likely to report feelings of powerlessness than those who relocated for their own reasons, or simply for a lifestyle change. This result suggests that respondent’s whose partners are bonded in particular areas (such as the rural scholarship program) feel particularly powerless to influence situations in their life. This may also explain some general comments on dissatisfaction regarding their own employment, as previous results have suggested, it is because of their partners employment (in some instances “conscription”) to the rural area, that they often find themselves working in areas outside their preferred occupation. A period of bonding, or simply financial constraints, means that spouses are unable to alter their present circumstance easily.

This conclusion is further supported by research conducted with female rural medical practitioners (White and Fergusson, 2001) who reported that female medical practitioners often commented they felt conscripted into rural areas.

“The category ‘conscription’ was assigned to those respondents who indicated that they were in rural and remote practice through lack of choice rather than through choice and included Overseas Trained Doctors, Registrars and Bonded Scholarship Holders”. (White and Fergusson, 2001, p.11)

In addition to social alienation and powerlessness, almost half (45%) of the respondents indicated that in order to improve their situation they often felt it necessary to do things that they would otherwise disagree with, or in other circumstances would not be part of (Normlessness). When examined by personal characteristics such as age, gender and RRMA, the results were unremarkable; with results indicating 40-50 percent of respondents (across all categories) agree that this was an issue they dealt with.

Of those respondents who scored positively on the Normlessness dimension, the largest commonality was the fact that the majority felt under a great deal of pressure to conform to various community pressures. For example, 85 percent of respondents who reported feeling under some pressure to “behave accordingly for fear of community gossip” scored positively on this dimension of alienation, as did 70 percent of those who felt pressured to join committees, and 66 percent of those who felt (in some part) that people wanted to be friends with them because the respondent was the partner of the local doctor. These results suggest that there is a relationship between community expectations and respondent’s perception of how they should behave, even if that behaviour is in conflict with respondent’s usual action.
Respondents were asked whether or not they agreed with a statement concerning their understanding of the reasons behind their present situation. While feelings of powerlessness refer to a perceived ability to control events, meaninglessness refers to an individual’s inability to understand events or behaviours. This makes it very difficult for individuals to predict the behaviours of others around them. Slightly over one quarter of respondents (26) felt that they found it difficult to achieve meaning out of events they are involved in. Those in the younger age category (26-35) were more likely to report feelings of meaninglessness than those in older age categories (32% as opposed to 27 percent in the 36-50 age grouping and 19 percent in the 51 and over age category). This finding is most likely explained through the increase in experience with the life on country towns, as respondents get older.

The dimension of alienation that least effected respondents was that of “work estrangement”. Researchers’ theorise that this form of alienation results from the loss of intrinsic meaning or pride in the work that an individual is doing. Less than a quarter of respondents (20) reported that they did not enjoy the work they were currently doing. This result is also supported by high proportion of respondents who described their work as interesting (89%), challenging (80%), and socially and financially rewarding (90%). All of these aspects combine to produce an intrinsically rewarding work environment. It is interesting to note that of the respondents who did score positively on this dimension, 11 (55 percent) were working in areas that were not consistent with their education or training.

Sociological research refers to alienation as not only a state of being, but also a process. The process of alienation involves a collection of continual changes in which the level of alienation increases or reduces. Therefore, an individual becomes more or less alienated, rather than alienated or not alienated. During the course of this process, the individual experiences a changeable and changing degree of alienation across different dimensions simultaneously at any one point in time, depending on the stressors that are present in that persons life at that particular moment. A cause for concern highlighted from this research is that 44 respondents (40 percent) responded positively to at least three of the five alienation questions. Of these 44 respondents 20 were non-Australian born. This figure represents slightly over half (51%) of all non-Australian born respondents supporting previous findings in this research that they represent a collection of spouses that may benefit considerably from any services and programs established by agencies such as the QRMFN.

The overall responses to the alienation statements varied considerably not only across individual characteristic groupings, but also within the five dimensions of alienation. Such a result suggests that respondents felt some degree of alienation on some dimensions but not on others (with feelings of social alienation, powerlessness and normlessness being evident in a number of respondents). Overall there was a general rejection (a 39 percent agreement with the statements) concerning alienation. Interestingly, there was a 56 percent overall acceptance rate among Non-Australian born respondents (as opposed to 36 percent of Australian born) and an overall acceptance rate of 41 percent of female respondents opposed to only 30 percent of male respondents. This suggests that Australian born male spouses were the least likely to affected by issues of alienation across the five dimensions measured.
Summative views about life as a doctors spouse in present location

The final section in the postal survey was aimed at determining overall levels of happiness and satisfaction with their current situation.

Respondents were asked to identify aspects of their current lifestyle that they were both happy with and which they felt made life difficult for them and their family. The following table presents the breakdown of the comments made by participants. It is interesting to note, that respondents made more negative comments than they did favourable responses.

The results of Table 3.40 indicate that community expectations and gossip combined with a lack of anonymity were perceived as the most negative aspects of country living, well below issues concerning the long hours their spouses are required to work. The inability to form close friends and social networks was also discussed as being an aspect of rural living that they had had to come to terms with.

Aspects relating to the ‘tyranny of distance’ such as distance from close family members, the amount of time needed for travel, and access to required social/cultural and physical needs (such as food stuffs) were also commonly reported as being very difficult to contend with at times.

What is interesting to note is that although several respondents commented on the expensive cost of living and other economic concerns, very few respondents (two only) commented on difficulties or concerns over their own employment issues or career paths, despite often commenting on the pressures of work that their partners were faced with. This particular result supports previous research, and confirms anecdotal evidence that the spouses of rural doctors often place the needs of their own careers well below that of their practitioner-partners. With regards to educational issues, again, the majority of comments centred on the needs of their children, or continuing education for the doctors. No respondent volunteered any comments, or expressed concerns about their own educational needs, despite many expressing a need for further professional development opportunities to be provided by the family network.

The most positive aspect of life as a rural doctors spouse focussed on the ‘rural lifestyle’ and slower pace of life. Several respondents commented on the clean environment, and noted the abundance of opportunities for out-door activities such as for bush walking or fishing. Often respondents framed their response in terms of opportunities for their children, the safe environment, and the benefit of having a small concerned community to look after the well being of the doctor’s family. In terms of professional and economic benefits, again, these were centred on the doctor, rather than themselves.
Table 3.40: Positive and negative perceptions of life as the spouse of a rural doctor
(rank ordered as nominated by respondents)

<table>
<thead>
<tr>
<th>Life as a doctors spouse</th>
<th>Number of responses</th>
<th>Example of comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative aspects (140) comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community expectations and gossip/privacy</td>
<td>28</td>
<td>Absolutely no privacy, everyone knows what I am doing before I do it</td>
</tr>
<tr>
<td>Lack of Family and or friends</td>
<td>27</td>
<td>Sometimes I feel so lonely, I have not family or close friends here. Simply acquaintances. I am tired of coming last in a list of priorities.</td>
</tr>
<tr>
<td>Distance</td>
<td>25</td>
<td>I am tired of the distances we have to travel, and the ridiculous cost of internal transport</td>
</tr>
<tr>
<td>Access to required needs</td>
<td>19</td>
<td>Limited access to culture and diversity, no banks, I can’t get certain items that I like</td>
</tr>
<tr>
<td>Economic and professional</td>
<td>14</td>
<td>Cost of living here is very expensive. Lack of career options, and professional people to talk to</td>
</tr>
<tr>
<td>Issues concerning doctor-spouse</td>
<td>10</td>
<td>I am very concerned about the extremely long hours worked by my spouse</td>
</tr>
<tr>
<td>Education for children</td>
<td>9</td>
<td>I am very concerned about the lack of educational opportunities, boarding school is very expensive</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Positive aspects

<table>
<thead>
<tr>
<th>Life as a doctors spouse</th>
<th>Number of responses</th>
<th>Example of comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural lifestyle</td>
<td>56</td>
<td>Clean water, clean air, loyalty of rural friends</td>
</tr>
<tr>
<td>Community</td>
<td>30</td>
<td>Close knit community and friends, relationship with patients throughout the years. Excellent clubs hobbies</td>
</tr>
<tr>
<td>Professional issues/economic</td>
<td>28</td>
<td>A much quieter lifestyle, shorter working hours, financially secure here. No travel time. Continuity of care means we can follow a patient right through a course of treatment</td>
</tr>
<tr>
<td>Family</td>
<td>15</td>
<td>I feel very safe here, great for our young children. Children are always looked after</td>
</tr>
</tbody>
</table>

Advice to future spouses and families:

On completion of the questionnaire, spouses were then asked, if they could provide advice to future spouses and families of doctors who are intending to move to rural areas, what would that advice be? Table 3.41 provides a breakdown of respondent’s comments. The most common types of advice centred on positive attributes of country life and encouragement. Twenty respondents offered comments such as “go for it” and “make the most of all opportunities”. This response does indicate that many spouses are ‘in favour’ of this lifestyle. Only one respondent suggested that people should “think twice” about moving to a rural location.

The second most common type of advice concerned the importance of becoming involved with local clubs and community organisations, developing and maintaining hobbies. Sixteen respondents offered advice in this manner. This result is not surprising, given how important such activities were rated by respondents in aiding their own settlement and orientation. A number of respondents (20) suggested that spouses should thoroughly investigate both the rural town and the medical practice prior to relocating. This included undertaking a locum in that area first if possible. Advice included investigating housing, schooling, and other
facilities before making a decision to stay long-term. It is interesting to note that only one respondent suggested that a spouse should examine his or her own career prospects also. In terms of negative aspects, 11 respondents warned that spouses should be mindful of their actions, be careful who they spoke to, and who they befriended. An additional five respondents suggested that they should befriend either other doctors or other professionals if possible. Eight respondents suggested that spouses should be prepared to set limits on community involvement and be prepared to say “no” to community demands and expectations, a further five warned of the long hours their spouses would need to work, and the demands of the community on the doctors time. Only five spouses commented on the strain this lifestyle places on family (and spouse) relationships.

Table 3.41: Advice to future rural medical spouses

<table>
<thead>
<tr>
<th>Advice offered</th>
<th>Frequency of comments</th>
<th>Examples of respondent’s comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouragement for lifestyle</td>
<td>20</td>
<td>Seize the opportunity; it will widen your experience; give the opportunity to get to know yourself better. Pray, get involved, relax and enjoy - don't expect to find happiness if you weren't happy before you got there</td>
</tr>
<tr>
<td>Prepare yourselves; investigate community (such as housing, schooling) prior to relocation. Have realistic expectations</td>
<td>20</td>
<td>Choose the place very carefully and prepare yourselves as much as possible to adapt to things that you will not receive/able to access. Talk to as many spouses in rural situations to get a full understanding of what to expect. Have realistic expectations - integrate slowly - don't rush - make the most of your opportunities</td>
</tr>
<tr>
<td>Become involved in local community, establish hobbies</td>
<td>16</td>
<td>Get involved within the community from the outset eg sporting groups, church groups, committees etc</td>
</tr>
<tr>
<td>To set limits and put own family first. Take regular holidays.</td>
<td>11</td>
<td>Set ground rules with people you meet. Some friends can treat you as open 24 hours for consultation</td>
</tr>
<tr>
<td>Choose friends carefully</td>
<td>5</td>
<td>Make friends with local police families - they are often experiencing similar things - work situations also often overlap - helps spouse to socialise away from work, but not have problems with gossip as police are often ostracised in the same way. Make friends with people who are new to the area as the locals seem content with their own company and don't seem that interested in getting close to new people in town</td>
</tr>
<tr>
<td>Work on spouse/family relationship</td>
<td>5</td>
<td>Make sure you have a good solid basis for a relationship and you both communicate well with each other. Try to have enough family time - build a network - have hobbies, activities</td>
</tr>
<tr>
<td>Live out of town. Protect your privacy.</td>
<td>5</td>
<td>Don’t live in the town - establish some distance. Keep you private lives to yourselves until you are sure of new friends, but don’t isolate yourselves. Make sure you want to be ready to live in a goldfish bowl and want to be the centre of attention. Please if possible, try and live outside of the community on your private property</td>
</tr>
</tbody>
</table>
Be prepared for very hard work

5

- Be prepared for hard work, but enjoy the rewards.
- Be prepared for hectic life and long hours.
- The work is hard, but work to live, not live to work.
- Don't let work determine how you live your life - have other priorities

Other advice

- Buy lots of DVD's - cause there are no movie cinema's and TV is not good - seriously : you put in the hard yards it will pay off.
- Ask them if they have a forward plan for their time there - do not trust all you meet - you will make some special friends.
- Don't try to change anything immediately. Introduce changes slowly and respect your patients don't treat them like 'country bumpkins'.
- Be as self-sufficient as possible before arriving.
- Check out local council re willingness to assist with issues - schooling very important - check out standards of housing.

The types of advice that respondents wish to impart to new rural medical spouses parallel the areas that the majority of participants view as having major effects on their own lifestyles. A relatively high number of comments urge those considering a career in the bush to follow through with their plans and suggest that the hard work involved is worth the rewards. Respondents do, however, point out that it is extremely important for them to thoroughly investigate opportunities first, and have realistic expectations concerning the kinds of issues they will encounter. These results support earlier findings that those whose expectations were not met, were the most likely to be unhappy with their present situations.

Becoming involved in community clubs and organisations, as well as pursuing hobbies or interests were also suggested. As previous results have shown, such activities not only make up for the lack of entertainment facilities, but have also been described as a way of helping to reduce stress levels by providing ‘time-out’ from otherwise busy schedules. Many respondents also commented that being involved in local organisations was the best way to meet new friends.

Given the number of respondents that were concerned about a lack of privacy or anonymity, it is not surprising that the greatest warnings came in terms of avoiding community gossip, and to set limits on time spent dealing with queries concerning health matters (outside of consultation times). Both these issues were raised as being both time consuming and emotionally draining. It was also interesting to note that a number of respondents would advise new medical spouses not to live in the centre of town, but to find suitable housing on the outskirts. This was seen as away of increasing one’s level of privacy.
General Conclusions

It is important to highlight, that when viewing these results, some caution is required with regard to their interpretation due to the relatively small proportion of respondents. Although the demographic breakdown of respondents is proportionally representative of the 360 spouses QRMSA currently has listed on its database, it is difficult to generalise these results to the entire population of rural medical spouses and partners in Queensland. These results do however indicate that the experiences, needs and concerns of respondents identified in this report are ‘real’ and greatly impact on any decisions families may make regarding continued residence in rural locations. In addition, these experiences are substantially different across a number of dimensions (such as gender, ethnicity, age and degree of remoteness) and these dimensions should be acknowledged in any attempts to address issues raised.

