



New Zealand Rural General Practitioners 1999 Survey— Part 3: rural general practitioners speak out

Ron Janes and Anthony Dowell

Abstract

Aims To describe themes about rural general practice from the written responses in the 'New Zealand Rural GPs 1999 Survey'.

Methods A postal questionnaire surveyed all rural general practitioners (GPs) in New Zealand (NZ), who were asked for comments or suggestions about rural general practice. These responses were explored for themes about rural practice.

Results Of 338 completed questionnaires (response rate – 75%), 138 contained written responses. The positive themes of rural general practice included: forming strong relationships with patients and the community, and practising the full spectrum of general practice, including emergency medicine. The negative themes included: heavy workloads, frequent on-call, inability to get time off, and feeling undervalued and underpaid by funders. Retention solutions included: better pay to adequately reflect the skills and workload, more salaried positions with guaranteed working conditions, and better rural continuing education. Recruitment solutions included: reducing barriers for foreign doctors to enter NZ, establishing a rural GP career pathway, and increasing the number of rural registrars.

Conclusions This study highlights both the positive and negative features of NZ rural general practice, and makes it clear that further concerted and sustained action is required to improve retention and recruitment. The GPs' written comments provide detail on the challenges facing rural general practice, as well as informed comment about potential solutions.

Rural general practice in NZ is facing increasing difficulties with retention and recruitment,¹ and the rural GPs in the current workforce are stressed.^{2,3} The key issue, identified by the rural GPs themselves, is a significant workforce shortage which in turn leads to heavy workloads, frequent on-call duty, and lack of rural locums to enable time off for professional development and holidays.^{4,5} The workforce shortage was also an important issue in 1986, when the last national survey of rural GPs was done.⁶

In November 1999 the Health Funding Authority (HFA) adopted the Rural GP Network's Rural Ranking Scale (RRS) for defining 'rural' GPs entitled to claim a rural bonus payment.⁷ Only GPs scoring 35 points or greater (maximum 100 points) were considered 'rural' and entitled to apply for a 'rural bonus' payment. With a clear definition of a 'rural GP', and the availability of a database of NZ rural GPs compiled by one of the authors (RJ; unpublished data), the opportunity existed to directly survey the entire rural GP workforce and ask them to comment on the state of NZ rural general practice. Initial quantitative data from this survey have been published.⁸

This paper provides further information to inform policy makers about the scale and depth of current difficulties, and details the solutions suggested by the rural GPs themselves.

Methods

An anonymous postal questionnaire was used to collect information from rural GPs. Our previous paper describes the methods used (questionnaire development, distribution and data analysis), and presents initial quantitative data on the rural GP respondents.⁸

The participant information sheet stated:

‘Basic information about rural general practice and rural GPs in New Zealand is desperately needed to assist with lobbying for improved working conditions (training, locums, CME, etc). The attached questionnaire is designed to collect that information’

The questionnaire included an open-ended question that asked rural GPs ‘for any further comments or suggestions about rural general practice’. The database for this paper consisted of the transcripts of the written responses, which were read multiple times by one author (RJ), and then purposefully analysed for themes about rural general practice. The analysis consisted of intentional collation of raw data into common themes and sub-themes in a systematic manner. After this analysis, key concepts were further refined.

Results

Response rate Questionnaires were sent to 559 rural and semi-rural GPs—417 were returned completed (an overall response rate of 75%). Of the 417 completed questionnaires, 74 had RRS scores of less than 35 points, and 5 had not completed the RRS. This provided 338 appropriately completed questionnaires, of which 138 contained written responses to the open-ended question asking ‘for any further comments or suggestions about rural general practice’. The demographic data of the 138 rural GPs providing written responses were similar to those of the 338 rural GP respondents.

Qualitative data The following are outlines of the three main themes that were read from the data

- *Positive aspects of rural general practice*
- *Negative aspects of rural general practice*
- *Suggested solutions*

The three key sub-themes identified for each category above were:

- The job
- Support for the job
- Unique factors about the job

(Supportive quotes from the rural GPs are cited in the text.)

Positive aspects of rural general practice

The job

The core work of rural general practice was described as interesting and rewarding by many rural GPs. There was the challenge of providing the full spectrum of care from birth to death, and of using emergency skills with critically ill patients. Furthermore,

they reported that patient continuity of care was greater in rural areas, and there was the opportunity to get to know the person and their family. As well, in rural areas, they felt they were valued and respected members of the community. All of this contributed to a high degree of job satisfaction.

