

## ORIGINAL RESEARCH

# Medical family support needs and experiences in rural Queensland

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## ABSTRACT

**Introduction:** Family issues have been recognised as major contributors to both rural GP retention in, and loss to, rural practice. This qualitative interview survey of rural medical spouses sought to identify and understand the support requirements and experiences that could be used to formulate strategies that may positively influence rural medical family retention. A concurrent key informant interview of 14 agencies associated with rural medical practitioner support sought information on those agencies' specific spouse/family support strategies. Aims: The study's specific aims were to: investigate the experiences and needs of families in terms of support to settle and remain in rural and remote areas; and identify the range and type of formal and informal support strategies available to, and used by, rural medical families.

**Methods:** This was a qualitative study with two independent, but complementary, components: (1) in-depth, semi-structured interviews with families of 15 purposively selected rural GPs; and (2) information provided by 14 support organisations.

**Results and Discussion:** Medical family support needs and experiences varied with time in a rural setting. The most frequently mentioned early difficulties included integrating into a community (9/15); childcare and schooling (8/15); being seen as the 'doctors spouse' (ie, loss of own identity) (7/15); and housing and housing maintenance (7/15). Support needs changed over time as respondents established their own support networks. Increasingly, support was required for timeout from the community (5/15), and to keep abreast of changing practice management requirements (4/15). Few formal support strategies were reported as known or used by spouses. Informal support strategies included partners of other GPs; hospital functions and informal social gatherings; clubs and organisations; local church groups, and friendships with other itinerants in the community. Spouses indicated important



potential sources of support (both when new to community and later on) as a need for a 'head start' with local and regional networks (14/15); ability to talk to other spouses in similar situations (12/15); support for timeout or leave (12/15); access to a GP other than the GP spouse (10/15); information about childcare (9/15); practice and business management (8/15); and dealing with housing issues (6/15). Additionally, an orientation package was seen as a means of assisting new arrivals to get settled (12/15). The survey of agencies/organisations providing direct and indirect support revealed that there is little directly-funded family support in Queensland, although a number of bodies either have support activities in place or planned. The potential number of players presents a risk of duplication of effort unless there is effective inter-agency dialogue.

**Conclusions:** Like their medical partners, spouses appreciate and value peer support and understanding. Strategies aimed at rural GP retention should consider the rural medical family as a unit for support purposes. Support organisations and rural communities must recognise and cater for changing support needs over time. The agency interviews provided some hope for the future, although funding for support activities appears to be limited. Perhaps of greater concern is the possibility for duplication of effort and activity, particularly in some areas, and potentially at the risk of ignoring others.

**Keywords:** Australia, recruitment, retention, rural medical family support, rural medical workforce.

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## Introduction

Although many factors have been demonstrated to influence the departure of GPs from rural practice, spouse and family factors are among the most common<sup>1,4</sup>. Previous research indicates important links between professional support (eg locum and holiday relief) for the GP and the impact on the family (eg in terms of undisturbed family time and time out of the community)<sup>1-7</sup>, but the importance of providing specific support for a GP's spouse and family has also been recognised<sup>3,4</sup>. That said, the policy and strategy focus has remained predominantly on GP retention, with little specific attention given to the key issues and ameliorating strategies which specifically address the support of GPs' families<sup>4,8</sup>. Even less is known about the relevance and success of strategies in this regard and their impact on retention.

Previous research on why GPs left rural practice indicates that workload, and professional and personal support issues were significant factors contributing to GPs' decisions to leave rural practice<sup>1,2</sup>. Many GPs specifically mentioned issues concerning on-call and the associated interruptions to 'family time'. These combined to wear down practitioners and their families over time. A lack of formal strategies to share workload and difficulties associated with cooperating

with neighbouring practitioners further contributed to professional and personal dissatisfaction<sup>1</sup>. A study of work patterns among Medical Superintendents with Right of Private practice (MSRPP) in Queensland argued that while rural practitioners are both economically and socially important to rural health and communities, their support needs and those of their families are not well understood<sup>6</sup>. The authors identified the need for further investigation into the social and family support structures, as well as the professional needs of rural practitioners themselves.

