

Australian Medical Workforce Advisory Committee

**INFLUENCES ON PARTICIPATION IN THE
AUSTRALIAN MEDICAL WORKFORCE**

AMWAC Report 1998.4

June 1998

© Australian Medical Workforce Advisory Committee 1998

ISBN 0 7313 4094 9

This work is copyright. It may be reproduced in whole or part for study or training purposes subject to the inclusion of an acknowledgement of the source. Reproduction for purposes other than those indicated above requires the written permission of the Australian Medical Workforce Advisory Committee.

Enquiries concerning this report and its reproduction should be directed to:

Executive Officer
Australian Medical Workforce Advisory Committee
Locked Mail Bag 961
New South Wales Health Department
NORTH SYDNEY NSW 2059

Telephone: (02) 9391 9933
E-mail: amwac@doh.health.nsw.gov.au
Internet: <http://amwac.health.nsw.gov.au>

Suggested citation:

Australian Medical Workforce Advisory Committee (1998), Influences On Participation In The Australian Medical Workforce, AMWAC Report 1998.4, Sydney

Publication and design by Australian Medical Workforce Advisory Committee.

Printing by Copybook, Sydney.

CONTENTS

Abbreviations	iv
Terms of Reference of AMWAC	v
Membership of AMWAC	vi
Membership of the AMWAC Female Medical Workforce Working Party	vii
Introduction	1
Background	1
The Research Project	1
The Main Characteristics of The Current Female Medical Workforce	3
Executive Summary	4
Characteristics Of The Interviewees	4
Key Findings From The Qualitative Analysis	5
Conclusions	10
Recommendations	13
Attachment	
Human Capital Alliance, A Study Of The Issues Surrounding Female Participation In The Australian Medical Workforce, June 1998	

ABBREVIATIONS

ABS	Australian Bureau of Statistics
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMPCo	Australian Medical Publishing Company
AMWAC	Australian Medical Workforce Advisory Committee
ASMOF	Australian Salaried Medical Officers Federation
CME	Continuing medical education
DHFS	Commonwealth Department of Health and Family Services
EEO	Equal Employment Opportunity
ENT	Ear nose and throat surgery
F	Female
FMP	Family Medicine Program
FRACP	Fellow of Royal Australasian College of Physicians
GP	General Practitioner
H	Hospital non specialist
HIC	Health Insurance Commission
M	Male
O&G	Obstetrics and gynaecology
OTD	Overseas Trained Doctor
PSA	Public Service Association
RACGP	Royal Australian College of General Practitioners
RMO	Resident Medical Officer
S	Specialist
UK	United Kingdom
VMO	Visiting Medical Officer
VR	Vocational registration

TERMS OF REFERENCE OF AMWAC

The Australian Health Ministers' Advisory Council (AHMAC) established the Australian Medical Workforce Advisory Committee (AMWAC) to advise on national medical workforce matters, including workforce supply, distribution and future requirements. AMWAC held its first meeting in April 1995.

AMWAC Terms of Reference

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

MEMBERSHIP OF AMWAC

Independent Chairman

Professor John Horvath Physician, Sydney

Members

Mr Eric Brookbanks Assistant Secretary, Business and Temporary Entry Branch,
Commonwealth Department of Immigration and Multicultural
Affairs

Ms Meredith Carter Director, Health Issues Centre

Dr William Coote Secretary General, Australian Medical Association

Mr Michael Gallagher First Assistant Secretary, Higher Education Division,
Commonwealth Department of Employment, Education, Training
and Youth Affairs

Dr Susan Griffiths General Practitioner, Minlaton, South Australia

Assoc. Prof. Jane Hall Director, Centre For Health Economic Research and Evaluation,
University of Sydney

Dr Richard Madden Director, Australian Institute of Health and Welfare

Mr Ron Parker Secretary, Tasmanian Department of Community and Health
Services

Professor Nick Saunders Dean, Faculty of Medicine, Monash University, Melbourne

Dr Robert Stable Director General, Queensland Department of Health

Dr David Theile Surgeon, Brisbane (former President, Royal Australasian College
of Surgeons)