Although differences across personal characteristics of respondents will be addressed in the following section, a number of conclusions can be drawn concerning the overall experiences of rural medical spouses. These include:

- Rural medical spouses are likely to be female, between the ages of 36 and 50 and Australian born.
- Are likely to have two or more children.
- Come from a mixture of rural and urban backgrounds. Older spouses are however more likely to have spent at least some of their childhood (prior to age 18) residing in either a rural or provincial location.
- Spouses with no rural upbringing are just as likely to reside in remote areas, as spouses who were raised in country areas. Spouses from provincial backgrounds are more likely to choose less remote areas.
- Rural medical spouses are likely to be tertiary educated, and employed as either a health or allied health professional.
- Are likely to be working in employment that is consistent with their education and training; although, those working as ‘Practice Manager’ are likely to be working outside their area of training.

The majority of respondents are involved in social activities, clubs or community organisations. In addition, over half of respondents are also involved with the Queensland rural Medical Family Network. Such organisations are perceived as important avenues for social contact and support. They are seen as a way to become involved in the local community, make friends, provide entertainment, and as a way of reliving the tensions and stresses of what is perceived at times to be a difficult environment to live in. A number of spouses are also heavily involved with community churches, both as a means of spiritual and social support.

As a large number of respondents have no immediate family living close by, social support is perceived as being extremely important. The majority of respondents reported that their spouse was their major confident, followed by friends within the community. A small proportion of spouses reported having no other friends or confidents and relied solely on telephone contact with other family members.

The majority of respondents felt it important that organisations such as the QRMFN provide both social and professional orientation programmes to new rural medical spouses. Many commented that it is very difficult for ‘outsiders’ to form friendships within small
communities, and that orientation programmes may aid new spouses in this process. The majority of medical spouses from urban areas are either not prepared for life in rural areas, or have unrealistic expectations, therefore pre-move orientation programmes may also be of great benefit. As this research has demonstrated, there is some correlation between whether expectations have been met, and overall levels of satisfaction with present situation. In support of the introduction of pre-move orientations is also the fact that a number of rural spouses are dissatisfied with both the level and accuracy of information that is provided to them by either employers or agencies such as Queensland Health, the Health Insurance Commission, and the Department of Immigration prior to relocating.

The results of this research show that while the majority of respondents had some choice in the decision to move to the rural area, most are there because of their medical-spouses employment. In many cases, these medical-partners are bonded to rural areas. Only a small proportion of spouses moved to rural areas for their own reasons. Most spouses recognise the fact that this decision had some effect on their own careers, and many put the needs of their partner’s career, over that of their own.

Although the majority of rural medical spouses reported receiving adequate levels of support from local communities, there are a number of aspects of living in small communities that have a direct impact on overall levels of satisfaction. Although some issues are experienced by all members of rural communities, others are specific to spouses of rural doctors.

Specific to rural doctors:
- The long hours medical-partners are expected to work and the effects this has on relationships, family, and ability to socialise.
- Lack of choice when it comes to private, confidential health care, for them and their families.
- The increasing demands of community expectations, in particular:
  - Expectation to serve on community organisations, to donate both time and money.
  - Expectation of both self and family to behave in certain ways to avoid community gossip.
  - Expectation to be continually aware of community events, and happenings.
  - Expectation to be partner’s full-time 24-hour receptionist – even at the local supermarket.
  - Expectation to be everybody’s friend: To either know, or not know (depending on circumstance) patient medical details.

Issues not specific to rural doctors:
- Lack of suitable career options, professional associations and interactions.
- Lack of suitable religious and or cultural facilities
- A general lack of anonymity and personal privacy

Although all respondents had experienced to a greater or lesser extent the above pressures of living and working a small rural community, and that such pressures at times made life difficult, few spouses reported such experiences made their time in the bush unbearable, or that they would choose to leave because of them. There were, however, a number of other aspects of their current life that were listed as likely to reduce their length of stay in rural areas.
These included:

- Access to suitable schooling for their children: This was a particular concern to spouses with children of secondary school age, or university age. While over half of the respondents were satisfied with the current level of education their children received, the lack of availability of secondary or tertiary education combined with a desire not to be separated from their children made relocation to a larger city the preferred option. Few respondents reported the cost of suitable education an issue.
- The socialisation of children was reported to be of concern by several spouses. This issue was more a concern for respondents whose partners were frequently relocated. This was also a major concern for spouses of Overseas Trained Doctors.
- Lack of family close by and social isolation. This was made worse the cost of national and international telephone calls, and because cost of transport within Australia made visiting family members very difficult.
- Employment issues, professional interaction and satisfaction. Many respondents commented on the sacrifice of income and professional development that they needed to make in order to provide both personal and professional support to their medical spouses.
- The quality of recreational facilities, adequate access to required needs.
- Lack of availability of locums for the medical practice, lack of holidays. Lack time off, in particular during times of sickness or family emergencies.

The combination of the above factors has resulted in many respondents feeling alienated across several of the dimensions alienation examined. In particular, due to the pressure of community expectations, feelings of status dislocation, (working in areas outside their levels of expertise or training) lack of both social and professional options and because many of their spouses are bonded to rural areas, respondents reported feeling varying degrees of powerlessness. Several spouses commented that they feel they are unable to influence many aspects of their life, there was, however, one decision they did feel they had a have a vote in. That is the decision to leave the rural area. Over half the respondents who replied to this question wanted to leave the rural practice within five years. Although many of the above reasons were cited, in many cases it was because they felt powerless to change the parts of their life they believed were out of their control. Adding to feelings of powerlessness were also feelings of normlessness. As previously indicated, many spouses reported feeling under pressure to act in particular ways that they would otherwise choose not to, or feel pressured into joining community committees or groups that they would, in other circumstances, not be part of. Both these situations increased the feelings of powerlessness that many respondents had expressed already.

Underlining a number of the conclusions discussed in this report so far is the fact that many of the opinions and concerns expressed by rural medical spouses centre directly or indirectly on the partner’s medical practice. Very few respondents placed their own needs, either personal or professional ahead of those of their partners. Even with the results of nearly ten years of research, rural medical spouses are still well and truly “married to the practice”.

---

13 Taken from the title of research conducted by Wise et al, 1996.
4.0 Comparing the perspectives of spouses across gender and Ethnicity

Overall gender differences
The results of this study have previously highlighted a number of significant differences between male and female spouses: These differences centre on two main themes:

1. Qualifications and Occupations:
   - Males were more likely than females to be employed full time
   - Females were less likely to be employed in work consistent with training
   - Males were more likely to be employed in non-health related occupations
   - Females were more likely to hold health related qualifications
   - Males were less likely to be employed inside the medical practice
   - Females were likely to be unemployed or work in the home

2. Social orientation and community living:
   - Males were less likely to have close friends or confidents (though less likely to feel socially isolated)
   - Females were more likely to be concerned about expectations concerning community involvement/awareness
   - Males were more likely to be concerned with being ‘invisible’
   - Males were more likely to be concerned with their own professional satisfaction
   - Females were less likely to have relocated in rural area for personal reasons
   - Females were less likely to be concerned with a lack of recreational opportunities
   - Males were less likely to comment on lack of access to health care

Although there are a number of differences between male and female experiences, it is difficult to determine exactly what effects they have on overall perceptions of respondents. In an attempt to determine the effect of such differences, Figures 4.1 and 4.2 present a correlation analysis of a number of aspects of rural living (both positive and negative) that female and male respondents commented on. Using Small Space Analysis, (SSA) it is possible to gain a greater insight into aspects of rural living, and the effects they have on the overall satisfaction of rural medical spouses.

The following SSA plots represent a spatial representation of the issues and lifestyle factors that respondents identified as affecting their experiences in the bush (each aspect is represented on the plot as a number). The closer each point is to another, the stronger the correlation between them and others surrounding them. Beside each data point is the proportion of respondents that rated this aspect positively. In terms of the five dimensions of alienation, each percentage represents the proportion of respondents that rejected the alienation statement. In terms of the community expectations, it refers to the proportion of respondents who did feel they had experienced this particular form of social pressure.
Figure 4.1 represents three polarising facets, each facet containing a number of clusters of issues that correlate highly with each other. The first major facet pertains to issues relating to the doctors working environment, and the effects this has on rural spouses. Points six through to nine demonstrate the impact that the long working hours of the doctor have on the socialisation of respondents. The percentage figures by each point indicate that the small proportion of female spouses that were content with the time the doctors could spend with their families were also most likely be satisfied with levels of personal privacy and anonymity. In addition, these spouses were also likely to have reported lower levels of powerlessness and meaninglessness (points 12 and 13). The 19 percent of respondents who did not feel they had to modify their behaviour in any way (point 25) were also more likely to report low levels of alienation on the powerlessness or meaninglessness dimensions. Furthermore, these spouses were also more likely to be satisfied with the levels of time they were able to spend with their spouses.

This particular cluster of results demonstrates the impact that the time doctors are able to spend time together as a family has on female spouses. They have the ability to form and maintain close friendships and also socialise more as a couple. It is possible that this factor allows for greater levels of interaction between family and community (leading to an increase of confidence), thereby reducing the impact of the lack of anonymity or personal privacy. In addition, this higher level of contact within the home may also reduce the need for respondents to feel they need to interact with their community on a more formal basis.
The second facet, relates predominantly to community expectation and contact. Central to this facet are issues that focus on social isolation. Forty percent of female respondents said that they rarely felt lonely or isolated (point 15). This point is strongly correlated with issues relating to both work and social involvement. Those spouses who did not feel significantly socially isolated were also more likely to feel low levels of normlessness (pressured to do things they would not normally do). In a similar vane, these spouses were less likely to feel certain community expectations, such as pressure to stay at home (point 20), pressure to remain invisible (point 24), and to a lesser extent pressure to be involved on committees, or to have experienced people wanting to form friendships on the basis of their partners occupation (point 22). These respondents also responded positively to issues of work enjoyment, and satisfaction with levels of professional development (points 16 and 10 respectively).

Forty two percent of female respondents responded positively to issues concerning satisfaction with health care (point 11). This issue is correlated strongly with other issues related to personal wellbeing such as social interaction, and employment issues. That fact that these issues are also correlated to some degree with several community expectations (points 18, 19, 22), may suggest that spouses who feel overall confident in their physical and emotional wellbeing are better equipped to deal with the pressures and expectations of local communities. This seems particularly evident for women who are established in the community in terms of their career paths and physical wellbeing.

The final facet relates to other professional considerations such as professional satisfaction and interaction (points 2, 3, 4), recreation (point 5) and the availability of locums (point 16). Given that these issues are removed from the main clusters of results, indicate that they are separate concerns, with little correlation to other issues, and specifically, with the dimensions of alienation. This distance indicates that although these respondents are unhappy with many of these issues, they have a less dynamic impact on other variables as those located around the main clusters.

It is important to note that only 16 percent of female spouses were satisfied with the provision of locum services (point 1), it is not surprising therefore that this aspect lies within relative isolation. It is interesting to note this point is also directly opposite of those who reported satisfaction with the time doctors spends with their families. Furthermore, the issue of locums is also polarised from those who are satisfied with recreational facilities/opportunities (point 5). It is surprising to note that poor locum availability was not strongly correlated with issues of isolation. One possible explanation may be that female spouses are resigned to the fact that there is little they can do about this issue, therefore they have chosen to concentrate or other lifestyle opportunities they can control (such as professional development on community).

It is interesting to note that satisfaction with recreational opportunities was not strongly correlated with other lifestyle aspects. This result suggests that the availability of recreational services (such as theatre, movies, etc) was not an issue of major concern for female respondents, despite approximately half reporting dissatisfaction with facilities.

Sixty-five percent of female spouses were content with levels of professional satisfaction (point 4), 58 percent with personal income, and only 35 percent were satisfied with professional interaction. Like availability of locums, and recreational services, these factors do not have strong correlations with other lifestyle factors. This finding may suggest that these are issues that female respondents feel they have little control over, therefore are more
accepting of. It is interesting to note, that professional satisfaction is not strongly correlated to either professional interaction or income. For female respondents, this result may be representative of the fact that many are employed as nurses, practice managers, or homemakers, and receive more satisfaction from their actual duties than from the extrinsic benefits their position gives them.

The distribution of variables in Figure 4.1 presents a number of interesting findings that support the results discussed in this report. For female respondents, issues concerning peer interaction, personal income together with the availability of locums were all aspects of life that were not directly correlated with other that lifestyle factors that had a more dynamic impact on their wellbeing (despite the fact that few respondents rated these issues positively (professional satisfaction and personal income being the exceptions). Issues that had a greater impact on their lives (and subsequent levels of alienation) included access to health care, professional development, and being able to spend suitable amounts of time with their spouse and family. Positive ratings on these issues meant that respondents were more likely to be able to deal with the lack of privacy and community pressures and expectations.

The majority of these particular issues can be directly targeted by the QRMFN with the continuation of its bursary programme, as well as the continued offering of professional development courses. These results indicate that continued learning and professional development are aspects of their life that female respondents view as very important to their continued presence in the bush and that they are aspects of their career that they have some degree of control over.

Certain community expectations and the effect they have on respondents subsequent behaviours (such as behaving in certain ways to avoid gossip), combined with effects of spouses irregular working hours) have the greatest impact on feelings of powerlessness and normlessness. Such results suggest that these are areas that the QRMFN should continue to develop strategies for. Working more closely with spouses within their own communities (facilitating meetings with local rural medical spouses, and possibly inviting in local speakers) may help to overcome some of these issues.
Figure 4.2: SSA depicting relationship between Male respondents’ responses and dimensions of alienation

Figure 4.2 depicts the relationship between variables identified for male spouses. The results suggest axial facets displaying four dimensions: personal issues, social issues, community issues and professional issues. It is important to note that these configurations are not chosen arbitrarily, rather they relate naturally to content.

Sixty-five percent of male respondents reported low levels of normlessness; this dimension is strongly correlated with a low perception of powerlessness (point 12), suggesting that male respondents are less likely to be influenced by community pressures or expectations. In addition over half of male respondents (56%) were satisfied with recreational activities, an issues that is also correlated with low levels of powerlessness. Less than one quarter (23%) of male respondents were satisfied with the time that their spouses spent with their family (point 8). Yet those who did score this positively, were also less likely to be concerned about modifying their behaviours, and less likely to report feelings of powerlessness. In a similar vane, the 58 percent of males who did not feel that community members either befriended them because they were the partners of doctors (point 22), or the 12 percent who did not think community members continually asked them intrusive questions (point 23) also reported low levels of powerlessness.

Central to this facet is the issue of powerlessness and normlessness. This may suggest that male spouses are affected to some degree by change in traditional gender roles, particularly if they have become the main caregiver while their partner is working. This theory is also supported by the fact that included in this dimension are concerns over community members...
asking inappropriate questions, and knowing that their friendships within the community are based on personal characteristics, not because they are the husband of the local doctor. Both these community behaviours may be indicative of a perceived by male respondents as a loss of power or control over his environment.

Central to the “social issues” dimension is the fact that male spouses are not perceived to be invisible in the local community (point 24), that they have a role to play in their own rights. This issue is strongly correlated with the 74 percent of male respondents who rated negatively on the meaninglessness dimension of alienation (point 13). Also lying in this cluster are issues of work alienation, and social isolation (points 15 and 16). This cluster of results demonstrates the importance of having a positive balance between work and social life for male respondents. Being able to spend time with friends (point 9), a positive work environment (including job satisfaction and professional development), and suitable access to health care (point 9) result in lower levels of alienation. It is interesting to note, that all of these aspects were rated positively by over 50 percent of all male spouses.