A study that profiled rural spouses and their roles recommended strategies specifically addressing the support of rural spouses<sup>3</sup>. These recommendations focused on supporting the spouses of rural GPs to prepare for rural life. They also encouraged rural communities to acknowledge and understand the circumstances associated with rural medicine and facilitate the use of the professional skills of the rural GP spouse. Others have argued similarly<sup>5</sup>.

An Australian Commonwealth-funded investigation of the characteristics of sustainable rural general practice identified distinctive criteria of sustainable rural and remote general practice that included the practitioner support environment and, in particular, the ability to share workload, the reliability of locum relief allowing adequate time-off with



family, and family wellbeing, such as spouse employment and family education<sup>4</sup>. Community expectations of the medical practitioner and proactive community support of the practitioner and family were also identified as essential components of sustainable rural practice. Another study demonstrated both the importance of, and the processes by which communities can develop on-going strategies to recruit and retain health services in their areas, including targeted support for GP families<sup>5</sup>.

## Method

The specific aims of this study were to:

- ◆ investigate the experiences and needs of families in terms of support to settle and remain in rural and remote areas.
- ◆ identify the range and type of formal and informal support strategies available to and used by rural medical families.

Data collection involved two independent but complementary components:

- ◆ in-depth, semi-structured interviews with families of rural GPs.
- ◆ information provided by support organisations, including key informant interviews and documents relating to support strategies.

### *Interviews with spouses of rural GPs*

A geographically stratified random sample of 16 established GPs with families (ie, at least a spouse or long-term partner) was drawn from the Queensland Rural Medical Support Agency (QRMSA) database. Geographic stratification was effected using RRMA classifications and designed to include families of rural GPs practising in both coastal and inland areas. The sample included families who had been in rural settings for less than 5 years (short-term) and more than 5 years (long-term).

The interview schedule was based on previous research undertaken by the research team. Interviews focused on social and professional links, past problems encountered in community life and the formal and informal strategies for overcoming these, as well as social interactions, and reasons for staying or leaving a community. Some basic demographic information was also collected. The interviews sought an understanding of the importance and effectiveness of the types of support services available to and used by interviewees.

### *Organisations providing support to rural GP families*

Semi-structured short interviews were conducted with key personnel from agencies currently providing support to families of rural GPs. These agencies included GP Branches of the Commonwealth and State Health Departments, Queensland rural divisions of general practice ( $n = 5$ ), QRMSA, Rural Doctors Association (Queensland), Queensland Rural Medical Family Network, Country Women's Association (Queensland), Bush Crisis Line and the Rural Doctors Help Line. Similar interviews were held with shire clerks and rural council contacts as appropriate. The purpose of these interviews was to identify current support strategies (formal and informal) available to medical families.

Qualitative data were analysed using QSR NUD.IST software and a keyword format (Qualitative Solutions and Research Pty Ltd, Melbourne, VIC, Australia). Themes were identified through the interview texts and explored within the context of the original schedule questions.

## Results and Discussion

### *Interviews with rural medical spouses*

A total of 15 (of 16) spouses agreed to be interviewed (13 females, 2 males). All lived in areas designated as RRMA 6 or 7 (remote). Eight were in sole practitioner towns, two had spouses who were in solo practice but were



not in sole practitioner towns. The remainder had spouses who were in small group practice, or in communities with more than one medical practice/service. One was located in an Indigenous community, four were in mainstream communities, while the others were in communities with sizeable minorities of Indigenous people.

Three participants were involved in the early development of the Rural Doctors Association family support networks group which eventually became the Queensland Rural Medical Family Network (QRMFN). Two had already been resident, as professionals in their own right, in the rural community where they met and married the GP. These interviewees indicated that they had already established their own networks and friendships, and their own identity in the community through their work, before becoming the partner of the GP.

Eight participants were employed in their partner's practice as practice manager. The remaining seven participants, included professionals ( $n = 3$ ), a student and three who described themselves variously as housewives and mothers. Ten participants had young children still at home, three had grown children who were now independent and two had children at boarding schools. Only three participants had dependents or relatives living near by.

Five participants had grown up in rural areas. Six came from urban capital cities and regional centres in Queensland. The remaining four had some rural experience, such as extended holidays on rural properties owned by relatives. Although the median time resident in the current practice location was 18 years, this ranged from 8 months to 32 years. Indeed, a sizeable minority of families had spent between 2 and 4 years at their present practice location.