Dr Lloyd Toft President, Medical Board of Queensland

Mr Robert Wells First Assistant Secretary, Office of the National Health and
Medical Research Council, Commonwealth Department of Health
and Family Services

MEMBERSHIP OF THE AMWAC FEMALE MEDICAL WORKFORCE WORKING PARTY

Chairman

Professor Nick Saunders	Dean, Faculty of Medicine, Monash University, Melbourne (from February 1998)
Professor John Hamilton	Dean, Faculty of Medicine and Health Sciences, University of Newcastle (until January 1998)

Members

Dr Jennifer Alexander	Past President, Royal Australian College of Medical Administrators
Dr Alex Bune	Consultant Physician, Sydney (nominee of Committee of Presidents of Medical Colleges)
Mr John Harding	Head, Labour Force Unit Australian Institute of Health and Welfare
Ms Dell Horey	Convener, Maternal Health (nominee of Health Issues Centre)
Dr Margaret Kilmartin	Division of Rural and Community Health, University of Tasmania
Dr Julia Lowe	Department of General Medicine, John Hunter Hospital, Newcastle
Dr Chris Merry	Doctors-In-Training Group, Australian Medical Association
Dr Sue Phillips (from February 1998)	Health Workforce Section Commonwealth Department of Health and Family Services
Professor Rosemary Pringle	Faculty of Humanities, Griffith University
Ms Susan Rogers (until February 1998)	Legal Services Branch Commonwealth Department of Health and Family Services

Dr Jill Sewell

Director of Clinical Services
Centre for Community Child Health and Ambulatory
Paediatrics, Royal Children=s Hospital, Melbourne
(nominee of Australian College of Paediatrics)

Dr Yvonne White

Consultant Psychiatrist, Sydney
(nominee of Australian Medical Association)

Mr Paul Gavel

Executive Officer, AMWAC

INTRODUCTION

Background

In October 1996, AMWAC presented a joint AMWAC & AIHW report to AHMAC on female participation in the Australian medical workforce. This report provided an in depth quantitative analysis of the impact of increasing female participation on the Australian medical workforce, where previously information had been largely piecemeal or anecdotal.

In 1995, women comprised 26% of medical practitioners in Australia, an increase of 3.3% over the past decade. Women represent approximately 46% of commencing medical students, and 45% of first degree graduates from medical schools in 1995 were women. The percentage of women in the Australian medical workforce is projected to increase to 30% by 2000 and 42% by 2025. This trend is influenced by the increasing number of female medical graduates and the comparatively large number of male clinicians aged 55 years and over proceeding through to retirement (AMWAC & AIHW 1996).

Increasing female participation in the Australian medical workforce is expected to have an impact on the future supply and distribution of medical practitioners because of the different work characteristics of male and female practitioners. For example the AMWAC & AIHW report found that female medical practitioners= work practices presently differ from their male counterparts in that female practitioners are more likely to be working part time, to be working in a capital city or major urban centre, and to be working as a general practitioner. Women are much less likely to be in specialist practice. In addition, women tend to leave the practice of medicine, or practise at quite low activity levels, for a period of time during their career, coinciding with child bearing and child rearing and this in turn results in their average lifetime workforce contribution being around 68% of male practitioners= contribution (AMWAC & AIHW 1996).

However, while the AMWAC & AIHW report provided robust and reliable data on the main characteristics of female medical practitioners' workforce participation, it still did not provide information on why particular career choices and workforce participation decisions were being made. As a result, AMWAC and the AMWAC Female Medical Workforce Working Party recommended that a qualitative study be undertaken of the factors influencing career choice of both female and male practitioners. It was also suggested that this may need to involve both a historical/retrospective study and an ongoing prospective cohort study. This second report on the influences on participation in the Australian medical workforce reports the results of the retrospective study, which involved medical practitioners who graduated between 1967 and 1992.