As with female respondents, relatively small proportions of male respondents were satisfied with levels of privacy and anonymity (point 7 and 8), not surprisingly, these two issues are also correlated with the pressure to modify behaviour to avoid community gossip (point 25), an issue that only 36 percent of male respondents had not experienced. This particular cluster of results indicate that the small proportion of males who rated these aspects positively were also more likely to report lower levels of social or work alienation, suggesting that maintaining levels of privacy/anonymity are very important to the overall wellbeing of male spouses.

Distributed across a separate axis is a cluster of points relating to community expectations and concerns (points 17-21). Central to this cluster appears to be the expectation that male spouses be continually aware of community events (point 17). Only a small proportion (11 percent) did not feel this to be a community pressure they had to contend with. Surrounding this point, are other community expectations that centre on community involvement (points 18, 19, 20). As the percentage figures indicate, however, these were pressures experienced by fewer respondents. It is interesting to note, that that slightly less than half of male respondents felt they had experienced the pressure to remain and home (point 21), and that they should be not working. The placement of this particular facet suggests that, although these are expectations that males have experienced (or at least are aware of) they are not issues that they seem particularly concerned with: a point that is supported by discussions with male spouses.

The distribution of the data in this cluster suggests male respondents (as with females) are acutely aware of community pressures and expectations, interestingly these centre more around community awareness, than whether they do, or do work. As with female spouses, community issues are strongly correlated with each other, indicating that these types of expectations are prevalent for both male and female respondents. These results do, however, suggest that they have less of a dynamic effect on males than they do on females, as demonstrated by the differing cluster patterns between the two genders.

Like the female respondents, only a small proportion of males (10 percent) were satisfied with current levels of locum provision (point 1), however, given its situation on the axis, and its lack of proximity to other factors, locum provision (although viewed as inadequate), is not
seen by male spouses as an aspect that they have any control over, thereby does not have a
dynamic impact on other behaviours or feelings.

The final facet for male respondents seems to relate to professional issues including
satisfaction (point 4) interaction (point 3) and personal income (point 2). Over half of the
male respondents (52 percent) reported high levels of professional satisfaction, but less that
one quarter (24 percent) were satisfied with current levels of professional interaction.
Furthermore, only 44 percent (point 2) viewed their current income level as adequate. Given
the position of this facet in relation to the others, this particular cluster may represent issues
that impact least on male spouses. Issues such as time spent with spouse and family (facet 1),
personal privacy general socialising and work enjoyment (facet 2) seem to have a greater
impact on male respondents wellbeing. Although professional interaction and income levels
are rated positively by only a small proportion of male spouses, the effect on subsequent
behaviours seem negligible (as is indicated by the distance these points are to issues of work
and social alienation).

Conclusions
These results supports the conclusions made by Wise et al (1996), in that there are many
substantive differences between the experiences and perceptions of male and female rural
medical spouses. As the SSA plots indicate, many of these aspects are consistent with
traditional gender role differences and gender stereotypes, and that these
differences/stereotypes can be exacerbated by several conditions of life within rural
communities. As previous results demonstrated, males are more likely to be employed full
time, and in their original careers. For this reason, they appear to be less effected by
community expectations concerning employment. As Figure 4.1 has demonstrated, female
spouses seem more affected by community expectations concerning their decisions to work,
as well as questioning over traditional gender roles such as child-care.

A major difference highlighted by the SSA plots is the effect that perceptions of social
alienation has on respondents. Seventy three percent of male respondents, as opposed to only
40 percent of female respondents responded positively to the dimension of social isolation
(point 15). For female respondents this issue was at the centre of a polarising facet associated
with expectations that they remain at home, work alienation and normlessness. For male
spouses, lower levels of social isolation were correlated more with higher levels of friendship
interaction, good access to health care, and issues of privacy and anonymity.

Male respondents appear to be more concerned over access to suitable recreational and
entertainment facilities than are female spouses, and are more vigilant of their involvement
with the community. This is particularly evident if they feel they are challenged in any way
regarding their ability to provide for their family, the nature of their friendship networks, or
other aspects they consider an invasion of their privacy.

Interestingly, although the majority of all respondents were very dissatisfied with locum
 provision, none specifically raised this as an issue that would drive them away from rural
practice.
Gender differences and projected length of stay:
Data from the SSA plots demonstrate that although and male and female respondents experience similar conditions and environments, a number of factors (including gender, previous rural experiences and differences in employment situations) greatly effect how they interact with these environments. As tables 4.1 and 4.2 demonstrate, these results may in part, explain differences in projected length of stay in present locations between male and female respondents. When comparisons were made on this basis, it was the female respondents that were most likely to opt for the shorter periods of stay, and the male respondents who were likely to nominate longer periods of stay.

Table 4.1: A comparison of female and male respondents by projected length of stay in current location (%)

<table>
<thead>
<tr>
<th>Projected length of stay</th>
<th>Male [N=18]</th>
<th>Female [N=55]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 0-5 years</td>
<td>44</td>
<td>53</td>
</tr>
<tr>
<td>Within 6-10 years</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>11 years or more</td>
<td>22</td>
<td>13</td>
</tr>
</tbody>
</table>

When reasons for projected length of stay were compared, a number of differences were apparent. As Table 4.2 demonstrates, female spouses were more likely to nominate either social concerns, concerns over their family’s education, or concerns relating to their spouses occupation as reasons they would leave the rural location. Male respondents were more likely to nominate concerns over their own career prospects as reasons they would leave the rural location.

Table 4.2: A comparison of female and male respondents by reasons for projected length of stay in current location

<table>
<thead>
<tr>
<th>Reasons for prediction</th>
<th>% Male respondents [N=29]</th>
<th>% Female respondents [N=113]</th>
</tr>
</thead>
<tbody>
<tr>
<td>To complete child’s education</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Once family finished high school</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Retirement</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Social/family</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Own career</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Economic</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Unsure</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Had enough/exhausted</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Period of bonding complete</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

The above table echoes some the differences between male and female respondents outlined in the SSA plots. Female respondents are more likely to leave the rural area for reasons of family and social isolation than they are for either their own career aspirations or economic reasons. The opposite is the case for male respondents. Males were more likely than females to have moved to rural areas for their own reasons; they were also more likely to have a rural background (therefore less likely to be affected by the remoteness of the area). Given these differences, perhaps it is not surprising that the male respondents opt for longer stays than the female respondents. Comments from male participants indicate that it is important to them that they contribute equally to the financial security of their family. If this is perceived not to be the case it is likely that they will consider leaving the rural area. Given that over the half
of male respondents rated professional satisfaction as high, and over 80 percent rated work alienation as low, in some part, explains why males are more likely to predict longer periods of settlement.
Examination of the perspectives of Overseas Trained Doctors.

The results from this survey indicate that spouses of OTDs/TRDs have slightly different experiences, perceptions and expectations than many Australia born respondents. Yet results indicate that overall, respondents with OTD spouses, are no unhappier than other spouses (with approximately 95 percent reporting general satisfaction with the life at present). Despite this result, there were several issues that were unique to their particular situation, and these issues, if not addressed, had the potential to greatly impact on their decisions to either stay or leave rural practice.

Differences included:

Employment issues.
- Respondents’ spouses were more likely to be bonded to a rural area, often resulting in feelings of “conscription”
- Respondents were more likely to be relocated to another hospital/practice in another area
- Respondents were more likely to feel community pressure to stay at home, and or delay own career (this pressure may, however, come from the respondent’s spouse as opposed to opinions expressed by the community).

Social issues
- Higher proportion of OTD/TRD spouses reported having few close friends, these spouses were more likely to report being unhappy
- They were more likely to be concerned over access to religious/cultural facilities
- They were more likely to choose shorter projections of stay in present location
- While they were more likely to undertake pre-move preparation, they were less likely to view expectations as being met
- They were more likely to view lack of family close by as a major problem
- OTD/TRD spouses were more likely to view quality of provided housing as either poor or very poor
- They were less likely to be expected to be involved in community organisations

Alienation: Spouses of OTD/TRDs were –
- More likely to feel powerless
- More likely to feel degrees of normlessness
- More likely to feel socially isolated

Involvement with the QRMFN
- Less likely to be involved with the QRMFN (almost 60 percent of OTD/TRD spouses had no QRMFN involvement)

General summary:
Although overall comments and responses from spouses of OTDs project a general level of contentment, as the above summary demonstrates, there are several aspects of their particular situation that are a cause of concern for them. Figure 4.3 presents an SSA plot of the responses made by spouses of OTD/TRDs to a number of issues, and represents the relationship between these issues and to subsequent dimensions of alienation.
Figure 4.3: SSA depicting relationship between spouses of OTDs respondents’ responses and dimensions of alienation.

The results of Figure 4.3 suggest modular facets displaying several major themes: In the centre of this plot, are situated a number of points relating specifically to respondents’ relationships with their spouse and their family. This centre ring represents a number of aspects of a respondent’s experience considered important for a meaningful life. Clustered around point 13 (meaninglessness) are social alienation (point 15), professional development (point 10), access to health care (point 11), and issues concerning spouse’s time with family (point 9).

Slightly less than half (48 percent) of OTD/TRD respondents rejected the question of powerlessness, (fewer than that of Australian born respondents), yet this issue is strongly correlated with the dimension of meaninglessness (point 13), and the rejection of the social alienation statement. Access to confidential health care (point 11) and professional development (point 10) are also a central aspect of their experience and are strongly correlated with lower levels of powerlessness.

Only 32 percent of spouses rejected the normlessness dimension (point 14). This result indicates that these respondents feel more pressure to alter their behaviour in ways they would otherwise consider inappropriate (for example modifying his/her diet because of a lack
of access to suitably prepared foodstuffs). This issue is also central to lower overall levels of alienation. It is interesting to note, that also in this central ring are those who felt that the community did not view them as an on-call receptionist for their doctor spouses. Although the response to this question was similar to those of other respondents, it seems to have greater importance for OTD/TRD spouses, and is more closely correlated to issues of powerlessness and meaninglessness.

The interaction of factors in this central ring suggested that spouses of OTDs/TRDs are more affected by a loss of control, than other respondents. All these issues suggest that those respondents who retain control over their healthcare access, the time they spend as a family, and their community persona, were more likely to feel less alienated than those who feel they have little control over these issues. This result is not surprising, given that many already feel they have little say over where they are living or how long they have to remain there.

Radiating out from the central ring are issues concerned with community involvement and social needs. The dispersion of these factors suggests community expectations in particular, have less of an impact on their general wellbeing. As with Australian born respondents, only a small proportion of OTD/TRD spouses reported adequate levels of privacy and anonymity (27 percent and 24 percent respectively), yet these factors do not seem to have a direct impact on respondents’ levels of alienation. More strongly correlated to issues of meaninglessness are adequate facilities for religions/cultural practice (point 26), recreational facilities (point 5) and professional interaction (point 3). Sixty two percent of OTD/TRD spouses reported high satisfaction with religious facilities, and while not located in the central ring, its proximity to positive levels of meaning, suggests it is an important factor for the wellbeing of respondents. Interestingly, only 31 percent of these respondents were satisfied with recreational facilities (point 5) and 35 percent satisfied with levels of professional interaction. Like religion, however, while correlated with levels of meaning, these factors do not appear correlated to other lifestyle factors. As with responses from Australian born respondents, these may simply represent issues that are related to their location, and therefore they have no power to influence.

As with the other SSA plots, professional satisfaction (points 4), personal income (point 2) and satisfaction with locums (point 1), are located on the outer ring. This dispersal suggests that they are issues respondents view as having limited direct impact on their wellbeing (regardless of whether they are viewed as satisfactory or not), as again, many feel they have little ability to influence these particular issues. As with Australian born respondents the majority of OTD/TRD spouses were dissatisfied with current locum provision. As with all other respondents, locum provision is not strongly correlated to other lifestyle factors. While the majority of comments from respondents express concern of the difficulty of getting locums, many OTD/TRD spouses recognised that often it is their partners who are actually providing relief for other doctors.

Conclusions:

These results support conclusions that suggest OTD/TRDs and their spouses have slightly different experiences in the bush than Australian born doctors and their families. Issues of community involvement, community expectations, and professional concerns differ in their focus and their affects on families. As such, the QRMFN needs to address these issues in particular, if it wishes to aid in the retention of these families in their present locations. As previously discussed, spouses of OTD/TRDs are more likely to predict that they will leave the rural environment as soon as they are able (usually this is a soon as their partner’s bonded
period is over). It is therefore vital for their retention in rural areas that their experiences in
the bush are positive ones; only by ensuring they are adequately supported and have
improved access to religious and recreational facilities may it be possible to extend their stay
in the bush.

Many of the reasons given for this desire to leave the bush are beyond the purview of the
QRMFN, however, the network can offer some interventions that may prolong these spouses
rural stay. Such interventions may include:

• Aiming to increase the number of OTD spouses involved in the QRMFN and helping to
foster community awareness, and community involvement.
• Trying to ensure that families are not repeatedly relocated
• Providing social orientation programmes, and even pre-move programmes so they are
better equipped to deal with the lack of facilities. This should information concerning
multicultural agencies and support services in their local area.
• Closer monitoring of the cultural and spiritual needs of OTD/TRD spouses and their
families. QRMFN Hub representatives could undertake cultural awareness programs to
adequately prepare them for dealing with cultural issues that may arise.
• Continuing to provide professional development courses and scholarships
• Ensuring that dietary requirements of OTD spouses are taken into consideration at
QRMFN events.
• Being aware of the specific health needs of OTDs and their spouses.
5.0 QRMFN Needs Analysis

The QRMFN was established in 2000 and comprises a group of voluntary medical spouses/partners who utilise a variety of formal and informal means to provide assistance to Queensland rural medical partners and their families. The QRMFN management team comprising of seven members determines policy and planning and liaises with the QRMSA Family Network project officer who coordinates the QRMFN programs.

Prior to 2001, a minimal amount of funding was provided annually to the QRMFN by QRMSA to support the QRMFN in their activities. As a response to the shortage of rural medical practitioners in Queensland, the Commonwealth Department of Health and Aging (DoHA) significantly increased their funding of the QRMFN so that the network could enhance and expand the assistance they provide to rural doctors and their families.

The Queensland Rural Medical Family Network was established to assist rural and remote doctors families by:

- Reducing the sense of isolation
- Providing a means of networking with peers
- Assisting in counselling and problem solving
- Improving the quality of life of rural spouses and their families

In the three years that the QRMFN has been operating, it has developed important relationships with the Queensland Rural Divisions of General Practice and several other medical and community stakeholders. The network runs a number of programs such as the rural bursary programme, an information 1800 telephone hotline, and assisting with the cost of telephone counselling. In addition, it provides social and educational opportunities for spouses at medical conferences and Continued Medical Education workshops.