### **Early difficulties**

When asked to describe what they had found most difficult when moving to their present rural location, the most common issue raised concerned integrating into the community (9/15), this was also linked to issues such as

being seen as the 'doctors spouse' (7/15) (ie, loss of own identity), and community expectations based on the actions of previous GP spouses (4/15).

*I think the singular one was that I felt that I was merely and primarily recognised as 'the doctor's wife'. And I can remember being incredibly irritated by that - feeling that my identity had been defined for me. I dealt with it, and you know, with time and maturity it hasn't really been a problem.*

*When I went to the hairdressers soon after we arrived, I got told all about the ex-doctors' wives and how bad they were, and how antisocial, and 'it's really good that you're going to be part of the community and working'.*

Childcare and schooling issues were raised by eight participants in both positive and negative ways. These included considerations about sending children to boarding school, and the difficulties of identifying appropriate and acceptable childcare arrangements. Such issues have been reported to result in families leaving rural practice<sup>1,2</sup>. A positive aspect was that children were seen as a way in which spouses could develop networks in the community.

*There was no [childcare] ... and I didn't work for about 18 months and then I got to know some people who I could ask about babysitting and that stuff... someone who knew someone who knew someone. Some of those things were unsuitable too, so I stopped working because the child care arrangements were unsuitable....*

*The children were a good way of networking into the community, being involved at nursing mothers, at playgroup, at preschool and then all through school with tuck shop and reading and then I went back on to staff then too.*



It is noteworthy that even those who had moved from one rural setting to another and, therefore, already had experience in 're-settlement', reported similar difficulties when setting up in their new community. This reinforces the need for community-specific, up-to-date information or orientation packages for new arrivals. Increasingly, rural medical spouses have careers that they wish to pursue, but limited childcare services, as well as limited employment opportunities, can lead to dissatisfaction and pressure to move on<sup>1,2,5</sup>.

Housing and housing maintenance were also identified as difficulties (7/15). Knowledge of appropriate contacts and protocols for rectifying housing problems and the overall time it took for identified problems to be addressed was raised. This was particularly evident with those on Queensland Health contracts where the bureaucratic process resulted in lengthy delays and frustration.

*The communication factor is really bad, because it goes through so many different people. Because we have to tell the hospital, and the hospital have to go through district office, and they have to go through QBuild, then QBuild have to go back through one of their contractors as to who's going to do the job. Then it has to weave its way all the way back again to say yes it's all getting done and this is what's happening and when... you never know when it's going to happen. And because they only have one contractor in town that does QBuild jobs, one painter that does QBuild jobs in town, so he gets all the QBuild stuff in plus if he does all his own work, but 'When I can get there I'll get there'. That makes it a lot more difficult for everyone involved, but all the trouble you have to go through it's like, 'yeah, righty oh'. I mean that's life.*

Such a process almost certainly leads to lengthy waiting periods and increasing frustration across time, especially if the issue is related to comfort; such as waiting for air-conditioning to be repaired in summer. This very issue has been reported as a significant factor in GP families leaving

rural practice<sup>1,2</sup>. It is important, therefore, for bureaucrats and senior managers to recognise the importance and significance of such issues (to retention) and to develop and enact more streamlined and family-friendly means of responding to requests for property maintenance and repairs. It needs also to be recognised and acknowledged by bureaucrats and managers that it is generally cheaper to retain a medical family through proper and timely support than to recruit and place a replacement family<sup>5</sup>.

### **Formal support**

Participants were aware of few formal strategies. Ten participants named the QRMFN and its predecessor (Rural Doctors Association Spouse subcommittee) as support organisations. One participant identified the QRMSA family support subcommittee accurately, although at the time of the survey this subcommittee had not long been established. However, knowledge of these organisations did not necessarily relate to use of, or affiliation with them – two participants had never heard back from one organisation after initial contact, two had purposely not joined and two confused agencies. Participants often decided not to join support organisations because they already had established local links.