The Research Project

To assist in the preparation of the report and conduct the primary research, consultants, Human Capital Alliance, were engaged. The consultants= terms of reference were:

1. To identify the issues which affect and shape female and male participation in the

Australian medical workforce and to develop a national perspective on these issues. To be able to identify these issues, the successful consultant will need to consider matters such as:

- a. career choice and work issues;
 - b. working hours;
 - c. children/child care arrangements;
 - d. partner=s occupation and impact on career choice;
 - e. professional support.
2. Identify whether or not there are any generational and/or distributional differences apparent in the attitudes of female and male practitioners towards the issues which affect and shape their participation in the Australian medical workforce.
 3. Distinguish those issues which are specific to female and male practitioners.
 4. Identify any changes to factors affecting female and male participation in the Australian medical workforce which might influence practitioners to make different career choices (that is decisions made in the past or may possibly be made in the future).
 5. Provide an assessment of the magnitude and importance of the issues that are identified as influencing female and male participation in the Australian medical workforce.
 6. Ensure that the contacts used in the research are a representative sample of the current Australian medical workforce and include female and male practitioners who are currently employed and who are not currently employed in the practise of medicine (if possible); and cover all major age categories, rural/remote and capital city/urban practitioners, and practitioners from each of the main segments of the Australian medical workforce (general practitioners, specialists, specialists in training and hospital non specialists).

The consultants' findings are outlined in the attached report. The report also summarises the approach used by the consultants and provides data on the sample and how the characteristics of the sample compare with the characteristics of the Australian medical workforce as a whole.

The AMWAC Female Medical Workforce Working Party considers the sample to be representative of the Australian medical workforce. The Working Party was also impressed with the wealth of information gathered through the research process.

The Working Party would like to stress that this study involves retrospective research. One key difficulty with any retrospective qualitative research is accurate recall. The Working Party and the consultants have worked to overcome recall difficulties by ensuring the consultants= interviews focussed on key career events and the major factors behind career decisions. Key events and influences are likely to be recalled with greatest accuracy.

The Working Party also recognises that the findings of the study may be criticised for relating to events that were influenced by past attitudes, arrangements and practices. This possibility is acknowledged and indeed the only real check on this would be to conduct a similar prospective study, as previously recommended. Again to overcome this possibility the key research findings have been specifically analysed by major age category, so that past and comparatively recent events can be more easily distinguished. In addition, the conclusions of both the consultants and the Working Party have focussed on broad trends that are in fact consistently evident across all age groups studied. This would tend to suggest that the key findings relate to systemic issues, rather than particular practices that could be considered to be exclusively of the past.

The Main Characteristics of the Current Female Medical Workforce

The following is a short summary of the main characteristics of the current female medical workforce. This summary should assist with comparison with the research sample. The summary is taken largely from the AIHW Medical Labour Force survey 1995 (AIHW 1997) and the first report of the Medical Training Review Panel (MTRP 1997).

- In 1997, 46% of commencing Australian medical school students were female
- Of the 48,941 practitioners employed in medicine in 1995, 13,322 (27.2%) were female and 35,619 (72.8%) were male
- 53.6% of female clinicians and 42.7% of male clinicians were in primary care
- 31.6% of primary care practitioners, 14.0% of specialists and 31.6% of specialists in training were female
- Of vocationally registered primary care practitioners, 88.9% of males and 46.9% of females worked 35 hours or more per week
- Of specialists, 88.1% of males and 68.6% of females worked 35 hours or more per week
- For female specialists the main areas of practice were psychiatry (21.2%), anaesthesia (15.5%), paediatric medicine (7.0%), diagnostic radiology (6.3%) and obstetrics and gynaecology (5.5%). Only 1.4% of female specialists were in surgery.
- Of the 7,235 clinicians located in a rural or remote area, 1,614 (22.3%) were female.
- 1997 data shows that the specialist training programs currently favoured by women are paediatric medicine (62% of trainees are female), general practice (56.6%), public health medicine (50.7%), obstetrics and gynaecology (48.9%), pathology (46.0%) and psychiatry (44.6%).
- Specialties with low levels of female trainees in 1997 were surgery (17.2%), ophthalmology (20.0%), occupational medicine (25.0%) and radiology (27.6%).