This needs analysis was undertaken as part of the QRMFN research project, and incorporated in to the postal survey. Its purpose was to ensure that the QRMFN funds were being utilised appropriately to improve the quality of experience of the rural doctors families. The assessment aimed to determine the requirements for rural and remote spouses/partners in the areas of:

- QRMFN representation
- QRMFN functions and networking activities
- Involvement in the QRMFN
- Utilisation of bursaries

Involvement with the QRMFN

Slightly over half (51 percent) of the respondents to the survey reported having involvement with the family network. A positive achievement given the short period of time the QRMFN has been operating. A breakdown of these respondents shows that of those who did report QRMFN involvement, 81 percent were female, (51 percent of all female respondents). Only 19 percent were male (representing 33 percent of all male respondents).

When analysed by age category, almost 60 percent of respondents involved with the QRMFN are aged between 36-50, slightly over one quarter (28 percent) are older than 51, while only 14 percent are between 26 and 35.
Only twenty-eight percent of respondents who were from countries other than Australia are involved with the QRMFN. This figure makes up 22 percent of respondents who have had involvement with the family network in some form. The remaining 88 percent of spouses who are involved with the network are Australia born.

Of the respondents who reported involvement with the QRMFN, over half (56 percent) are located in RRMA 5. Those respondents in RRMA 6 and 7 make up 11 percent and 15 percent respectively. The remaining 19 percent are made up of partners living in RRMA 4 locations.

Interestingly, 47 percent of all respondents living in RRMA 6, and 50 percent of all respondents from RRMA 7 locations reported utilising the QRMFN services at some stage. This result suggests the importance of the family network to those partners in more remote areas.

Nearly all of those respondents (98 percent) who have involvement with the QRMFN have children.

Several respondents commented that although not heavily involved with the network, they appreciated the fact that the organisation was there if they needed it.

- It is nice to know that I would find a friendly, concerned ear, if I needed it.
- If I needed it, it is there to become involved in.

Other comments concerning the nature of involvement with the network included:

- I am mainly involved with teleconferences and participation. I am also involved with meetings and so on. I became involved with the network as soon as it was started.
- I met the rep, and then started to receive the newsletter, but that’s all.
- QRMFN is a big help for OTDs. They put OTDs in touch with each other.
- We should have a closer network, it’s very important, particularly if spouses are from other countries.
- I was introduced through the division, through the things that they did. I met the hub representative. They help with the problems of the people who are isolated, to do something so they don’t feel so lonely. They were very supportive and very helpful, they do telephone conferences and so on.
- Only now that the kids are older and we have another doctor in the practice can we attend events. Since then it’s been really good. It’s where I have met everyone. You see that there are a lot of people that have the same thoughts and concerns as you do.

Comments from respondents with little or no involvement with the QRMFN included:

- None what so ever, hadn’t heard about it.
- None, I have the newsletter and their telephone number, but nobody has contacted me, and I have not rung them.
- No real involvement with QRMFN. No orientation or involvement when we first arrived. I do receive the Backbone newsletter. I don't know what sort of support they offer. An orientation is necessary, but I don’t know what to include. But information on particular schools would be useful. We are provided with no information from QH or QRMFN. No one shows you the schools or so on.
• Not much help from network. My husband did get a call, or he called them. He was told something about family support. I was told about QRMFN by the division at one of the meetings.

Comments concerning appropriateness of involvement:
Respondents were asked to comment on whether they felt their involvement with the QRMFN was appropriate to their needs. The majority of spouses were very happy with the involvement with the QRMFN and the services they currently provided. Comments included:

• Great to see it - love the children’s competitions - like the news of other families, great to read of the Chater’s holiday - be positive, go forward
• I believe the work that has been done by the QRMFN is on the right track if some of the problems causing the rural doctor shortage are to be solved
• QRMFN get together in Brisbane was very supportive
• QRMFN is improving every year as it gains more data on its responsibilities & requirements
• Wonderful support emotionally

Some respondents were unsure of the actual role of the QRMFN, as these comments indicate:

• I don’t know what they do. Maybe they could help out with employment, that sort of thing.
• I would like some sort of get together with other people. We all have the same sorts of problems. A husband that’s never at home. We have to cope with the kids on our own. If we can talk to a few people, that would help a lot.
• In some places there is nothing you can do for anybody down there. There is nothing to do, nowhere to take the children to. The QRMFN hasn’t met my expectations, the communication and mentoring hasn’t happened, although it is getting better. It’s a matter of getting the people together who can organise these things and it’s starting.
• We should have a closer network particularly for the ones that are west or far north, some are quite isolated, particularly those from other countries. It’s very difficult for some of them to adapt to Australian outback life.
• Paying for things like travel is very important, they should be applauded, assisting with travel is very important. Make better efforts to involve spouses in MET activities.
• Don’t treat people as an extension of the doctor. Invitations need to go to the partner, not just the doctor. Ring someone up, not just post stuff to them. Ask for advice, not tell them. Include activities for the kids also.
• I do not wish to comment. Been there done that. I was willing to talk to anyone, but I’ve never been contacted by any representatives. All spouses who go to rural areas are all individuals they all the their own set of problems, some are common, but the ones that need the help will ask for it. The resources are there. The ones that don’t perceive themselves as needing help, wont ask for it.
Satisfaction with the QRMFN

Participants were asked to rate on a scale of 1-5 their level of satisfaction with services offered by the QRMFN (1 being “very satisfied, 5 being very dissatisfied).

Overall, 47 percent of respondents reported being either satisfied or very satisfied with the services provided by the family network. Almost one quarter of respondents opted for a neutral response, but commented that overall, they were happy with the QRMFN. Only 3 percent of respondents reported that they were dissatisfied with the current services provided by the QRMFN. Interestingly, the participants who reported dissatisfaction with the family network were all male spouses.

Comments concerning spouse satisfaction with the QRMFN included:

- I’m only getting into it now, and I’m finding it’s been really great.
- More could be done and more notice for events (perhaps a year in advance so that logistical arrangements can be taken care of).
- QRMFN is improving every year as it gains more data on its responsibilities and requirements.
- They appear very in tune with needs
- Thoroughly enjoyed the spouses conference - provided good opportunity to make contacts

Several comments from male spouses included:

- I don’t have much to do with them, but I would like some kind of contact, I’m getting the newsletter, but that’s about all.
- I do pay attention, but I haven’t heard of this. Nothing they could provide could be useful.
- Very little involvement. Only [QRMFN representative] occasionally. No formal contact. Only newsletters, but they get pushed to one side.
- Not much contact with them at all. It’s really important to put other males in touch with each other. To talk about how they feel about it all, even just to say hi for a social chat. It would be good, to share their feelings about how they are doing, how they’re feeling.
- The QRMFN are more targeted towards the wives of doctors - male spouses are an afterthought.
- The QRMFN is too late for me - I already have my survival strategies in place. I have survived and will continue to do so.

Future requirements and services:
Spouses were given a list of services the QRMFN currently provides, or would like to develop in the future. They were asked to rank them in order of priority, from very important (1), to least important (5). Overall, respondents rated all activities at least mid-range on the priority scale, indicating that all were seen as important services the QRMFN should provide. It is interesting to note, when these responses are examined by population town size, those respondents who live in towns of less than 5000 people have prioritised services quite differently to those residing in towns with populations over 5000. In addition, those residing in larger populated towns rated each option consistently of lesser importance than did those from smaller towns.
As Table 5.1 demonstrates, for those respondents residing in smaller towns, social programs such as children’s activities, social orientations and newsletter are ranked as the most important. For respondents living in larger towns, health services are listed as being most important. Access to confidential health care, while listed as most important for these respondents was rated seventh on the list for those in smaller areas. Of note, is that respondents regardless of the town size they resided in prioritised the last three services in a similar way. Given the differences in population size, it is not surprising that respondents in the smaller towns have prioritised social services as the most important. It is unlikely that these respondents have much opportunity to socialise with other medical professionals on a regular basis, therefore events such as activities at CME events are seen as an important avenue for social networking.

Table 5.1: A comparison of respondents prioritising of QRMFN services by respondent’s residing town population size

<table>
<thead>
<tr>
<th>Desired activity</th>
<th>Mean</th>
<th>Desired activity</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's activities at CME events</td>
<td>1.6</td>
<td>Confidential medical facilities</td>
<td>2.1</td>
</tr>
<tr>
<td>Social orientations upon arrival in town</td>
<td>1.8</td>
<td>Social orientations upon arrival in town</td>
<td>2.1</td>
</tr>
<tr>
<td>QRMFN newsletter</td>
<td>1.8</td>
<td>Children's activities at CME events</td>
<td>2.2</td>
</tr>
<tr>
<td>Mentoring programs for spouses</td>
<td>1.8</td>
<td>Counselling facilities</td>
<td>2.2</td>
</tr>
<tr>
<td>Counselling facilities</td>
<td>2.0</td>
<td>Work orientation programs/bursaries</td>
<td>2.2</td>
</tr>
<tr>
<td>Work orientation programs/bursaries</td>
<td>2.0</td>
<td>Mentoring programs for spouses</td>
<td>2.3</td>
</tr>
<tr>
<td>Confidential medical facilities</td>
<td>2.1</td>
<td>QRMFN newsletter</td>
<td>2.4</td>
</tr>
<tr>
<td>Events just for spouses/partners</td>
<td>2.1</td>
<td>Gender specific activities at CME events</td>
<td>2.4</td>
</tr>
<tr>
<td>Internet based communication with others</td>
<td>2.3</td>
<td>Events just for spouses/partners</td>
<td>2.4</td>
</tr>
<tr>
<td>Gender specific activities at CME events</td>
<td>2.3</td>
<td>Internet based communication with others</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Providing children’s activities at MET events
When ranked in order of priority, of the ten issues, providing children’s activities was ranked the most important for respondents in smaller towns, and listed second for those in larger towns. Overall, fifty eight percent of respondents ranked this as either being Very important or Important (eighty percent of all females and 73 percent of all male respondents ranked this option as the most important). As MET activities were often the only form of peer interaction for many spouses, it was commented that being able to spend time with peers and partners was a welcome change. It allowed time for social interaction and professional development with like-minded individuals, and also gave their children time to socialise with others the same age.

Social orientation upon arrival in town
Respondents ranked this service as second most important. Providing social orientation on first arrival in a new town was ranked either Very Important or Important by 76 percent of all female respondents and 62 percent of all male respondents. These proportions were similar across age, ethnicity and RRMA categories. This result indicates that despite being ranked second priority, this service is seen as a very important aspect of the QRMFN.

Several participants did, however, comment that they had very little communication with QRMFN representatives (or the community) upon their first arrival in a new location,
therefore some form of initial contact would be greatly appreciated. As one respondent noted:

- Maybe they could ring me, if they knew a new person was coming into the town and say this person is new, and go out and have morning tea, tell them about the town, and about the services they offer. It doesn’t even have to be aimed at the spouse, but just where to enrol kids in school where things are and so on. It’s hard to try and find out where everything is.

- I think if they are going do it, they should grab people when they first arrive, and say, who they are, and ask what can we do for you. To help you out when you first arrive.

Confidential medical services
Almost three quarters of respondents (71 percent) ranked confidential medical facilities as being either Very Important (40 percent) or Important (32 percent). The mean ranking to this service was 2.1, indicating a strong preference for this type of service. This option was rated as the highest priority for those respondents residing in larger towns.

When examined by gender, 91 percent of those respondents who ranked the provision of confidential medical services as being Very Important were women.

When broken down by RRMA, the majority of respondents from RRMA 6 (90 percent) ranked the provision of a confidential medical service as being either Very Important or Important. This figure is followed by 74 percent of RRMA 5, 57 percent of RRMA 4 and 64 percent of those respondents residing in RRMA 7 locations.

Comments concerning the provision of medical serves were varied; some spouses were very concerned by the lack of confidential services, while others were more than satisfied with local facilities. Of those respondents who were concerned, issues of privacy and anonymity were their greatest fear.

Provision of counselling facilities
In mid 2002 the QRMFN introduced a telephone counselling service for rural doctors and their families. Responses to this initiative varied, this may be due to the amount of knowledge spouses had regarding this service. This service did rate a mean score of 2.0 from those in smaller towns and 2.2 from respondents living in larger areas. These ratings suggesting that overall this was seen as important service by all respondents.

Sixty-nine percent of all respondents ranked this service as either Very Important or Important. This service also appears to be more important to women. Overall, counselling services were ranked as equally important across the different RRMA categories. Interestingly however, 60 percent of those who ranked this facility as Very Important, were located in RRMA 5. Counselling services were also ranked more highly by those in the 36-50 age category.

Provision of the QRMFN Newsletter
The provision of the QRMFN newsletter was seen by the majority of respondents as an important service provided by the network. A breakdown of remoteness categories suggests however, that it is seen as more important by spouses residing in more remote areas. For example, seventy one percent of all respondents living in RRMA 7 locations ranked this
service as Very Important. Sixty percent of respondents living in RRMA 6 areas ranked this service as either Very Important or Important, as did to 64 percent or those living in RRMA 5, and 60 percent of those living in RRMA 4 regions.

Female respondents ranked the provision of a newsletter slightly more important than male respondents, (70 percent and 50 percent respectively) and older respondents were also more likely to rank the newsletter as an important service (74 percent of respondents over the age of 51 ranked this service as being either Very Important or Important, as opposed to approximately 60 percent of those between 25 and 50).

Comments concerning the provision of the newsletter included:

- Backbone is an excellent forum and good networking tool.
- I enjoy reading the newsletter and I enjoy the fact that they are there if I need them.

Mentoring programs
Respondents ranked providing mentoring programmes as the next most import service. Of those respondents who reported this as being Very Important, sixty percent were in the 36-50 age category. Over fifty percent of all respondents in the 51 and over category ranked this service as being Very Important. When these results are examined by RRMA, 85 percent of respondents in RRMA 7, and 70 percent of respondents in RRMA 6 ranked the provision of mentoring programmes as either Very Important or Important. These percentages are slightly higher than those recorded by respondents in RRMA 5 (68 percent) and RRMA 4 (65 percent). These results do suggest that spouses who reside in more remote areas see a greater need for mentoring programmes than spouses who live in the less remote centres.

One spouse noted that the she believed that mentoring should be one of the major focuses of the network:

- A spouse meeting for interaction and mentoring. Activities should always complement the doctor; it shouldn’t lose sight of that.

Work orientation and Bursaries
The provision of work orientation and bursaries was ranked as either Very Important or Important by 67 percent of spouses. In particular, participants in the remotest areas ranked this service as being an important aspect of the QRMFN, with 80 percent of participants from RRMA 7, and 65 percent of participants from RRMA 6 ranking this option as either very Important or Important. Approximately 70 percent of respondents between the ages of 25 and 50, ranked this service as being Important, as did those aged 51 or over.

Several participants did note, however, that the use of bursaries to fund leisure activities such as “flower arranging” was an inappropriate use of QRMFN funding, given that some medical families would be more likely to afford such classes than other families in rural locations.