'The practice population and the medical challenges are both interesting and rewarding and I would recommend rural health care to anyone'

Support for the job

There were several comments from rural GPs that mentioned local continuing education initiatives, which made keeping up-to-date with health information easier. Other GPs mentioned support they received from specific organisations, such as their local Independent Practitioners Association, the Rural GP Network, the Goodfellow Unit, or the Northern Rural GP consortium. The assistance from part-time GPs (mainly female or older semi-retired GPs) was especially valued by those GPs fortunate enough to enjoy their support.

'I am very lucky to have a long-term locum who does a fairly regular 4/10, and full-time for my holiday (I cover her for her holidays)'

(No respondent stated that income was a positive factor in their work as a rural GP.)

Unique factors about the job

Positive comments acknowledged that each rural area is unique—and that some rural areas, where it was more attractive to live, had no rural GP workforce shortages.

'(Town) is a slight enigma as far as rural health goes, in the fact that there is always a plentiful supply of doctors wishing to work part-time or full-time here'

Negative aspects of rural general practice

The job

While the core work of rural general practice was described positively, rural GPs were almost unanimous in condemning their excessive workload. Specifically, they described the 'double jeopardy' of a heavy daytime workload followed by a night or weekend on-call. Indeed, doctors were planning to leave their practice because of its effect on them and/or their family.

Part-time doctors were reluctant to work full-time because of the concern of the effects of overwork. They clearly identified the following components of their excessive workload, which were further aggravated by the general shortage of rural GPs:

- Large patient lists during daytime clinics.
- Increased amounts of unpaid paperwork and administration.
- Frequent on-call duty.
- Lack of locum-relief for holidays and study leave:

'On a bad day, I feel trapped by a very heavy workload, disruption to family life and the need to spend a lot of time after work doing letters and chasing up things for patients'

'I have commenced in rural general practice relatively recently. As a consequence of the demands my work places on me, my family and I do not enjoy the quality of life I once aspired to. I intend working very hard over the next 6–12 months to reverse this situation. If I am not successful in improving our quality of life, I firmly intend to leave rural general practice'

'(I) feel overloaded with red tape (ACC/AITC, etc) computers, on-call, college demands (MOPS) and increasing patient expectations. At the same time, the financial incentives are falling year by year as expenses rise. Audit for MOPS is always difficult'

'After 14 years of 1:1 and 1:2 call it is time to change—for the sake of myself and my family'

'Biggest problem is lack of locums to get holidays, etc. Other problem include increased paperwork and other non-paid administration. Decreasing income doesn't help'

'We need help with locums! Locums don't want to do call! Rural general practice would be OK, except for the call'

'Lack of GPs in surrounding areas, which means we have to cover, no locums available'

Support for the job

Overwhelmingly, rural GPs felt they were unsupported: their role was undervalued, their work poorly paid, and their specialty lacked a defined career pathway. All of these factors were felt to be directly contributing to the workforce crisis and causing practice ownership to be more of a trap, than an asset.

'So far, the message is that we are moderately useless, worthless, and doing a job that is not appreciated because we are working 24 hours a day and are not supplying as good a service as the towns do with their efficient city surgeries and after hours clinics. There is no-one speaking strongly in support of the experienced rural doctors'

'Central bureaucracy appears to have objective of denigrating general practice/family medicine = problems with Obst./changes to ACC Provider Certification/prospect of nurse prescribing/ encouragement of alternative medicine'

'I earn as much here full time as I did in an affluent city practice working 3 days a week and part time hospice work and practically no on call. There are nights on call I don't even earn enough to cover the rent I pay to stay here'

'Unfortunately our incomes are falling and overheads increasing, making the long-term outlook bleak'

'My investment in my practice has been reduced to a worthless asset/liability as it is impossible to attract anyone to the area'

'Investing my money for needed IT developments in a business, which may be unsaleable, would be unwise'

Unique factors of the job

This sub-theme highlighted that some difficulties were unique to either certain individuals or certain localities. Individuals with specific problems included: older

and retiring doctors, foreign-trained doctors, female GPs, and GP couples. Older and retiring doctors reported having to work beyond when they would have preferred to reduce or stop practising, because of the inability to find a replacement. They also lamented that their practice had almost no value. Some reported just wanting to find someone to care for their patients.