EXECUTIVE SUMMARY

Characteristics Of The Interviewees

Number of Interviewees

- The study involved the interview of 296 medical practitioners, who graduated between 1967 and 1992.

Gender Profile

- In total, 152 (51.4%) female medical practitioners and 144 (48.6%) male practitioners were interviewed.

Age Profile

- Of interviewees, 37.5% were aged under 40 years and 62.5% were aged over 40 years.
- Of female interviewees, 34.2% were under 40 years of age while 41.0% of male interviewees were in this age group.
- Overall, 31.8% of interviewees were aged between 40 and 44 years, 18.2% were aged between 45 and 49 years and 12.5% were 50 years of age or more. In 1995, 22.6% of the total medical workforce were aged between 45 and 54 years and 20.0% were 55 years of age or more.
- Age groups poorly represented among interviewees were doctors aged between 25 and 29 years (6.1% of interviewees) and doctors aged between 30 and 34 years (14.5% of interviewees). In 1995, doctors aged between 25 and 34 years represented 25.4% of the medical workforce. A major factor contributing to problems in gaining interviews with younger doctors was their high mobility (eg., overseas, changed address etc.).

Geographic Distribution

- In total, 61% of interviewees were from a capital city or major urban centre and 39% were from a rural or remote area. In 1995, 83.7% of the total medical workforce were from a capital city or major urban centre and 16.3% were from a rural or remote area.

Area of Practice

- The representation of medical disciplines among interviewees was consistent with total workforce figures for 1995. Among interviewees, 41.9% were general practitioners, 35.1% were specialists and 23.0% were hospital non specialists. The AIHW 1995 Medical Labour Force survey indicated that the medical workforce comprised 45% general practitioners, 36% specialists and 19% hospital non specialists and specialists in training.
- Of the 105 specialists interviewed, 28% were physicians, 14.4% were surgeons, 9.6% were pathologists, 16.3% were psychiatrists, 13.5% were anaesthetists and the remaining 18.2% were from other specialties. In 1995, 36% of the total medical workforce were specialists of whom 26.5% were physicians, 22.5% were surgeons, 4.6% were

pathologists, 14.5% were psychiatrists, 12.1% were anaesthetists and the remaining 19.8% were from other specialties.

Employment Status

- In terms of employment status, the majority of interviewees were either self employed in private practice (53.4%) or were salaried in the public sector (33.1%) while 2.0% were currently not working.

Hours Worked

- On average, female practitioners worked 38 hours per week and male practitioners worked 53.8 hours per week.
- Overall, men and women in the age groups 30 to 34 years and 35 to 39 years worked fewer hours per week than interviewees of other age groups. Among male and female interviewees, those aged 40 to 44 years and 25 to 29 years respectively worked the longest hours. Of female interviewees, those aged between 45 years and 49 years worked the second highest number of hours per week.

Spouse/Partner Relationships

- The majority (81%) of interviewees were in a long term relationship. Male medical practitioners were more likely to be in a relationship than were female practitioners (86.1% of male interviewees compared with 76.3% of female interviewees).
- Of the 19% of interviewees not in a relationship, 70% of males were aged under 40 years, while only 47% of the females were aged under 40 years.
- Significant differences were observed between female and male respondents in terms of their partner's occupation. Female medical practitioners were almost twice as likely than male medical practitioners to have a professional as a partner. Male practitioners were twice as likely as female practitioners to have a partner who was not working.
- Female practitioners who were in a relationship were more likely to be working part time than were female practitioners not in a relationship.

Key Findings From The Qualitative Analysis

Impact of Family Responsibilities

- The majority (95%) of female interviewees (general practitioners and specialists) indicated that, within their household, they carried the main responsibility for the care and rearing of children.
- Of the female interviewees with children, most indicated that they continued to work after the birth of their children; usually in a part time capacity. The findings suggest that female specialists return to medical practice following the birth of a child sooner than do female general practitioners.