Events just for spouses
Fifty eight percent of respondents ranked the provision of spouse/partner only events as either Very important or Important. An overall mean rating of 2.3 (2.1 for respondents in smaller towns, 2.3 for respondents residing in larger towns), suggests that the majority of spouses were at least in favour of this service being provided. Interestingly, all spouses (100 percent) who did not have children ranked this service as either Very Important or important. Seventy
percent of spouses who do have children also ranked this option as being important. Approximately 65 percent of spouses who were between the ages of 25 and 50 ranked this service highly, as opposed to those spouses who were over the age of 51, who were more likely to view this option as least important.

Such results suggest that organising events that do not include children would be supported by younger spouses, most likely who do not have children. Given the number of comments concerning lack of entertainment facilities, an occasional ‘spouses’ only social event at workshops may prove a popular addition to services provided.

**Gender specific activities**

Although several male respondents commented on the lack of services provided to male spouses by the QRMFN, only 51 percent of males ranked gender specific activities as being Very Important or Important, as opposed to Over 60 percent of females ranking this issue as being important. This may however, be due to the fact that several male respondents commented that events should be centred around “family activities” such as outings to parks, swimming and so on, as opposed to events such as golf trips of shopping excursions.

One male respondent commented on the lack of interaction with other male spouses, although did not think gender specific activities was necessarily the answer.

- I don’t see much of other male spouses. I would be interested in communication with other males. I have been a married spouse for 16 years, and I am sure I have some knowledge I could impart to them, and things they could impart to me. Would like to be involved in some form. But it doesn’t have to be males only.

- I don’t see a need for male type activities, the network is for families supporting the doctors, it shouldn’t lose sight of the fact we are the family of the doctor, not the doctor themselves.

Several spouses, were however, keen to be involved in gender specific activities:

- It would be good to find out about other male spouses, I come to events but you never meet their husbands. Just to be able to talk about things, to share common gripes, false impressions people have. It would be good to have a moan about it to someone who knows what you’re talking about without sounding pretensions.

- It would be much better if they could put male spouses in other rooms, and buy them drinks all night. Also to organise events for male spouses, like a golf game, it would help people to bond together.

**Internet based communication with others**

Respondents ranked providing Internet communication links between spouses as the least important of all the options. Forty six percent of respondents ranked this option as being Very Important or Important. Forty percent ranked this option as Least Important or Neutral, the others had no response to this option. It is interesting to note that the remoteness of respondents made little difference to their rankings on this issue.
It should be highlighted that the mean rating for this initiative was 2.5 on the 1-5 scale. While this is the lowest rating, it still indicates that this service was seen as being an important initiative. Individual comments indicate that while participants were keen to pursue Internet communication, many were unsure how this could be achieved.

One male spouse discussed his concern with relying on the Internet or Email as a means of communication:

- I think the Internet communication is not a good thing. I get countless Emails from business, and clients and so on. The last thing I need is to be stuck in front of the computer for any longer. I don’t check half the Emails I get even now. Communication needs to be more personal, either by phone, or in person.

- There should be other alternatives to email and Internet also, I get 70 emails a day, and my wife hardly uses it. They need face-to-face activities.

Comments from respondents in favor of Internet communication included:

- Perhaps they could provide books on teamwork, and run Internet chat rooms, where the males can talk, while the wives are out shopping.

Conclusions and recommendations
This analysis was conducted to ensure that the services offered by the QRMFN are appropriate to the needs of rural practitioners’ families, thereby assisting them during their time in the rural community. Participant’s comments, particularly during the initial interview process, demonstrated that it is important that families have the opportunity to express their concerns and frustrations in a forum where they feel their views will be listened to.

An important revelation of this survey is that while almost half of respondents (who were involved with the network) maintained that the network was meeting most of their needs, approximately 50 percent of the respondents had either no knowledge, or had not had any involvement with the family network. Of those who were aware of the network, many had received the newsletter, but had no other participation in the network’s events.

Several of those interviewed had voiced a willingness to be part of the network, to provide mentoring services or welcome orientations, but had not had their offers accepted. Results suggest that there is a need for members of the network (through the Hub representatives) to be more proactive in contacting rural medical spouses and advising them of the services that the QRMFN offer.

There seems to be a perception, particularly amongst male respondents, that the Family Network is predominantly for female spouses. While the majority of spouses/partners of rural practitioners are female, male spouses should not feel that they are excluded from activities. By providing a range of activities, which are not perceived to be for females exclusively (for example, shopping excursions) the network may be able to increase the number of male spouses attending their programs.

It is evident from responses from both the interviews and the postal survey, that the provision of social events is very important to some families, and not seen as an important function, by
others. Responses from this needs analysis indicate that rural spouses are not a homogeneous group, and that there are some services that are required by some, that would not be suitable for others. Taking into account differences such as gender, age, or presence/absence of children and simply level of remoteness, will be an important aspect of the future planning of the Family Network.

Several areas of service provision were highlighted as being of significant importance. These included:

- The importance of the provision of an information/orientation pack to new families upon arrival in a rural town
- To have initial contact with a Family Network representative upon arrival to a town. This should be made over the telephone and the representative should not arrive unannounced. Spouses should be asked whether they would like further contact, this should not be assumed.
- Children’s activities should remain a major focus of the networks’ activities at CME events, however, they should not be the only focus. Several respondents expressed a desire to be given an opportunity to spend time socialising with other spouses away from their children.
- The provision of confidential medical and counselling services.
- The continuation of bursaries and scholarships, although there were some calls to restrict such bursaries to vocational activities.
- The continuation of the “Backbone” newsletter. Some possible additions such as relevant men’s articles to be examined.
- The possible addition of activities such as golf to be included in CME activities if practical. While gender specific activities may not be necessary, the inclusion of “gender neutral” events could be examined.

Responses indicate that it is vital for the Rural Family Network to continue to provide face-to-face contact and not rely on Email or Internet communication. Research has demonstrated\(^\text{14}\) that a quality welcome of a new family leads to the creation of a positive impression of the community. It should be noted, however, that this is the responsibility of the entire community, and responsibility should not be the sole responsibility of the Rural Family Network. Greater links between the Network, the Rural Division of General Practice, medical employers, the local community and Commonwealth representatives need to be developed, to ensure that contact is maintained.

The QRMFN needs to ensure that offers of help by individual spouses are acknowledged and that the necessary follow-up is undertaken. This will not only ensure that positive relationships are developed and maintained, but will also help ease some of the workload placed on the management team, and on its area representatives. The QRMFN also needs to ensure that its representatives are well supported, have suitable guidance in their role, and the information they provide, either personally, or in the form of information packs, is relevant and up to date.

Comments from respondents indicate that there is a need for the network to broaden the scope of services that it currently offers. These services must be dependent on the demographics of the local community, some focussing on members without children, some on members of particular age groupings, and some for families who have been residing in

\(^{14}\) Roach, 2002
rural communities for extended periods of time. The Network needs to be representative of all rural families, at present there is a perception among some spouses that its services are predominantly for those relatively new to rural areas.

The QRMFN activities do not necessarily need to be run solely by the QRMFN. The QRMFN could facilitate events, but allow rural spouses or local services take responsibility for their organisation.

**Possible future directions:**
In order to address some of the concerns that have been voiced through this research process, it may be necessary for the QRMFN to re-examine its role, in terms of the types of supports it provides to the spouses of rural medical practitioners. Results indicate that respondents would like to see the continuation and increase in social supports and networking as well as offering activities at CME events and functions. There is a perception among respondents that the Family Network does not cater for male spouses, or female spouses without children. Perhaps a recruitment drive on behalf of the Network management team to attract males, and non-Australian born spouses to its committee, may help remove this impression.

Results from the main study clearly indicate that non-Australian born spouses are in need of greater social networks, one possible solution to this issue may be the introduction of pre-relocation orientation workshops. Responses clearly indicate that many spouses (particularly those new to Australia) have many unrealistic or false expectations and perceptions of what their experience will hold. As all respondents who reported being unhappy in their present situations, also acknowledged that many of their initial expectations prior to moving were either not met, or incorrect, addressing these initial concerns may help alleviate later unhappiness. Results from this study suggest that respondents who know what to expect, and how to deal with issues as they arise, are more likely to be settled in their current location.

Many respondents commented about the pressure of community expectations on them and their family. It is not possible to change the nature of the community, however, having a strong Family Network that is supporting doctors spouses, may help to address this issue. No respondent listed the Family Network as a source of support, or as a specific organisation they felt a member of, yet over 70 percent reported being involved in community organisations or clubs. Utilising local communities more in their activities, may aid both the Family Network and medical spouses become part of the larger community dynamic. If the rural community feels they have something to offer the doctors spouse (and vice-versa), then community pressure may no longer be so profuse. Changing community perceptions and stereotypes is a long-term process, however, by addressing the needs of its own community (of rural medical spouses), the QRMFN will take the first step in resolving these larger issues.

Queensland Rural Medical Family Network is actively and effectively supporting many of the needs of Queensland rural medical spouses, however, as this research also suggests, there are still a number of issues that the QRMFN need to address in order to continue to support these spouses. There are also many medical families who are not utilising the services of the QRMFN.

Responses from this research suggest that there are some areas of need that the Network is not currently addressing, or could be approached in a different manner. These include a greater awareness of the requirements of spouses in different communities and a greater need
for consultation with community representatives. QRMFN representatives need to ensure that new arrivals in a community are given the opportunity to participate in the Family Network activities, an up-to-date welcome pack, with a calendar of QRMFN events, and a list of necessary contacts should be the first step. Furthermore, it is vital that contact be maintained after that initial meeting (if desired), so that spouses are not left to feel isolated after initial contact has been made (an issue raised by several respondents).

Variations in QRMFN functions that reflect the needs of all of its members will greatly enhance the profile of the QRMFN, as it will be seen to be recognising the individual needs of its members regardless of age, gender or ethnicity. In addition, the inclusion of an annual forum, where spouses have the opportunity to suggest directions and activities of the Network may help the QRMFN management team to gain an insight into the different needs of its members.

**Some final comments:**

The results of this needs analysis acknowledge and identify the issues and concerns of rural medical partners and their families. It is important to note that problems and concerns vary from region to region, it is therefore imperative that any attempt at identifying solutions take regional and individual differences into consideration, and that solutions be directed at a local level, where factors individual to that specific family and their community be taken into consideration.

The role of the partner of a rural medical practitioner is a complex mixture of supports. This includes, support for the partner, support for the practice, and support for the patients. It is a job that involves the subjugation of their own interests and often, their own careers. “It is, moreover, a vital contribution to the health of the rural community in many ways, that are at times, under-valued and under-supported” (Wise, et al, 1996, p68). Research conducted by the QRMFN clearly shows that social and professional isolation of spouses (and the resulting feelings of powerlessness) are major factors in any decision to leave the rural area. It is vital therefore that the QRMFN continues to develop its strategies and interventions in order to support and empower rural medical families. Furthermore, it is of major importance that the Commonwealth continue to financially support programs that aid rural medical families and allow these agencies to reach their desired objectives. The happiness of the medical spouse and the medical practitioner are indelibly linked if we wish to recruit and retain practitioners in rural Queensland, as one spouse commented:

“A spouse/partner has to be supported and happy for the medical practitioner to firstly go to the rural place, and secondly for the doctor to stay, the partner and children must be happy.”
6.0 Focus groups

The concluding section of this research consisted of a series of four focus groups conducted across selected areas of rural Queensland. The purpose of these groups was two-fold; firstly, to ascertain whether there was a general consensus among rural medical spouses regarding the interpretation of the main survey results, and secondly to discuss the findings of the QRMFN needs analysis and to engage participants in discussions around the family network and its future direction. The focus groups utilised semi-structured, open-ended discussions. This process allowed the researcher to explore areas of the original research results that needed clarification, as well as to enable participants to raise other areas of concern or importance. The research utilised a power-point slide presentation that interspersed research results with a series of discussion prompts and questions. All participants completed a demographics data question sheet (Appendix Five).

In order to help obtain the desired number of group participants the focus groups were conducted in combination with a social function (either a luncheon or dinner sponsored by the QRMFN). Flyers and invitations were sent out to rural medical spouses in selected regions. Members of the QRMFN management committee as well as area representatives from the local Division of General Practice then followed up these invitations. The focus groups were held in the following regions during April/May 2003.

- Roma (Luncheon meeting)
- Biloela (Dinner meeting)
- Atherton (Dinner meeting)
- Charters Towers (Luncheon meeting)

Although the focus groups were attended by a range of spouses (including male spouses and spouses of OTDs), a separate focus group consisting of eight OTD spouses and one OTD doctor was held at Charters Towers.\(^\text{15}\) At each event all partners residing in the selected region were invited to attend the focus group. A breakdown of age and demographics of participants is detailed in Table 6.1. The duration of each focus group was planned for two hours, although the majority ran to approximately 2.5 hours. A QRMSA administration officer recorded written notes during each focus group.

<table>
<thead>
<tr>
<th>Region</th>
<th>Male</th>
<th>Female</th>
<th>Age 35+</th>
<th>Age 36-50</th>
<th>Age 51+</th>
<th>With dependent children</th>
<th>Employed in health profession (incl. prac man)</th>
<th>Not in paid employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roma</td>
<td>1</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Biloela</td>
<td>0</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atherton</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Charters Towers</td>
<td>8</td>
<td></td>
<td>7</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

\(^{15}\) It was not until the group had begun that it was realised that one participant was an employed medical practitioner, whose spouse was not a practitioner himself. It was felt that this participant did not bias the discussion so was allowed to continue within the group.
Roma Focus Group

The first focus group was conducted in Roma on the 3 April 2003. The focus group was held as part of a luncheon provided by the QRMFN. Eight people attended the meeting including two spouses of OTDs and one male spouse.

General Discussion

Based on a presentation of the results of the survey data, there was general agreement with the research findings. Several issues presented in the presentation were highlighted by participants and discussed in further detail. In particular these included a general agreement with the findings concerning pre-move preparation and orientation, pre-move expectations and reasons for moving. All but one participant reported moving to the rural area predominantly for the needs of their doctor-spouse. Participants discussed the fact that many undertook little or no pre-move preparation, and agreed that a pre-move orientation pack would be useful. For this particular group, community expectations were also highlighted as being an issue all female participants had experienced, with many agreeing that community members often felt they had “ownership” of the doctor’s spouses. As with the survey results, this was not an issue expressed by the male participant (who grew up in this area).

When results were presented concerning issues such as privacy, access to health care, social orientations, and isolation, the majority of participants concurred with the survey findings. All participants agreed that access to health care was of particular importance and would greatly appreciate the opportunity to have access to an independent medical practitioner (although several participants were treated by their spouses, the majority would rather see another professional). All female participants expressed concerns over issues of medical privacy, and shared experiences of times when that privacy had been breached by practice staff. All spouses agreed that one of their main concerns was the time away from home and family that doctors had to spend and were hopeful that developing “family friendly” models of practice would help alleviate this issue, though none could see how such a model could be realistically be implemented.