'I am retiring in 6 weeks whether or not I get a replacement. I have been trying for two years to try to sell or give my practice away - I have a tentative long-term locum arriving who may or may not stay. He is offered entry at NO COST'

Foreign-trained doctors reported a number of difficulties, mainly to do with the registration process.

'Problems with initial registration - Having to travel to (large urban centre) costing \$450 airfare for interview which lasted 5 minutes. Leaving family only 2 days after arriving in New Zealand. Could these documents not be sighted by someone more locally'

Female GPs described a number of unique difficulties, which were further aggravated if their partner was a GP. (These problems unique to female GPs are dealt with in a separate paper on gender differences in NZ rural general practice in this issue.⁹)

Locality-specific problems related to either the financial disincentive of working in some low socioeconomic areas or how the rural ranking scale has negatively impacted on some rural localities.

'Huge unpaid debt. It is not unusual to get up in the middle of the night to someone with \$200–\$300 debt who has no intention of paying. This is demoralising'

'There are many truly rural doctors who have very responsible onerous on-call work but, because of the 'remote orientated' questions of the rural ranking scale, miss out. They are still stressed with rural doctor stresses, have no access to after hours clinics etc but are largely ignored by 'remote' rural doctors and urban doctors alike. The rural GP network is dominated by remote GPs. The ranking scale is secretive and inappropriate, and does not cover the scope of rural practice stresses'

Suggested Solutions for Rural General Practice:

The rural GP respondents suggested a range of solutions to improve working conditions.

The Job

Solutions to make the workload manageable included:

- On-call: Fixing the 'on-call problem', or at least shifting it so that it is someone else's problem, was the most important issue for most rural GPs.

The two key suggestions were to:

- Remove the requirement for GPs to provide 24-hour service, and make it the responsibility of District Health Boards, who might then have to pay for additional doctors to assist with on-call coverage (e.g. weekends) to make rosters reasonable.

- Provide adequate payment for providing on-call services in rural areas.
- Workforce shortage: After on-call, the shortage of rural GPs was the second-most-important issue to solve.

Solutions here included:

- Encourage more part-time GPs: Make rural general practice more attractive to, and accepting of, part-time doctors. This, of course, requires onerous on-call schedules to be addressed (see above), as well as addressing female GP issues (e.g. spouse's career). If on-call was not an issue, older rural doctors might even consider deferring retirement to work in a part-time capacity.
- Provide more rural locums: It was suggested that the RGPN Rural Locum Support Scheme be expanded from 2 weeks (up to 4 or even 6 weeks) so that adequate time off for holidays and education was guaranteed.
- Train more NZ rural GPs: The lack of a rural career pathway was seen as an issue needing urgent attention. Selection of rural students to medical school, greater exposure to rural health and rural areas during medical school and house surgeon years, a dedicated rural GP training programme, and better postgraduate educational opportunities tailored to rural practice were all suggested to increase the number of doctors with the skills and desire to work rurally.

Support for the job

Solutions to support rural GPs included:

- Improve the income: Rural GPs felt they were underpaid for the job they were doing. In comparison to their urban colleagues, they thought the demands of their job, with greater involvement with on-call and emergency care coupled with larger patient loads, should be rewarded with a higher income. Many felt this should be in the form of an adequate salary, with guaranteed time-off for holidays and education, which would then avoid all the practice ownership and patient debt issues as well. While others simply suggested the income should be adequate 'to allow a good lifestyle as a part-time GP'.
- More support from the RNZCGP: One rural GP commented:
'I seem to need an RNZCGP 'case worker' to work more closely with me to achieve accreditation'

(This comment is included specifically, to acknowledge that the College has since started just such a programme to assist members complete their accreditation.)

Unique factors about the job

Suggested solutions here included:

- Make solo doctor localities survivable: 'On-call duty every night' should not be tolerated except in exceptional circumstances (e.g. Chatham Islands). It was stated that there should be a minimum of two rural GPs, on salary if necessary, to provide safe services (for the patients and the doctor). Upskilling rural nurses to share the on-call duty was another solution.