- Compared with female interviewees, male interviewees were less likely to mention that having a family had influenced their career decisions in any way; either positively or negatively. Among male interviewees, the family was mentioned most often in relation to its impact on practice location decisions. A small number of male specialists indicated that having family responsibilities had influenced their choice of specialty.
- Overall, female practitioners were more likely than male practitioners to have curtailed their career for family reasons. This was evidenced in several ways:
 - *by suppressing career expectations*; where an early decision was made to forego a potentially attractive career (most often in a specialist discipline), in favour of a career more amenable to blending career and family
 - *by restricting choice*; where preferred career options were avoided in favour of those that provided greater flexibility and allowed work on a part time basis
 - *by elongating the training process*; where having children before or during training required a reduction in work and training time, significantly increasing the duration of training, and even when part time training was available, increasing the potential for non completion
 - *by limiting their role within the profession*; where female practitioners accepted a lesser role within their profession because there was little time available for professional activities after fulfilling work and family commitments

Spouse/Partner's Career

- The study finds that female practitioners are more likely than male practitioners to have altered their initial career choices in order to accommodate the career ambitions of their spouse/partner. This effect is most evident in terms of decisions about occupation and associated training, location of work and hours worked per week.
- In comparison with female practitioners, more male practitioners reported that spouse/partner considerations had no effect on their career decisions.
- In total, 53% of female general practitioners indicated that spouse/partner considerations had both positive and negative effects on their career. The two most common effects were on choice of discipline and changes in job location. A further 27% of female general practitioners felt their spouse/partner had had a positive impact on their career. In many cases this was observed when they worked together in the same practice. For 18% of female general practitioners, accommodation of spouse/partner concerns had negatively influenced their career ambitions.
- Almost one third of female general practitioners interviewed had medical partners.
- In contrast with female general practitioners, most male general practitioners described the effects of their spouse/partner as positive (53% compared with 27%) or of no effect (32%). Only 4% of male general practitioners indicated that spouse/partner considerations had had a negative impact on their career.

- Compared with female general practitioners, less female specialists (38%) indicated that spouse/partner considerations had both negatively and positively influenced their medical career, while a similar proportion (19%) indicated that it had a negative impact. As with female general practitioners, this negative impact was greatest when their spouse/partner was also a medical practitioner.
- For female specialists the main negative impacts were on choice of specialty and on their geographic mobility.
- Female specialists perceived the most positive contribution of a spouse/partner occurred when the spouse/partner assumed the main parental role for crucial periods during their specialty training.
- Male specialists were the group least affected by spouse/partner considerations, with 50% indicating that it had no influence.
- Male practitioners were more likely to have travelled overseas to further their careers than were female practitioners. On the other hand, female practitioners were more likely to report having experienced difficulties finding the time to pursue their studies overseas because of spouse/partner career considerations and/or family responsibilities.

Barriers to Specialist Training and Specialist Practice

- The length and structure of specialist training, and then specialist practice itself, were seen to have significantly influenced the decisions of both men and women to pursue specialist careers, although the greater impact was upon women.
- Female interviewees tended to take a longer and more complex pathway to achieve specialist qualifications than male practitioners. Women indicated experiencing interruptions to their training program either because of family responsibilities, changes in location to support their partner's career or a personal decision to explore new areas.
- Interestingly, while the journey to gaining specialist qualification was often longer for female practitioners, not all perceived this as a negative experience and indeed some felt the longer journey was more rewarding.
- In comparison with female specialists, most male specialists had taken a direct route to gaining their qualification; fairly single mindedly pursuing their career objective. As a consequence, the length of time from commencement to completion of training for male specialists was much shorter than for female specialists.
- Family considerations were indicated by female specialists as the main factor influencing their decision to enter specialist training and secondly whether to continue with specialist training.