Queensland Rural Medical Family Network Needs Analysis

When participants were presented with the results of the QRMFN needs analysis, participants were generally in agreement with the findings presented. This was the first time that all participants had gathered for one event, several, had not actually met the other medical spouses prior to attending this meeting and had very little contact with the QRMFN except for receiving the orientation package on their first arrival.

Table 6.2 presents a breakdown of the issues that were discussed in relation to the QRMFN and its services.
<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Comments and discussion focus</th>
<th>Desired Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon arrival</td>
<td>As with the main findings, spouses viewed some form of orientation process extremely important. This should be firstly by phone, then in person if requested. First contact should be made by QRMFN – not vies versa. Initial contact should be by phone as often new spouses are inundated by invitations and requests. Participants commented that including information on local community and business representatives in any orientation pack would be useful, as often spouses are left to fend for themselves, this was seen as a very isolating experience, especially as the doctors needs are usually taken care of by employers.</td>
<td>If possible, a pre-move information pack would be very useful. This would involve much greater interaction between QRMFN, workforce agencies and Medical employers. QRMFN should make contact with spouses as soon as practicable. Orientation packs could include relevant town information, schools, uniforms, maps and guides and information on childcare. Perhaps a small grocery hamper that provides basic items for one or two days. Information packs could also contain information on local clubs and religious services. This initial contact must be followed up soon after first contact, either by phone, or preferably in person. This was second visit was often felt to be neglected.</td>
</tr>
<tr>
<td>QRMFN Services</td>
<td>Participants generally agreed with the research findings concerning the prioritising of QRMFN activities. Although spouses are usually very busy, participants agreed that the network should continue providing both social and educational services. The network should help to foster greater communication between medical spouses, and continue to provide programmes at MET events. This group also felt that gender specific activities would be useful at these events so that male spouses would get an opportunity to interact with other males. All agreed that the “Backbone” newsletter was a valuable resource, but could include more “testimonials” from male and female spouses. Participants were very concerned about access to confidential health care and support. The counselling services were welcomed, however, more needed to be done to address medical concerns.</td>
<td>The Backbone newsletter could include more spouse testimonials, and spouses could be asked to provide these. More involvement with local communities was needed. QRMFN representatives could see that its services are advertised in local newspapers (for larger towns) and ensure that local councils are aware of their activities. Ensure that QRMFN contact details are given to all new spouses. Continue with Revive Survive weekends (considered extremely important). Continue to provide child minding activities at CME events, host evening events with no children present. To lobby for the provision of a ‘doctor for doctors’ program that includes doctor’s spouses and families. More interaction and events for male spouses. To include educational activities that spouses can gain university (or TAFE) credit for, such as PM courses and small business courses. Continue to offer educational bursaries. To perhaps include a bus tour for spouses to local sights during MET events</td>
</tr>
<tr>
<td>Satisfaction with QRMFN</td>
<td>Participant’s comments echoed survey findings. Spouses feel the QRMFN provides a beneficial service, however, it is not widely known among participants.</td>
<td>QRMFN needs to ensure that it is consistent with its provision of information packs and orientation programs. Greater liaison with medical service providers may help to ensure new spouses are informed with the network. The QRMFN needs to ensure that follow-up contact with spouses is maintained, and</td>
</tr>
<tr>
<td>Time away from family</td>
<td>Participants agreed that for the majority of spouses, the medical partner was their major confident. As the doctor often spent little time at home, loneliness was a major issue. The extended periods of absence were also seen as a major strain on relationships, and sometimes lead to relationship breakdowns.</td>
<td>QRMFN should follow and support discussions on family friendly models of practice. Although participants supported the calls for more doctors, they felt this was not likely to happen in the near future. All QRMFN could do was provide social support for spouses in need.</td>
</tr>
<tr>
<td>Initial arrival period</td>
<td>This was described as being the most difficult period for spouses.</td>
<td>QRMFN needs to ensure that spouses are contacted upon arrival and not left to feel isolated.</td>
</tr>
<tr>
<td>Work issues</td>
<td>All participants had experienced concerns of employment issues. Concerns over actual employment, working with spouses, and conflicts between spouses and other practice staff were also discussed. Competition between medical practices and between private practitioner and Qld Health Officers was also seen to impact on spouse’s well being. In addition, several participants discussed the fact that some rural clinics are not as up-to-date as in urban areas, changes in ideas were sometimes seen to cause conflict. Several participants commented that although Qld Health does provide certain benefits to its employers, working conditions often forced medical officers to turn to general practice.</td>
<td>QRMFN needs to continue to facilitate social events amongst medical spouses if possible. While competition between practices is an issue, participants feel it should not impact on spouses. QRMFN should continue to provide opportunities for professional development. This was seen as a way of spouses maintaining their own development needs and reducing feelings of powerlessness.</td>
</tr>
<tr>
<td>Availability of locums</td>
<td>All participants reported having some difficulty with finding locums. Several did, however, comment that they often deferred seeking medical treatment if they knew the regular doctor was away. Not only did this have financial implications, it also meant the returning doctor had an increased workload trying to deal with these extra patients.</td>
<td>QRMFN could look at lobbying for funding to provide locums for doctors (and their families) so that they can take a much needed break.</td>
</tr>
<tr>
<td>Cultural and religious maintenances</td>
<td>Several participants noted that for some spouses, continuing religious practice is often an area overlooked by employers and workforce agencies. The ability to continue with one’s spiritual life was seen as an important part of the settlement process. Often this was not possible.</td>
<td>Participants suggested that providing information on local religious services in the orientation pack would have been very useful.</td>
</tr>
</tbody>
</table>

### Biloela Focus group

This focus group was held on April 8, 2003 at a local restaurant. The discussion was held in the evening at a dinner sponsored by the QRMFN. Six medical female spouses attended this session.

### General discussion

This group started with a presentation of the research results, as with other groups, there was a general consensus with the research findings, and participants were satisfied with the results of the QRMFN needs analysis. Several participants did comment that they had frequently been involved with similar discussions at conferences, with little or no feedback. Participants were in agreement that they would like to see any new policies or programs resulting from this research. Table 6.3 presents a breakdown of the issues that were raised:
<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Comments and discussion focus</th>
<th>Desired Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon arrival</td>
<td>Participants felt that as far as they were aware, there was little in the way of a “good neighbour policy”. That there was little support for spouses on their first arrival. Participants also commented that often they are not aware that new spouses have arrived in the area.</td>
<td>QRMFN must ensure that new medical spouses are contacted. This can only happen if there is greater communication between the QRMFN and medical employers. QRMFN representatives must be able to reach isolated areas to contact new spouses.</td>
</tr>
<tr>
<td>QRMFN Services</td>
<td>Participants were not aware if QRMFN had a charter, or what its policies were. QRMFN social services and programs at CME events were greatly appreciated. It was seen as important that the network not lose sight of its social function. QRMFN could facilitate more events within local communities. Child-minding facilities at conferences and dinners were seen as very valuable. The QRMFN newsletter was seen as a valuable resource, but it must ensure that it is sent directly to the spouses. The Revive Survive weekend was seen as an excellent opportunity for networking. This event should be continued.</td>
<td>Participants would like to see a charter or mission statement. QRMFN representatives could help spouses to organise bi-monthly events such as lunches or dinners. Inviting other guests would be seen as useful. The Network did not necessarily need to fund these events, simply facilitate its organisation. The Network must ensure that it maintains an adequate database of rural medical spouses.</td>
</tr>
<tr>
<td>QRMFN profile and resources</td>
<td>Participants commented that they felt there was little interaction between the QRMFN representatives and its members. Participants would like to see more interaction. This would include being able to provide comment on its activities and desired services, having some input in its operations. QRMFN was started as a Grass Roots organisation, and it should remain so. It was felt that members did not often hear from QRMFN representatives or the Division (the RWO). Often spouses felt isolated and abandoned by rural health organisations.</td>
<td>Participants would like to see more interaction from QRMFN representatives and rural health organisations such as the RMFN. The Regional Workforce Officer should take a greater role in supporting rural spouses, and take direction form the QRMFN in this regard.</td>
</tr>
<tr>
<td>Spouse Health</td>
<td>Participants raised the issues of access to confidential health care for themselves, their families, and their spouses. A doctor for doctors program would be a very useful service.</td>
<td>Participants agreed that they would like to see doctors for doctors service that included doctor’s families.</td>
</tr>
</tbody>
</table>
Atherton Focus Group

This focus group was held on April 16, 2003 in conjunction with a dinner at a local Atherton restaurant sponsored by the QRMFN. Ten participants, including two male spouses and one spouse of an OTD attended this focus group.

General discussion:
This discussion started with a presentation of the research findings. As with the previous groups, there was general agreement with the research conclusions, and participants took the opportunity to relay similar experiences and stories. An in-depth discussion took place on why spouses from provincial backgrounds would not wish to live in more remote areas (RRMAS 6 and 7), and it was felt that this was because many simply did not wish to leave their “comfort zone”. Often individuals with provincial backgrounds have some exposure to more rural or remote areas, and are fully informed of some of the hardships that this can involve. For this reason, the group felt many spouses did not want leave the security of a provincial town, for a smaller, more remote area where resources and facilities (such as foodstuffs, recreational and schooling opportunities) are scarce or inadequate. As one participant commented “many people just aren’t willing to change”. It was interesting to note that much of this discussion centred around the initial orientation process, with all agreeing that the medical families initial experiences have a large impact on how long they chose to remain in the rural environment.

From this general discussion, the focus of then turned to the QRMFN, the results of which are summarised in Table 6.4.

Table 6.4: Atherton Focus group

<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Comments and discussion focus</th>
<th>Desired Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon arrival</td>
<td>Participants viewed an examination of the orientation process was necessary, as several received no real orientation upon their arrival. As with previous groups, participants felt this should be firstly by phone, then in person if requested. Contact should be made by QRMFN. Information on local services, schools, should be provided, as many felt this information was not provided by the medical practices.</td>
<td>A pre-move information pack would be very useful. This would involve much greater interaction between QRMFN, workforce agencies and Medical employers. QRMFN should make contact as soon as practicable.</td>
</tr>
<tr>
<td>QRMFN Services</td>
<td>Participants generally agreed with the research findings concerning the prioritising of QRMFN activities. The QRMFN should continue providing both social and educational services. Participants discussed the provision of the counselling service. While thought a good idea, male participants commented that they would be unlikely to utilise such a service</td>
<td>The QRMFN should also provide information to medical university students and student bodies. This would help raise the profile of the QRMFN, and make it known from the start that there are support services for spouses of doctors regardless of age. It was suggested that doctors leaving the rural areas could be encouraged to be the first point of contact for new doctors and families, if that is possible.</td>
</tr>
<tr>
<td>Time away from family</td>
<td>Participants agreed that for the majority of spouses, the medical partner was their major confident. As the doctor often spent little time at home, loneliness was a major issue.</td>
<td>QRMFN should lobby employers to introduce family friendly models of medical practice. It was felt that more could be done to help facilitate a push for</td>
</tr>
</tbody>
</table>
The male participants commented that it was often difficult for them to find suitable child-care for times when their partners were on-call. An issue raised by participants was the fact it was difficult to keep children entertained as medical spouses are often left without transport. Frequent on-call requirements of the doctors means they usually need to take the vehicle with them.

Mentoring system
Participants all agreed that some form of mentoring system would be very useful. Although many also commented that this would be difficult to achieve, since mentors need specific training, and could be a time consuming process.

QRMFN Profile
Several participants felt the QRMFN should re-examine its profile and aim to attract more members. It needs to make sure that the events it organises are suitable for all members, and be seen to support spouses and doctors who do not have children.

The QRMFN needs to ensure all spouses received information and newsletters, several participants were not aware of the 2002 Revive Survive weekend.

Spouse Health
Participants were very concerned about the issue of access to confidential health care. Several spouses chose to see doctors in other towns, while others chose to see their spouse. The majority of participants did feel that this was an issue that needed addressing.

Charters Towers Focus Group
This focus group was held on 8 May 2003 in conjunction with a lunch that was funded by the QRMFN. Seven spouses of Overseas Trained Doctors (and one OTD) attended the group from five different countries.

General discussion
This focus group concentrated on issues raised by spouses of OTD/TRDs during the course of the research process. Topics raised by the group participants included, access to on-going education, employment, social support and religious and cultural maintenance. In addition, participants discussed the fact they felt abandoned by agencies such as Queensland Health, and had very little contact with the Rural Division of General Practice. Only one participant reported having any contact with the QRMFN. Table 6.5 presents a breakdown of the discussion.
Table 6.5: Charters Towers Focus Group

<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Comments and discussion focus</th>
<th>Desired Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation process</td>
<td>No participant reported receiving any contact from the QRMFN her initial arrival. Participants commented that their orientation was left either to the medical practice, or to other rural medical spouses. Participants indicated that some form of contact with the QRMFN would be very useful. All participants felt that they were well received within the community on their arrival.</td>
<td>Participants were interested to hear that there was QRMFN orientation material available, and they would be interested in making contact with the network.</td>
</tr>
<tr>
<td>Lack of employment opportunities</td>
<td>All participants were concerned with the lack of employment opportunities available to them. Seven of the eight participants were not working at this stage and commented that it was unlikely that would gain employment in the near future. Seven of the eight participants were university qualified; the fact that they could not find employment was very frustrating for them. Participants also felt that often employers would prefer to give positions to local people as opposed to the wife of a doctor.</td>
<td>Participants would like to be able to access information concerning distance-learning education. It was felt that it would be useful if this type of information were made available in a resource pack that the QRMFN could provide.</td>
</tr>
<tr>
<td>Religious practice/cultural</td>
<td>The maintenance of cultural and religious practices was seen by some of the participants as being particularly difficult. There were no facilities for either Hindu or Muslims, and it was very difficult to obtain suitably prepared foodstuffs. Maintenance of language skills for the young children was also an issue of concern. Two participants reported that members of the local church had been externally helpful in their initial settlement and had been an important point of contact.</td>
<td>The provision of information relating to multicultural support agencies, and support groups was seen as an important addition to any orientation pack for OTD spouses.</td>
</tr>
<tr>
<td>Social support</td>
<td>Several of the participants reported feeling lonely, and that they would appreciate some form of contact from the QRMFN. All participants felt that their children had settled in well, and had begun to form friendships. Participants felt that it was important that the QRMFN offer subsidised airfares to allow them to attend events such as the Revive and Survive weekend. Participants also noted that it was difficult for many of them to attend local events because often they were left with no transport. As the doctor is often required to be mobile, this meant they would usually have the car.</td>
<td>Participants commented they would like to have bi-monthly gatherings, initially facilitated by the QRMFN. Most were unaware of the services provided by the QRMFN, but felt that it is important for the agency to provide opportunities for socialising.</td>
</tr>
<tr>
<td>Educational opportunities</td>
<td>Participants felt that the QRMFN should continue to offer education programs at CME events, and would be interested in making use of them. In addition, it was felt that the provision of a small bursary was also something they thought a valuable service.</td>
<td></td>
</tr>
<tr>
<td>Information provision</td>
<td>Participants noted that the level of information provision by QH, HIC and Immigration was often very poor or inaccurate.</td>
<td>It was hoped that better communication between the various agencies would improve this situation.</td>
</tr>
</tbody>
</table>
7.0 Conclusion and Recommendations

This research was conducted to ascertain whether the QRMFN programs are meeting the needs of Queensland rural medical spouses. The rural medical family networks are now realising that rural medical spouses, although sharing many common experiences, do not experience them in the same way, or through the same set of cultural or social lenses. The nature of the rural medical workforce has changed dramatically over the last ten years. New medical spouses have different sets of expectations concerning life, career, and the kinds of situations they expect to encounter. The number of medical professionals in rural areas with ethnically diverse backgrounds is increasing, and they bring with them a different set of perceptions and experiences and therefore are in need of different kinds of supports. Medical workforce agencies such as the QRMSA and family support networks such as the QRMFN need to be aware of these needs and continue to improve and develop their services and activities accordingly if they are to maintain the necessary standards of support. Only through continued dialog with their client base can this happen.