Discussion

This is the first NZ study to directly survey all active rural GPs for their opinions on the state of rural practice. The results support the previously published quantitative data from this questionnaire study,⁸ and expand upon them. While the survey results were collected 4 years ago (December 1999 to March 2000), the stability of rural healthcare continues to be fragile, with workforce shortages still common in many localities.

The positive aspects of NZ rural general practice, which were not evident from the quantitative data, emerged clearly from the written comments: continuity of care, practising the full spectrum of medicine (birth to death, emergency care), knowing the person and their family, and being valued by the patients and the community. These positive factors are the reasons GPs stay in rural areas. These positive factors have been cited by GPs in other countries as well,¹⁰⁻¹³ and confirm that rural general practice is an interesting, challenging, and highly rewarding profession.

Counterbalancing the positive aspects of the job are a number of negative aspects, chiefly to do with overwork and feeling undervalued, especially by the funder. Overwork consisted of too much on-call duty and too many patients needing care. These factors, and especially the stress of on-call duty, have been catalogued by rural GPs in NZ^{1,5,14} and other countries,¹⁰⁻¹³ as have the solutions.^{4, 10-18}

There has been a rural GP workforce shortage in NZ since at least 1986,⁶ however rural GPs in this study clearly felt it was getting worse. These GPs highlight the urgent need to improve the working conditions of the existing workforce, in addition to promoting recruitment. Indeed, if recruitment is to ever stand a chance, retention is critical.¹⁹

Regarding retention initiatives, the RNZCGP is providing extra assistance to GPs struggling to complete accreditation. The government-funded Rural Locum Support Scheme has started supplying rural GPs with 2 weeks per year of locum relief, and other funding has been made available to District Health Boards specifically for retaining rural GPs and improving onerous on-call rosters. A topic that needs wider discussion and debate is that of rural GP salaries; suggested by many respondents as one of the potential solutions to the workforce problem. A contract could guarantee adequate pay, time-off (holidays and education), and reasonable rosters— with no worries about debts, arranging locums, or selling practices. This was an option many rural GPs seemed ready to discuss.

Regarding recruitment initiatives, although designed to supply short-term locums, the Rural Locum Support Scheme, by internationally advertising NZ's attractiveness as a place to work, may assist with foreign doctor recruitment to permanent posts. Just recently, the NZ Rural General Practice Network has been awarded the contract to assist with the recruitment of long-term rural locums. The RNZCGP is working with both universities and others to develop a career pathway for rural general practice.

The NZ government has increased the medical school intake (by 20 places) at the universities in both Otago and Auckland, with preferential admission of rural-origin students to these places. Moreover, these two universities submitted a joint funding proposal in September 2003 for a 12-week rural multidisciplinary training experience for all medical students, which will also include nurses and other health professionals.

If approved, this will be an encouraging development; demonstrating that the NZ government and universities have recognised their social responsibility²⁰ to train doctors and other health professionals, specifically to meet the needs of the NZ population.

The results of this study detail the positive factors that are retaining NZ rural GPs, and these factors should be clearly highlighted in educational initiatives with medical and other health students. Continuity of care, knowing the person and their family, and being valued by patients and communities are more fully appreciated by a prolonged immersion in a rural training environment. Other advantages of a significant immersion in a rural setting would include experiencing a balanced alternative to the present emphasis on urban tertiary hospital placements. Teaching medical students in rural areas provides a sound generalist educational experience,²¹ and 'in rural communities, the social forces impinging on healthcare can be more readily defined, while opportunities for intervention are more accessible to the students'.²² This type of rural community-based medical education has been trialled successfully in Australia.²³ Of real concern in NZ, however, is whether the depleted rural medical workforce has the capacity to take on the additional challenge of becoming teachers, supervisors, and mentors to these students.

In conclusion, this study is the first to describe what rural GPs think about the state of NZ rural practice, and what needs to be done to improve it. Initiatives that will address their identified concerns have begun. Restructuring of medical school training, and rural general practice itself, is essential if young doctors with the appropriate skills and attitudes are to be attracted in sufficient numbers to live and work in rural areas. Without these changes, more and more rural areas will be without GPs, and rural people will have to rely on other options for their medical care.

Author information: Ron Janes, Associate Professor of Rural Health, Department of General Practice and Primary Health Care, Auckland University, Auckland, and The Institute of Rural Health, Hamilton; and rural GP, Wairoa Medical Centre, Wairoa, Hawkes Bay; Anthony Dowell, Professor, Department of General Practice, Wellington School of Medicine, Otago University, Wellington.