- A significant finding of the study is that both male and female specialists will often choose specialities on the basis of the work conditions and the level of commitment required in terms of hours worked and time on call. A large proportion of both male and female specialists indicated that they had selected a specialty on the basis that it was flexible and family friendly. These issues were particularly important to female specialists and younger male specialists. These findings inform current female participation rates in the medical workforce and specialist training programs, where women are best represented in dermatology, psychiatry, radiation oncology, pathology and anaesthesia.
- A number of female interviewees specifically indicated that they chose not to work in surgery or obstetrics and gynaecology because of the hours of work and the impact of these demands on lifestyle.
- Some female specialists also noted that they had experienced difficulties in trying to negotiate more flexible working hours with public hospital administrators and that this had led them to leave the public hospital system in favour of private practice.
- Another common theme which emerged, amongst both male and female interviewees, was the importance of positive (and negative) experiences in undergraduate and particularly early postgraduate training, on subsequent career decisions.

General Practice as a Career Option

- Both male and female practitioners reported actively choosing general practice for family reasons. In addition, some male practitioners reported choosing general practice following disillusionment with the public hospital system or specialist training.
- Just over half of the interviewed female general practitioners stated that general practice was always their first career choice. The majority of these women chose general practice because it had flexible working hours which accommodated family commitments. Other factors cited as being important in choosing general practice were its emphasis on continuity of care and 'whole person' approach to treatment.
- Similarly, over half of the interviewed male general practitioners indicated that general practice was their first career choice. Some male general practitioners reported that they 'fell' into general practice after failing to gain a specialist training position or a specialist qualification.

Cultural Factors and Attitudes

- The most obvious attitudinal factor highlighted by interviewees was a negative attitude towards part time work, particularly the notion that one is not a >doctor= unless one works full time.
- Female interviewees, particularly older women, reported experiencing overt sexual discrimination during their career.

- Some male interviewees expressed a negative view about women in the medical workforce, and these practitioners tended to be older.
- In terms of colleague attitudes, female specialists were more likely than female general practitioners to report experiencing negative attitudes. Generally, these experiences were associated with them expressing a wish to work or train part time.
- Several female practitioners, including practitioners in the younger age groups, indicated that they were questioned about their personal life, including intentions to marry and/or have children, during interviews for jobs and training placements.
- A number of younger doctors were strongly critical of the adverse working conditions they experienced in public hospitals.
- The important and positive role played by mentors and role models in early career decisions was a theme often referred to by both male and female practitioners.

Rural Practice

- For male interviewees working in a rural location, the most common reason for choosing rural practice was growing up in a rural area. The next most common factor was a positive rural experience.
- Unlike their male counterparts, for female interviewees working in a rural location the most common reason for doing so was their partner's job.
- Both female and male practitioners described the pleasures of the rural lifestyle and the scope of practice as important factors in remaining in rural practice.
- The education of children was a major concern for rural doctors, and a number of interviewees indicated they had left rural practice solely for this reason.
- Concerns were also raised about negative attitudes towards rural practitioners from urban doctors. This was particularly noticeable amongst rural specialists, who felt teaching hospital specialists gave more support to their urban colleagues.
- The other main concern raised by rural practitioners, both general practitioners and specialists, was the need for locum relief.

Reasons For Choosing Medicine

- The three main reasons given by female practitioners for choosing a medical career were being good at mathematics/science, for altruistic reasons and due to family influence.
- The three main reasons given by male practitioners were family pressure, for altruistic reasons and good school results.

Generational Differences

- Few differences were evident between the older (pre 1980 graduates) and younger (post 1980 graduates) with respect to family responsibilities and the influence of spouse/partner career. However, younger male practitioners were more likely to report instances of part time work or changing their work pattern to help look after the family or to facilitate their spouse/partner's career aspirations.
- The majority of female practitioners aged under 40 years, working part time, were doing so for family reasons.
- The length and nature of specialist training continues to have a major effect on the career decisions of younger doctors. Almost 80% of younger female specialists interviewed, and a significant number of younger male specialists, indicated they had chosen their area of specialty practice on the basis that it provided flexible working hours which allowed them to balance work and family commitments.
- In total, 70% of younger female general practitioners interviewed indicated they chose general practice due to its flexible working hours, the absence of a requirement to do after hours work and because it fitted in well with family commitments.
- Compared with their older colleagues, younger doctors were more likely to be critical of the excessive hours and poor working conditions of public hospitals. Other issues mentioned included insufficient time for study, lack of a proper mentor system, lack of vocational guidance, the suicide of colleagues and concern about competition for training positions.