This research highlights the continued contribution that rural medical spouses make to both the medical practice and the local community in general. In 1996, research by Wise et al, coined the term “married to the practice.” Despite the recent workforce changes, this situation is still very much the rule rather than the exception. The QRMFN cannot operate in a vacuum. Its committee members are volunteers; therefore it is the responsibility of the Rural Workforce Agencies and Commonwealth stakeholders to ensure that the Medical Family Networks are adequately supported, not only in terms of financially, but also in terms of communication links, employment strategies, and medical workforce support for the doctors. As this research has demonstrated, in such a collaborative environment the QRMFN will have better access to the information and support it needs to continue to provide much needed networks for Queensland rural medical spouses.
List of recommendations:

In order to address some of the issues highlighted by rural medical spouses, the QRMFN needs to continue to concentrate its efforts on three groups of strategies:

Strategies that target the spouse directly, such as health, social and professional support. In addition, the QRMFN needs to ensure that the needs of male spouses and spouses and families of Overseas Trained Doctors and Temporary Resident doctors are catered for.

Recommendation 1:
The QRMFN should continue to maintain current services and activities. In particular these include, child-care services at MET events, mentoring workshops, educational bursaries, and an annual “Revive and Survive weekend and a telephone counselling service. In addition, the QRMFN should continue to provide opportunities for social networking both at CME events and within local communities. The events should also target the needs of spouses of Overseas Trained Doctors, and include opportunities for meeting not only other rural medical spouses, but also other community members, volunteer groups and agencies.

Recommendation 2:
The QRMFN in conjunction with the QRMSA should examine the feasibility of providing a ‘Doctor for Doctor’ service that includes the treatment of rural medical spouses and their families. In addition, the QRMFN in conjunction with other stakeholders should provide a medical professional at larger CME events to conduct basic health checks. This could include blood pressure checks, Pap tests, and general health check ups.

The QRMFN needs to raise the awareness of issues facing medical spouses in terms of access to confidential health care amongst medical services providers and Commonwealth agencies.

Recommendation 3:
The QRMFN should continue to include educational programmes at CME events, and if possible, give spouses the opportunity to apply for university/TAFE credit for these workshops. This could include small business courses, book-keeping, and Practice Management.

Recommendation 4:
The QRMFN should provide orientation packages for all new rural medical spouses. Such packages should contain up to date information concerning the town and its facilities, information on local schools, day-care, and public services. The orientation pack should also include information on parenting support services and programs that operate within local areas, as well as information and contact numbers for health and sexual health help-lines and support groups. Orientation packs need to be tailored to specific locations, and situations. For example, orientation packs for spouses of OTDs should include information on Immigration, employment, and Health information. Orientation packs could also include vouchers from local business and perhaps a small food parcel. As this research highlights, the needs of individual subsections of spouses need to be taken into consideration, if the orientation system is to be effective.

16 This small parcel could include basic items such as bread, milk, breakfast cereal and tea/coffee. This would simply provide basic supplies for a family’s arrival into a new home.
In addition, the QRMFN needs to continue to develop its mentoring program and have this implemented as soon as it is able. The QRMFN and its local representatives needs to ensure that follow-up contact is provided after this initial meeting if requested.

**Specific additions to QRMFN services in this area could include:**

- Culturally appropriate resources included in the orientation pack that includes information on local multi-cultural services and organisations. This pack should include the location of suitable religious facilities such as Churches, Temples and Mosques, location of nearest food suppliers that are able to handle specialist food requirements. A further addition could also include information from existing OTD spouses on how they have endeavoured to maintain their own religious and cultural traditions.

- Cultural awareness training for Hub representatives
- Stronger relationships between the QRMFN and multicultural agencies in rural areas
- Specific cultural dietary requirement catered for at QRMFN sponsored events. This could include vegetarian meals, and Halal food if possible.
- The QRMFN must take steps to ensure that the specific health need of OTD spouses are catered for. Networking with multicultural agencies as required.

**Recommendation 5:**
Utilising appropriate forums, the QRMSA and the QRMFN must take responsibility for providing information to the Commonwealth that recognises the importance of children’s educational needs to the recruitment and retention of rural medical practitioners and develop policies accordingly. This issue is particularly relevant for children approaching year 12 and beyond.

**Recommendation 6:**
The Queensland Rural Medical Family Network, while continuing to support all rural medical spouses, should (given budgetary considerations) concentrate its financial resources on spouses residing in RRMA 5 to RRMA 7 locations. This should include limiting travel costs to attend QRMFN events to those residing in the more remote locations.

---

**Strategies that specifically target the working environment of the medical practitioner.**
- Including lobbying for ‘Family friendly’ medical practices that include more realistic working hours and less on-call commitments.
- The provision of suitable holiday periods, and a locum services.

The QRMFN in association with QRMSA need to act as an advocate for rural medical spouses.

**Recommendation 7:**
The QRMFN and QRMSA should further develop it relationships between medical service providers, the Rural Divisions of General Practice and Queensland Health Employers to ensure that new medical spouses are provided with information regarding the QRMFN. This is particularly important for spouses of OTDs. The provision of QRMFN information prior to a new doctors’ arrival would also aid in preparing doctors for what they can expect from life in rural and remote Queensland. The QRMFN could look at developing a “cultural orientation pack” that would specifically inform spouses of OTDs about life in rural towns.

In addition, the QRMFN should negotiate with the appropriate government agencies and rural medical service providers in order to ensure the provision of adequate facilities for new rural doctors. This should include the provision of suitable housing and basic services.
Recommendation 8:
It is crucial that Queensland Health recognise the important contribution of OTDs and TRDs to the health and wellbeing of rural Australians. Overseas Trained Doctors must be provided with all the accurate and relevant information they need prior to their arrival in a new country area. The QRMFN needs to ensure that contact is made with the families of OTDs and that this contact is maintained (if requested). The QRMFN and QRMSA should act as an advocate for rural medical spouses. Utilising the appropriate forums, these organisations need to ensure that the Commonwealth is aware of the disruption that continual relocation has on the education and socialisation of children, particularly if they are from culturally and linguistically diverse backgrounds, and take steps to prevent this.

Recommendation 9:
Government departments have to be made aware of the pressures of rural doctors workloads, and the effects this have on spouses and family. The Rural Medical Family Networks need to continue to press for the development of ‘Family Friendly Models” of medical practice. Such models would recognise the differing needs of rural doctors and their families and develop strategies aimed at reducing doctor’s workloads (including on-call requirements) as well as providing suitable opportunities for time away from the medical practice.

Recommendation 10:
Commonwealth agencies need to be made aware of the occupational needs of rural medical spouses, and in association with the QRMFN should develop strategies to address these needs. Examining options such as Internet based work opportunities as well lobbying for funding and providing funding for educational training may help to address these issues.

Recommendation 11:
The QRMFN and QRMSA need to maintain an up-to-date database of rural medical spouses. It is the responsibility of both agencies to provide information to medical families about QRMFN activities. Correspondence to medical spouses needs to be sent directly to them if possible, rather than simply being addressed to the doctor’s medical practice.

Recommendation 12:
The QRMFN with support for the QRMSA must utilise the results of this research when working with specific communities to recruit and retain rural medical practitioners. State medical service providers, rural medical practices, and rural communities should be made aware of the issues faced by new doctors and their families. Prospective medical employees need to be made fully aware of the advantages and disadvantages of living and working in rural and remote areas. This may assist in the development of realistic expectations, and therefore better prepared to deal with many of the joys and hardships they will experience. Rural medical spouses should also be informed of the role they will play in supporting both the medical practice and the community. By ensuring employers, employees and communities are aware of their roles and responsibilities, the experience of the both the doctor and their families will be more positive ones, thus reducing the desire for spouses to continue to search for their hollow log.
Strategies that specifically target the rural community. This could include greater interaction between the rural medical spouses, the local community and the Queensland Rural Medical Family Network. As Wise previously noted, (1996) rural communities should be assisted to understand the circumstances of rural medical practice as a family concern and how it can be supported for the mutual benefit of the medical family and the community. It should also be encouraged to take advantage of, and facilitate access to the skills brought to the community by the rural doctor’s spouse.

**Recommendation 13:**
The QRMFN must continue to develop and monitor the program of activities that it offers, in accordance with the demographics of rural medical spouses and the local communities it supports. It is important that the QRMFN take advantage of and utilise local community knowledge and expertise when organising events, thereby providing local solutions to local issues. Activities sponsored by the QRMFN should not serve to further isolate its members. As respondents have commented, many of the issues they face are not necessarily unique to rural medical spouses, but to rural life in general. The QRMFN could aim to facilitate regular gatherings of medical spouses within individual communities; this could include inviting spouses from other disciplines/professions. Such meetings (perhaps initially funded by the QRMFN) would allow spouses to socialise with other individuals and add to the social networks of spouses.

Strategies that examine the QRMFN policy and planning agendas, and actual make up of the QRMFN management team and its regional representatives. The QRMFN needs to ensure that it continues to be representative of all rural medical spouses, and that it modifies its services accordingly.

**Recommendation 14:**
The QRMFN should attempt to ensure that the events and activities that it provides are relevant to all medical spouses and not gender or age biased. For example, the QRMFN newsletter could include more articles that are of interest to male spouses. The QRMFN could also examine the possibility of providing a ‘Parents only’ evening at CME events and arrange suitable child minding facilities. The QRMFN needs to be perceived as an agency that supports all rural medical spouses, rather than an organisation solely for female spouses with children.

**Recommendation 15:**
The QRMFN must be representative of rural medical spouses (in terms of age, gender and ethnicity). Presently there is no male representation on either its management team, or amongst any of the Hub representatives. In addition, there appears to be little involvement of spouses of OTDs/TRDs. Employing a revolving committee (eg. minimising the amount of time individuals spend on the management team) could help in creating a more representative committee, while at the same time reducing the time commitment on individual members. While it is recognised that involvement of the management committee is voluntary, the committee should make all attempts to attract a range of individuals to is team.
Recommendation 16:
The results from this research suggest that the QRMFN representatives and to the same degree, the Regional Workforce Officers do not have the resources (or time) to carry out the desired initial orientation/contact for new spouses. While representatives can/do service areas surrounding their own locations, it is not possible for them to travel to more remote/distant areas given their own commitments. This report recognises the time commitment that the QRMFN management team, and its hub representatives already donates to the QRMFN, therefore it is unrealistic for them to be able to reach all surrounding areas. It is the recommendation of this report that the QRMFN in association with the rural workforce agencies investigate the possibility of utilising other individuals for this purpose. This could include approaching students such as social workers or other allied health students who themselves, may live/work in rural areas.

In addition, Regional Workforce Officers working out of the Rural Divisions of General Practice should be encouraged to take a more active role in spouse support issues. This should include making regular visits to remote areas to contact spouses, as part of their regular visits to rural medical practices.

Recommendation 17:
Through its association with the QRMSA, the QRMFN should endeavour to annually canvas rural medical spouses as to the kinds of events and activities that it provides. The QRMFN although servicing the majority, is not meeting the needs of some of its members (such as OTD and male spouses). This research has demonstrated that the spouses of OTDs and (to some extent) male spouses need the same access to support networks as female spouses, yet these individuals are the least represented either on the management team, or at QRMFN events. ‘Top-down’ strategies to date, have been ineffective in meeting the needs of these individuals, therefore a ‘bottom up’ approach may in the long term benefit all QRMFN members.
References


Department of General Practice The University of Melbourne, and Department of General Practice Monash University. (2001). *GP wellbeing project final report.* Melbourne: Departments of General Practice, University of Melbourne and Monash University.


Kamien, M. (1987). *Report on the ministerial inquiry into the recruitment and retention of country doctors in Western Australia:* University of Western Australia, Department of Community Practice: Claremont, WA.


Appendicis

Appendix One: Rural, Remote and Metropolitan Area Classification (RRMA)

Throughout this report the measure of remoteness RRMA has been used. Many regional programs are targeted at areas of geographic disadvantage and the convenient label of being ‘rural’ often refers to these areas. However, there is not a generally accepted or generally applicable definition for the Australian context that can be used to identify rural areas. As a result, the RRMA classification was used to determine eligibility for an area of program funding. The RRMA classification was used to assign each Statistical Loca Area (based on 1991 boundaries) to one of seven categories that were further aggregated into three basic zones (Metropolitan, Rural and Remote).

The seven RRMA categories are:
1. Capital cities (Metropolitan Zone)
2. Other Metropolitan Centres (Metropolitan Zone)
3. Large Rural Centres (Rural Zone)
4. Small Rural Centres (Rural Zone)
5. Other Rural Areas (Rural Zone)
6. Remote Centres (Remote Zone)
7. Other Remote Areas (Remote Zone)

The use of the word ‘rural’ in several of the category names of the RRMA classification was not originally intended to be a definition of rurality. However, over time, RRMA category names have evolved into a simple definition of rurality.
Appendix Two: QRMFN Postal Survey
Queensland Rural Medical Family Network Spouse/Partner Survey

Dear rural medical spouse/partner,

Re: Follow-up survey to the QRMFN State wide research into the experiences and perceptions of spouses of Rural Medical Practitioners.

Nigel Bond, research analyst for the Queensland Rural Medical Support Agency has recently conducted a series of interviews of spouses from across the State to determine the issues affecting rural medical families and to find out what the QRMFN can do for you. It is now important to clarify how many people agree with the issues and themes identified in these interviews and / or wish to contribute further information to this investigation.

To plan appropriately for the future, the QRMFN also needs your feedback about the effectiveness of its current programs in addressing the issues and concerns of the spouses of rural medical practitioners. Even if you have not participated greatly in QRMFN activities over the past year, your input would be most valuable.

This survey is completely anonymous. We ask only for the town you live in so we can determine if there are some areas in which we need to increase or direct specific activities. You do not have to answer any question you do not wish to. An overall summary of the results will be published in the QRMFN newsletter Backbone early in 2003.

When completed, can you please post the surveys in the enclosed reply-paid envelope by 14 January 2003. Should you have any questions concerning this survey, please feel free to contact Nigel at QRMSA on (07) 33528333.