*I was aware of a support group for the wives ... but I didn't really feel the need for it at the time. I was getting out and about anyway.*

One participant identified a specific division of general practice's support program, but she had not accessed it because: 'I would feel funny ringing them, you know, I don't really know them'. Several participants also noted that one organisation appeared to be focused on one area of the state, rather than meeting the needs of spouses across the state. It is difficult in a state the size of Queensland for groups based in one area to be abreast of new arrivals elsewhere and their needs. There would appear, therefore, a need for organisations specifically tasked and funded to provide support for rural medical families to be more active and



consistent in their contacts with rural medical families across the state. This might be best achieved by ensuring that 'endorsed' representatives of the organisation are distributed throughout the state to act as 'local' contacts.

A couple of participants also remembered that there were some formal structured events held within their communities to orientate families. In some instances the event was timed to include a number of new arrivals, and this relieved some of the focus on the medical family.

*Well, I think the first week we had arrived the people ... had a BBQ specifically to welcome us and the new bank manager and policeman at the time - so it was a special BBQ for the new people coming in and the following week there was some function at a club that we were formally invited to and officially welcomed.*

*There was a morning tea at the hospital which was to meet the doctor and his wife - I hate those things and I hated being called Mrs Doctor.*

These events can be both productive and counter-productive. On the positive side they can provide GP families with an early introduction to their new community and to the key players within the community. In contrast, such events can lead to unwelcome approaches (such as informal requests for medical advice), or cause anxiety to those who are not comfortable in such settings.

### **Informal support**

Participants reported a range of informal arrangements, most commonly the support provided by the partners of other GPs (8/15), either in their own town or in a nearby community.

*Others in the city will say I know what it's like, but they don't know what it's like and here I am very close friends with the other GP's wife. Even if I can't tell her specifically what's wrong, I can call by and say I need a cup of tea and I hate this place today. No*

*matter whatever I say to her she says 'I know, I know'.*

Other informal activities included hospital functions and informal social gatherings which enabled participants to gain information about community banking, postal arrangements and garbage, and clubs and organisations such as the Isolated Children's Parents Association and the Country Women's Association.

*There was a hospital function and we were invited out to properties, just social gatherings, the people with business downtown said if there was anything we needed just to let them know. The lady at the ... helped us out with all kinds of information, just general information about how you do things.*

### **Most important early support**

When asked to nominate the most important support they received when first out in rural practice, nominations included church contacts, childcare groups, local clubs and organisations and local friends. A common feature of all of these is that they provided the respondents with opportunities to integrate into the community and to cope with separation from their previous circle of contacts.

*[Most important] was the childcare, I could get out to work and the friendships, people to have a chat with. If my husband's not around I could spend all my weekends on my own with the children so it's nice to have the friendships to fall back on, and people to spend time with.*

### **Experiences of early support**

Participants were asked how the support (formal and/or informal) they had received early on could have been improved. Three spouses commented specifically on formal strategies, suggesting that the method of promoting family



support, and the way in which it was delivered, could have been improved.

*All of the people that were supposed to be mentors, perhaps if they could have been the people who were involved in the teleconferences each time... we had a committee of people from southwest Queensland and I feel as if we were isolated from the rest of the state and I don't think that should have been the way it was... The mentors should have been able to get some support from each other and I'm not sure that they did...*

*There were some advertisements ... just recently in the Country Life and one of the locals brought it to me and said 'why is living in the bush so horrible?' It really concerned me that she brought these articles about rural spouses and families and strategic business plans and people find out about rural retention payments and stuff. A lot of country people already see us as being on a good income and we have to be very careful. I mean, no one else gets paid for living in the bush...I think if that's the only reason [GPs and their families] are here then maybe we don't need those sort of people in the bush, because bush people will see through those sorts of doctors and families very quickly.*

### **Changed support needs over time**

When asked how they felt their support needs had changed over time, two participants felt that they no longer needed the same level of support now that they had established support networks. Others ( $n = 5$ ) indicated that support to enable timeout from the community, to provide support for elderly parents in other areas, or to travel out to see children at boarding school, were important changes from their early support needs. Four commented on the need for specific information relating to practice management issues, particularly in view of recent changes to general practice such as accreditation and tax issues. Other comments included an increased need for support in relation to coping with the local community as the GP's wife.