Conclusions

Male and female practitioners participate in the medical workforce differently. Definite trends are noticeable and the research presented in this report illustrates some of the key factors that have shaped career choices and workforce participation decisions.

The research also shows that barriers do exist that influence the structure of the medical workforce. These barriers confront female practitioners mostly, and occur most noticeably during vocational training and the child rearing period of a woman's life. These barriers are associated with some specialist medical College training policies and practices and with the public hospital system. At the same time, in highlighting this it should be stressed that some of the issues raised are quite complex and also not unique to the medical workforce.

The majority of medical practitioners interviewed - male and female - indicated that overall they were satisfied with their professional careers. However, the career paths of male and female practitioners have often involved different experiences and have been fashioned by different career stimuli. The research shows that the major career drivers for male practitioners are associated with the professional work ethic and achieving a high standing amongst their peers. On the other hand, the career ambitions of female practitioners are modified by the priority they place upon the development and maintenance of personal and family relationships, which

requires them to balance family responsibilities with their clinical work.

The majority of medical practitioners interviewed were partnered and/or have family responsibilities. However, male and female practitioners interpret their family roles very differently. Female practitioners tend to be the main family carers. Thus, for female practitioners the care and maintenance of the family emerges as a high priority, either by choice or by default. As a result many women seek out career options that allow them the flexibility to accommodate both their professional and their family/social roles. For men, this is not such a high priority. However, there is some evidence that among younger male doctors it may be of growing importance. These findings are not surprising given they are in accord with the tenor of other Australian and international literature on women in medicine and women in other professions.

In many cases, the professional career aspirations of female practitioners have been subordinated to the career aspirations of their spouse/partner. This study found that female practitioners with partners had generally experienced interrupted or curtailed careers. This was particularly the case where both partners were medical practitioners and where there had been a lack of synchronisation and harmony between their respective training paths.

General practice is one area in medicine which allows sufficient flexibility for the family/social and professional objectives of female practitioners to be accommodated. This study shows that some female practitioners have selected general practice as a positive decision, some for pragmatic reasons, and others by default. Of particular significance have been adverse reactions to the hospital environment with its demanding shift work, comparatively rigid management practices and lack of part time training and work opportunities; and to specialist disciplines that are comparatively more demanding of time and involve time on call.

According to interviewees, access to flexible training and work opportunities emerges as one of the most important determinants of career choice for women. This is because flexible work environments allow female practitioners to combine their work and family/social responsibilities. Hence the favouring of disciplines such as dermatology, paediatric medicine, pathology and general practice. These disciplines have more flexible working environments and generally little or no requirement for irregular working hours and time on call. Female practitioners are least likely to train and work in areas that are demanding of time, compromise lifestyle responsibilities and aspirations, and offer little or no possibility for part time work. There was no evidence in the study to suggest that this pattern of participation was likely to change.

The work of the MTRP supports the continuation of the above trends. For example, the 1997 data on specialist training programs shows that the specialties with the largest proportion of female trainees were paediatric medicine (62.0% of trainees), general practice (56.6%), public health medicine (50.7%), obstetrics and gynaecology (48.9%), pathology (46.0%) and psychiatry (44.6%) (MTRP 1997). While all medical Colleges indicate they offer part time training, it would seem the only widespread practical application of this notion occurs within general practice.

Both the results of this study and the data from the MTRP suggest that current workforce

participation trends are likely to continue unless those areas of practice with comparatively smaller numbers of female practitioners and trainees work at ways to offer more flexible training and work environments. If this is not done the gender imbalance between general practice and specialist practice and within the specialist disciplines can be expected to continue and possibly even increase.

In common with the recently completed MTRP review of trainee selection in Australian medical Colleges, conducted by Dr Peter Brennan, is the notion that there is indeed a gap between rhetoric and reality in relation to women in medical training, particularly in the sense that despite specialist medical Colleges having developed policies and procedures in relation to women in training, concerns continue to be highlighted (Brennan 1998). In this study the majority of these concerns related to practical difficulties associated with the training environment and as such hospital staffing and work practices.