The enclosed Instant Lotto ticket is our way of saying ‘thanks in anticipation’ for the time we hope you can spend completing the following questionnaire.

Once again, thank you for your input. As President of the QRMFN I urge you to complete this extremely important survey, as it will greatly enhance our ability to support your experience in the bush.

Anne Chater. Chairperson, Queensland Rural Medical Family Network
1. What was the main reason for moving to a rural area? (tick one only)

a. My employment .................................................................

b. Spouse/partners employment .............................................

c. Partners rural scholarship ...................................................

d. Personal choice ...............................................................

e. For rural lifestyle .............................................................

f. Spouse/partner Overseas Trained Dr bonded to a rural area ...........

g. Raised in rural area ..........................................................

h. Partner selected for Drs for the Bush Programme .......................  

Other: ____________________________________________________________________

2. Did you have a choice/say in which area to move to? Yes ☐ No ☐

Comments: ___________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

3. Given an ideal situation what factors are most important to you in deciding which area to move to? (tick all appropriate)

a. Rural Lifestyle .................................................................

b. Employment .................................................................

c. Schooling for Children ....................................................

d. Recreation .................................................................

Other: ______________________________________________________________________

4. Do you feel your current place of residence is appropriate for you/your family’s needs? Yes ☐ No ☐ N/A ☐

Please specify_________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

5. Did you have any expectations/perceptions of moving into a rural lifestyle? e.g. Around employment, schooling, housing, lifestyle, hours your spouse/partner would be working

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________
6. Were these expectations:  
Met ☐  Not met ☐  Exceeded ☐
Comments:________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

7. Is your partner employed in a:
   a. Hospital ................................................................. ☐
   b. Solo Practice........................................................... ☐
   c. Group Practice....................................................... ☐
   d. Other *(please specify)* _________________________________ ☐

8. Did you do anything to prepare yourself or your family prior to moving to the rural area?
Yes ☐  No ☐  N/A ☐
Specify________________________________________________________________________
________________________________________________________________________________

9. How did the following experiences affect your settlement into the rural community?

<table>
<thead>
<tr>
<th>Experience</th>
<th>No problem</th>
<th>A major problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. The pace of country life</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>b. Life in a new environment</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>c. Making new friends</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>d. Local orientation</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>e. Finding schools/day care</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>f. Lack of family close by</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>g. Employment issues (self)</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>h. Employment issues (spouse)</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>i. Access to entertainment</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>j. Access to required needs (foodstuffs etc)</td>
<td>1  2  3  4  5</td>
<td>N/A</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

123
10(A). Did you receive any support from your spouse’s employer in becoming established? 

Yes ☐ No ☐ N/A ☐

10(B). Additional supports.

KEY:

|--------------|---------|------------|---------|-------------|

i. How would you rate the level of support you received from your spouse’s employer? (please circle)
   1 2 3 4 5 N/A

ii. How would you rate the quality of housing you received from your spouse’s employer? (please circle)
   1 2 3 4 5 N/A

11. How would you rate the accuracy of information provided to you by any organisation prior to moving to rural Queensland? (For example, from organisations such as AMAQ, RACGP, Queensland Health, HIC, ACCRM, Department of Immigration, QRMSA). (please circle).

KEY:

|-----------------|------------|------------|---------------------|-----------|

Please write down organisation

___________________________________________ 1 2 3 4 5 N/A
___________________________________________ 1 2 3 4 5 N/A
___________________________________________ 1 2 3 4 5 N/A
___________________________________________ 1 2 3 4 5 N/A
___________________________________________ 1 2 3 4 5 N/A
___________________________________________ 1 2 3 4 5 N/A

Comments:__________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

12. What involvement has the community had in your settlement into this area?

a. They have been very helpful/friendly ............................................................ ☐
b. They have had little contact with me ............................................................. ☐
c. They were unfriendly ....................................................................................... ☐
13. Please rate how applicable the following statements are to your current experiences

KEY:


a. I am expected to know what is going on in the community at all time:  
   1  2  3  4  5 N/A

b. I am continually expected to serve as a member of committees/boards:  
   1  2  3  4  5 N/A

c. I am expected to be my spouse’s receptionist, even at home, on weekends, or their day off:  
   1  2  3  4  5 N/A

d. As the partner/spouse of a Dr, there is the expectation that I should not work/do not need to work:  
   1  2  3  4  5 N/A

e. I feel I am expected to delay my career to look after the children/household:  
   1  2  3  4  5 N/A

f. Because I am the Dr’s partner, people want to ‘make friends with me’ to feel special:  
   1  2  3  4  5 N/A

g. Because I am the Dr’s partner, people often feel they have the right to ask me personal questions:  
   1  2  3  4  5 N/A

h. I am expected to be ‘invisible’, I am just the Dr’s partner:  
   1  2  3  4  5 N/A

i. I feel myself and/or my children are expected to behave in a ‘certain way’ to avoid community gossip:  
   1  2  3  4  5 N/A

14. Have you felt any other expectations from the community:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

15. Who are your main supports in this area?

   Family  Friends  Spouse/Partner

Other ________________________________________________________________

16. Are you involved in any specific recreational activities/hobbies, community/volunteer groups, social clubs?

   Yes  No
Access to confidential health care

17. When you visit a Doctor, is this usually:
   a. Spouse/partner? .................................................................
   b. Other Doctor in same practice as spouse/partner ......................
   c. Doctor in other town ...........................................................
   d. Dr in other practice, but in the same town ............................

18. Was this:
   In the last year ☐  Not for the last 5 years ☐  Not in the past 10 years ☐

Life in a country town as “the doctor's spouse”

19. Please indicate whether you agree or disagree with the following statements:

   KEY:

   a. As the spouse/partner of a medical practitioner, I find it difficult to maintain levels of privacy where I am living:
   b. I find it difficult to remain anonymous where I live:
   c. I am concerned that the long hours my spouse/partner is required to work affects his/her ability to spend time with the family:
   d. The long hours my spouse/partner is required to work affects our ability to make friends here:
   e. I am concerned about my own personal/professional development living in a small town:
   f. I am concerned about my ability to access confidential health care for my family and myself:

Social interaction

20. Do you have any close friends/confidants within the community?
   Yes ☐  No ☐
21. If you answered yes to Q 20, how did you come to meet these friends/confidants?
   a. Through my work .................................................................
   b. Through my spouse/partners work ...........................................
   c. Through clubs/organisations ...................................................
   d. Through school activities ......................................................
   e. Through my Church/religion ...................................................
   f. Other (please specify)  _________________________________________

22. How often do you interact with close friends?
   a. Once per week .................................................................
   b. More than once per week ....................................................
   c. Once per fortnight ............................................................
   d. Less than once per fortnight ...............................................  

23. Is this usually:
   a. In your own home ............................................................
   b. In friends homes .............................................................
   c. Out to dinner .................................................................
   d. Other (please specify)  _________________________________________

Cultural Identity

24. Have you ever experienced any issues concerning culture, ethnicity or religion that you have had to deal with since your arrival in this community?
   Yes ☐  No ☐  N/A ☐

   Please comment:
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

25. Do you have access to the religious and cultural services/needs that you require?
   If not, how has this affected you?
   Yes ☐  No ☐  N/A ☐

   Specify:________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
26. Have you ever felt it difficult to maintain your religious/cultural practices where you live now?

Yes ☐ No ☐ N/A ☐

Specify: ________________________________________________________________
______________________________________________________________
______________________________________________________________

27. Would you describe your community as?

a. Predominantly agricultural
b. Predominantly mining
c. Predominately industrial
d. Predominantly Indigenous
e. Other (please specify) _____________________________________________

Family

28. How happy do you think your children are living in this community?

(Please circle)

Very happy  Very unhappy  N/A

1 2 3 4 5

29. Do your children attend:

Local school ☐ Boarding school ☐ N/A ☐

30. Have the costs associated with boarding been a factor in determining the school of choice for your children.

Yes ☐ No ☐

Please Comment: ________________________________________________________

31. How happy/satisfied are you with the schools in your area?

(Please circle)

Very satisfied  Very dissatisfied  N/A

1 2 3 4 5

32. Have your children made any close friendships since arriving in the rural area?

Yes ☐ No ☐ N/A ☐
Overall Satisfaction

33. How happy are you living in your rural community?

(Please circle)

Very Happy 1 2 3 4 5

34. What are the rewards/benefits of living here?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

35. What, if anything do you dislike about living here?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

36. If you were asked to give advice to a Doctor and their family who were about to commence living and working in a rural area, what would that be?

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

37. How would you rate the following aspects of life in the rural area? (Please circle)

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Excellent</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Availability of locums (e.g. in relation to holiday planning)</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>b. Personal Income</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>c. Professional interaction</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>d. Professional satisfaction</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>e. Recreational opportunities</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>f. Social life</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>g. Personal anonymity</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>h. Personal Privacy</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

38. For how long would you like to stay in your current location? _____ Years

Specify reasons:___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

39. Please indicate whether you agree or disagree with the following statements:
**KEY:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I can do little about the issues in my life at present:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>b. Our situation is so complicated, I don’t understand what’s going on:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>c. In order to improve my situation, I have to do things that I sometimes disagree with:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>d. I often feel lonely or isolated:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>e. I don’t enjoy the work I do:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>f. In my daily work (or activities) I have to figure out how to solve problems:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>g. My daily work (or activities) involve doing the same thing in the same way repeatedly:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>h. My daily work (or activities) give me a chance to do things I enjoy:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>i. My daily work (or activities) gives me a chance to develop or learn new skills:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>j. I usually decide how I will do my daily work (or activities):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>k. I am free to disagree with those who supervise my daily work (or activities):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>l. My daily work (or activities) allows me to interact with people I like:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>m. I am responsible for my own success:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>n. My misfortunes are the results of mistakes I have made:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Queensland Rural Medical Family Network**

40. Have you had any involvement with the Queensland Rural Family Medical Network?  

   Yes ☐  No ☐

41. How satisfied are you with the Queensland Rural Family Medical Network?

<table>
<thead>
<tr>
<th>Very satisfied</th>
<th>Very dissatisfied</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Please Comment: ____________________________________________________________
42. Please rate how important is it that QRMFN provide the following services:

(Please circle)

<table>
<thead>
<tr>
<th>Service</th>
<th>Very important</th>
<th>Least important</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Mentoring programs for spouses</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>b. Social orientations upon arrival in town</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>c. Work orientation programs/bursaries</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>d. Gender specific activities at CME events</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>e. Children’s activities at CME events</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>f. Counselling facilities</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>g. Confidential medical facilities</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>h. Events just for spouses/partners</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>i. QRMFN newsletter</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>j. Internet based communication with others</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

Demographics

(Please circle)

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of birth:</td>
<td>Australia</td>
<td>Other (please state)</td>
</tr>
<tr>
<td>Residency:</td>
<td>Permanent Resident</td>
<td>Temporary Resident</td>
</tr>
<tr>
<td>Citizenship:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Length of time in Australia:</td>
<td>____ yrs _____ months</td>
<td></td>
</tr>
<tr>
<td>The town you live in?</td>
<td></td>
<td>Postcode</td>
</tr>
<tr>
<td>Current Occupation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you working:</td>
<td>Full time</td>
<td>Part time (less than 35 hrs per week)</td>
</tr>
<tr>
<td>Is your current work consistent with your training:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you find your work:</td>
<td>Interesting</td>
<td>Boring</td>
</tr>
<tr>
<td></td>
<td>Stressful</td>
<td>Financially rewarding</td>
</tr>
</tbody>
</table>
Demographics (cont.)

What level of education have you completed?  Up to grade 12  
University/college degree  Technical/trade qualification

Other: _______________________________________________________________

If you have children, please list their Year/s of Birth: __________________________

Please Circle:

Your age range:         Under 25  26 to 35  36 to 50  51 and over

From the date of your birth to age 18 was your home address in a:

Rural Area  Metropolitan area  Provincial City

Was this in:  Australia  or  Overseas

Is English your first language?  Yes  No

Have you had difficulty filling in this survey:  Yes  No

Is your partner a:  Queensland Health Employee  Private Practitioner  Other

Do you have any further comments about being a doctors spouse/partner in rural Queensland?
___________________________________________________________________________  
___________________________________________________________________________  
___________________________________________________________________________  
___________________________________________________________________________  
___________________________________________________________________________  
___________________________________________________________________________

Thank you for your time and support in filling out this Survey
Appendix Three: Interview Consent Form
The experiences of the spouses and families of Rural Medical Practitioners in rural and remote Queensland

- I have read and I understand the information sheet for volunteers taking part in this research project designed to investigate the experiences of spouses and families of rural medical practitioners in rural and remote Queensland.

- I understand that taking part in this study is voluntary and that I can withdraw at any time.

- I understand that no material that can identify me will be used in any reports in this study.

- I have had time to consider whether I will take part.

- I know who to contact if I have any questions regarding this study.

- I would like a copy of a summary of the results of this study. Yes   No

I _____________________________________________________________(full name)
Hereby consent to take part in this study.

Signature of participant ______________________________

Date___________

Researcher: Nigel Bond   Contact Details: QRMSA PO Box 167 Kelvin Grove
Ph. (07) 33528337
Email: nbond@qrmsa.com.au

QRMFN representative: Jackie Mooney, Ph. (07) 33528333

PLEASE KEEP A COPY OF THIS FORM FOR YOURSELF.
Appendix Four: Interview Information Sheet
An investigation into the experiences of the spouses and families of General Practitioners in rural and remote Queensland.

You are invited to take part in a research project that aims to examine the experiences of the spouses and families of rural medical practitioners in rural and remote Queensland. The research is a joint project between the Queensland Rural Family Medical Family Network (QRMFN) and the Queensland Rural Medical Support Agency (QRMSA).

Participation in this research is completely voluntary, and the interview should not take any longer than one hour of your time. The interview questions are designed to be as easy as possible. You do not have to answer any particular questions if you do not wish to and you may stop the interview at any time.

The information gathered from the interview will be used to gain a better understanding of the experiences of spouses and partners of rural medical practitioners and the issues they face living in rural and remote areas.

Questions in the interview will be asked on the following topics:
Section One: Demographics, the decision-making process, experiences upon arrival

Section Two: Settling in, living in a rural area, employment, family, schooling

Section Three: Overall settlement experiences, advice for other partners.

No material that can identify you will be used in any reports on this study. The consent form will be separated from the interview responses and tapes to ensure that neither the interview nor the tape recordings can be linked to an individual. The investigator will be the only person to have access to the consent forms or interview recordings.

A summary of the results will be made available to participants if they wish.

Please feel free to contact me on (07) 3352837, or Jackie Mooney (QRMFN) on (07) 3352833 should you have any questions regarding this study.

Thank you for your participation.
Appendix Five: Focus Group Demographics Data Sheet
We would like to know if the people at this focus group are representative of partners in rural and remote Qld. To help us with this, could you please complete the following:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Age range</th>
<th>Under 25</th>
<th>25-35</th>
<th>36-50</th>
<th>51 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Town you live in __________________________

If you have children, please list their ages __________________________

Current Occupation________________________

Country of birth _________________________