*I suppose I don't need as much support now as I did at first. They're definitely less - well you still need support - but I guess now I have enough friends and I know where I can get support, whereas early on I was probably a bit lonely, I wasn't working..*

*Probably changed to more business-related things now because of having the practice, and the GST coming in and stuff like that.*

*Getting out of the place, the time, the biggest problem is paying for it, the airfares and things. So I mean the only support I can see that would be really helpful so you could actually get to see your family.*

### **Sources of current support**

Participants identified partners and family as primary current supports. Other current sources of support included local and regional friendships, particularly those formed with spouses of other GPs and people in similar positions ( $n = 9$ ); support for timeout for their partners to spend with the family, which was not always readily accessible ( $n = 4$ ); and practice management support and training ( $n = 4$ ). A number of spouses commented on the opportunity that certain key practitioner events, such as the Rural Doctors Association of Queensland annual conference, provided for the family to take some time out of the community and to do some 'family things', such as shopping, sight-seeing and going to the theatre and restaurants.

### **Useful strategies**

Finally, participants were asked to consider a list of strategies and asked to indicate how useful each of these would have been, both when they were new to rural practice, and then later. Most important was the need for a 'head start' with local and regional networks. Fourteen would have found some ready-made local and/or regional contacts useful. Equally, one thought their local community was big enough to support a range of contacts and supports, without having to resort to a regional network. The need to talk to other spouses in similar situations was stressed. Spouses of



overseas GPs thought an employment network for their area would have been useful early on.

*A starting point and some suggestions would have been very good because for the first few weeks you can be so busy trying to set up a practice. I don't know any family who would find time to initiate some social interaction and find their own friendships.*

*Having a phone number of someone who's in that position and not having to explain lots of things because they're experiencing it first hand and they can say, yes, I know exactly what you're talking about.*

*[Regional networks] , oh yes, very important, you don't always want people knowing your business. In a small town, it's vitally important. It would be especially difficult in a one-doctor town because all the community is seeing your [spouse] as patients.*

Twelve participants also commented on the importance of support for timeout or leave. The remaining three were either under the state health system award, or had spouses in cooperative arrangements with other practitioners. Coordinating the locums and relief for GPs whose spouses were practice managers or professionals in order to get time away together was a particular issue, because two relievers had to be found and paid.

*This is needed, you need time and space with family. The GPs have such high workloads, it's critical otherwise you get burnout... I won't teach or get tied down or something that will keep us from taking off, but you also need to be able to afford it.*

*Timeout – it's important. It can be very lonely. One of the things I found hard was the first thing we did was buy a farm and I hated it because every weekend he went out to the farm and it took him away from us.... His relaxation was time at the farm and it was an issue in our marriage.*

Access to a GP, other than the GP spouse, also emerged as an important need. Ten respondents raised this issue, having either had to confront it early on as a problem to be addressed, or having recently discovered it as an issue. Even those participants who lived in towns with two or three additional GPs indicated that access to another GP was important where support networks revolved around social engagements with other medical families.

*You see, the thing is, I don't know how many other GPs there are in the area but you sort of know them and so I wouldn't go to any of them.*

*I'd rather not have a smear done by someone I might have to sit at the dinner table with!*

*It's an issue [my husband] absolutely hates it. We don't go to the surgery and sit in the waiting room, but when he's finished work and he's coming into the house and I'm saying, 'Oh M's not been well today', and he says, 'oh, can I switch off now?' It does put a lot of pressure on him and he can't be objective, so that's a big one.*

## **Orientation package**

Twelve participants saw particular worth in the concept of an orientation package as a means of assisting new arrivals to get settled. One even thought that this would be useful to have in advance of arrival in order to prepare, such as reviewing clothing and culinary requirements.

*... to prepare you for actually what's there, it might also entice other spouses to go. I know they have so much trouble getting people to go rural. If they know it's not that bad. I know that some doctors wouldn't mind going rural but the spouses say 'no, I don't want to go and sit out there' which I can't really blame them for.*

*That would be really useful, like bring wine glasses, bring a bread maker because the bakery isn't reliable...*





Following on from this, eleven thought that early preparation for rural practice was important; particularly in relation to knowing what to expect before getting out into rural practice and also knowing how to set up a practice. One stressed the importance of early preparation for rural practice, particularly focusing on the positive aspects of being in the bush in order to relieve some of the fear or stress.