The issue will need to be dealt with. Accordingly, the Working Party supports the suggestion in the MTRP/Brennan review that perhaps one approach to a resolution of the difficulties in this area would be a series of national workshops to develop workable solutions. In agreeing with this suggestion, it is important to stress that any workshops will need to have the development of workable solutions as their prime objective otherwise they risk just further reviewing the issues and revisiting now well known causes and concerns without any progress towards reform. It would seem that without some positive effort in this area the difficulties highlighted in this study are likely to continue to persist, in turn encouraging at the very least the maintenance of the current imbalances in workforce participation.

The Working Party also concludes that change is required in the organisation and management of many of the specialist training programs so that female practitioners can have the opportunity to better participate in the training program, and then ultimately within the medical workforce. In particular, interventions that help to create better access to non general practice training programs would be of greatest immediate value. In turn, this would create a better gender balance across the Australian medical workforce, recognising within the vocational training environment that women now comprise almost half of all medical graduates, and that their legitimate concerns should not be ignored.

The Working Party recognises that most of the impetus for workable solutions will need to come jointly from the specialist medical Colleges (as the overseers of training) and the public hospital system (as the main provider of training placements and therefore the training environment). There are a range of possible reform options, all of which could contribute in part to facilitating an improved gender balance across the Australian medical workforce; however, these are probably best pursued in depth through the national workshops rather than in this report. In addition, it is quite possible that potential solutions will not be without some financial cost, but speculation on this issue is outside the scope of the Working Party's activities.

It would also seem that the influences on workforce participation should be regularly examined. This retrospective study has identified factors which have influenced the career pathways of practising doctors. The factors influencing the careers of female practitioners were found to be

those which have influenced women in most professions for decades and these are likely to continue to exert influence. The study also found that the career expectations of male doctors appear to be changing with some younger men also making career choices based on flexibility and manageable work hours. Such changes have the potential to influence the structure of the future workforce in important ways. Prospective studies are required to monitor changes in current, and future, junior doctor cohorts= attitudes to training and the factors influencing their career choices and workforce participation decisions. These studies should be undertaken jointly by MTRP and AMWAC.

RECOMMENDATIONS

The Working Party considers it is desirable for State/Territory health departments, public hospitals and specialist medical Colleges to work towards greater flexibility in the training and work environment for medical practitioners as this seems to be the key influence on career choice and workforce participation decisions. If workable solutions are not found to the desire for more flexibility in the work and training environment then it is likely that the gender imbalance between general practice and specialist practice and within the specialist disciplines will continue. The Working Party recognises that the development of arrangements that accommodate greater flexibility may not be easy or without cost implications.

It is recommended that:

1. As a guiding principle, health departments, hospitals and private medical practices seek to make best use of highly trained male and female doctors by:
 - designing jobs as flexibly as possible, whilst maintaining consistency with good clinical practice;
 - ensuring appointments are made using non-discriminatory and transparent processes; and
 - promoting re-entry to the workforce using appropriate adjustment and retraining arrangements as necessary.
2. Associated with 1 above, health departments, hospitals and specialist medical Colleges should continue to seek greater female participation in specialist training programs.
3. To assist in the development of workable solutions to the issues concerning flexible employment opportunities, improved female participation in training programs, and the use of non-discriminatory and transparent selection processes; AMWAC, in association with the MTRP, should convene a national workshop. Participation in the workshop to be drawn from State/Territory health departments, hospital administrators, specialist medical Colleges and professional medical associations.
4. AMWAC continue to monitor trends in medical workforce training and workplace participation and explore innovative approaches to participation and retention, including drawing on developments in other fields.

As part of this monitoring process, AMWAC and the MTRP jointly undertake a series of prospective cohort studies to monitor and report on junior doctor training and career decisions and the factors that are influencing their workforce participation.

5. AMWAC to report progress on implementing these recommendations to AHMAC on a regular basis.