Acknowledgements: We gratefully acknowledge research grants from both the 'RNZCGP Research and Education Charitable Trust' and the 'Wellington Faculty of the RNZCGP'. We are also indebted to all those rural GPs who took the time to write comments on the questionnaire. Data from this paper were presented at the RNZCGP Annual Conference in Rotorua in 2002.

Correspondence: Associate Professor Ron Janes, PO Box 341, Wairoa 4192, Hawkes Bay. Fax: (06) 838-3729; email: ronjanes@xtra.co.nz

References:

1. Burton J, Difficulties encountered in rural general practice in New Zealand. *N Z Fam Physician*. 1997. December:41-4.
2. Jenkins D. Burnout in rural general practitioners. *N Z Med J*. 1998;111:328.
3. Dowell A, Hamilton S, McLeod D, Job satisfaction, psychological morbidity and job stress among New Zealand general practitioners. *N Z Med J*. 2000;113:269-272.
4. Burton J. Rural health care in New Zealand - RNZCGP recommendations. Occasional Paper Number 4., Wellington: Royal New Zealand College of General Practitioners; 1999.

5. Janes R. Benign neglect of rural health: is positive change on its way? *N Z Fam Physician*. 1999;26:20–22.
6. Seddon D, Turnbull T. The Royal New Zealand College of General Practitioners survey of rural general practice: report May 1986. *N Z Fam Physician*. 1986; Winter: 108–112.
7. Variation of Advice Notice Pursuant to Section 51 of the Health and Disability Services Act 1993 (Schedule 2, Appendix 11). Wellington: Health Funding Authority; 1999.
8. Janes R, Dowell A, Cormack D. New Zealand Rural General Practitioners 1999 Survey - Part 1: An overview of the rural doctor workforce and their concerns. *N Z Med J*. 2001;114: 492–495.
9. Janes R, Elley R, Dowell A. New Zealand rural general practitioners 1999 survey—part 2: gender issues. *N Z Med J*. 2004;117(1191). URL: <http://www.nzma.org.nz/journal/117-1191/814/>
10. Wainer J. Female Rural Doctors in Victoria: "It's where we live". 2001, Rural Workforce Agency, Victoria (RWAV): Melbourne. p. 71.
11. Tasmanian General Practice Divisions, General Practice Workforce Plan: issues and future strategies for Tasmanian general practice. Hobart: Tasmanian General Practice Divisions; 2001.
12. Hays R, Veitch PC, Cheers B, Crossland L. Why doctors leave rural practice. *Aust J Rural Health*. 1997;5:198–203.
13. Cuddy N, Keane A, Murphy A. Rural general practitioners' experience of the provision of out-of-hours care: a qualitative study. *Br J Gen Practice*. 2001;51:286–290.
14. Elley R. Women in rural general practice: the stresses and rewards. *N Z Med J*. 2001;114:358–360.
15. Rural General Practice Network, Recommendations for recruiting and retaining doctors to work in rural New Zealand. Christchurch: Rural General Practice Network; 2001.
16. Rural Expert Advisory Group, Wellington: Implementing the Primary Health Care Strategy in Rural New Zealand: a report from the Rural Expert Advisory Group to the Ministry of Health; 2002.
17. Canadian Medical Association, Rural and Remote Practice Issues [CMA policy]. *CMAJ*. 2000;163:1047–50.
18. Wonca Working Party on Rural Practice, Policy on Rural Practice and Rural Health. Traralgon, Victoria: Monash University School of Rural Health; 2001.
19. London M., Retention before recruitment - creating the contexts of sustainable rural health services. *N Z Fam Physician*. 2002;29: 83–85.
20. Kamien M, Boelen C, Heck J. Measuring the social responsiveness of medical schools. *Education for Health*. 1999;12:9–19.
21. Worley PS, Prideaux DJ, Strasser RP, et al. Why we should teach undergraduate medical students in rural communities. *Med J Aust*. 2000;172:615–7.
22. Kaufman A. Rurally based education: confronting social forces underlying ill health. *Acad Med*. 1990;65:S18–S21.
23. Worley PS, Silagy C, Prideaux D, et al., The Parallel Rural Curriculum: an integrated clinical curriculum based in rural general practice. *Med Educ*. 2000;34:558–565.