*That would have been wonderful because I didn't have a clue - even just recognised suppliers of medical equipment, where you buy sheets for the bed, all the basic stuff.*

*I guess that's OK, as long as it's positive. I think that's one of the things - you have to be positive and flexible. You can't come out here thinking we're going to do it this way because in lots of ways you have to go with the flow and fit in where you can... be flexible and think positive, so prepare by all means, but as long as it's positive and flexible in approach.*

*I read all the available publications, I searched things out on the internet as much as I could, but there could be much greater development of support information on web pages. I did read the information my husband received, on what kinds of issues were before the different professional groups and what kind of issues I might be facing in the surgery, sources of information...*

Childcare (and information about access and availability) was also raised as an important support need. Nine respondents identified it as being important throughout the time in a rural area, allowing spouses to work, meet and create their own networks of friends and support. Two respondents felt they were lucky to have friends and family locally available at the time of need.

*Yes, playgroups, and information about child playgroups, schools and what's available for the children in the community - I had to research that myself.*

Information and support regarding practice and business management were also seen as important. Many had come to practice management almost accidentally, such as originally as a means of seeing their spouse more regularly, or as a short-term staffing arrangement that eventually became permanent, or as 'something to do when the children were at school', so had no formal training in practice management. Thus, eight participants thought that ongoing support in this respect was essential - everything from how to set up the practice, through to specific needs relating to legislative changes and requirements. Two had overcome the problem through membership of the Australian Association of Practice Managers (AAPM), which both had found a useful. It was clear that few other spouses were familiar with the Association.

*As part of the orientation package this would be good. If there is a package for the wife, particularly if the wife is already in a supportive role with the husband in some way, it's very useful information, if there is a role that the wife can take up it would be very encouraging because you can be mentally prepared.*

*Yes, it's critical because it's necessary for your success, especially if you, the spouse, are the practice manager. You need information early on.*

*I've been a member of AAPM just about since it started in Queensland and AAPM was a wonderful part of my early life and I would say any spouse who runs general practice should be part of it. They provide wonderful information and training.*

As small businesses, efficient and effective practice management is an essential element in a successful, viable rural practice. As tax and small business regulations tend to change frequently, it is important that practices are up to date with these and able to efficiently enact practice-based changes in response. Additionally, many of the financial incentives available to rural practitioners are dependent on good knowledge of the specific requirements and efficient record keeping.



Housing was raised as one of the most difficult aspects of early rural life, and six respondents considered the issue worthy of inclusion in an orientation package.

*More information is needed on how to get things done. I think that should be part of orientation and it might have been for my husband, but he certainly didn't pass it on!*

### ***Survey of agencies/organisations providing direct and indirect support***

At the time of the key informant survey, four of the 14 organisations interviewed had formal spouse/family support strategies in place. Strategies ranged from information resources, through social networks to crisis support. Several others had plans to introduce support strategies, some of which were similar to strategies already available. Clearly the potential number of players presents a risk of duplication of effort unless there is effective inter-agency dialogue. That said, few of the spouses interviewed had either had contact with, or used the resources offered by these organisations.

## **Conclusion**

The spouse interviews identified a variety of needs – met and unmet. In most instances, the respondents had had to find their own solutions to difficulties – meaning, in many instances, repeating the errors and frustrations of so many others. The majority supported the concept of an orientation package which included both locally relevant information contact details, as well as more generally useful information such as that relating to managing a practice and dealing with government departments and contractors. Clearly, like their medical partners, spouses appreciate and value peer support and understanding. That said, some respondents, particularly those with rural backgrounds, indicated that they had no difficulties finding their own way.

It is surprising that the spouses and families of rural GPs have attracted so little dedicated support to date in view of the increasing evidence that family pressure (dissatisfaction) is a key factor in the decision to leave rural practice. Strategies aimed at rural GP retention should consider the rural medical family as a unit for support purposes, as well as at time of recruitment. This, then, should begin at the time of initial contact and interview with the GP. The agency interviews provided some hope for the future, although funding for support activities appears to be limited still. Perhaps of greater concern is the possibility for duplication of effort and activity, particularly in some areas and potentially at the risk of ignoring others. This would be unfortunate. Inter-agency communication – perhaps even collaboration – might be the most effective means of ensuring effective coverage of the key support issues.

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