Rural medical marriages: Understanding symbolic violence in the social practice of gender

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Abstract

This paper examines the social practice of gender amongst rural GPs and in rural medical marriages and considers Bourdieu's notions of symbolic violence and misrecognition important elements in understanding how inequitable gender relations are sustained and reproduced. Drawing on ethnographic research conducted in rural Western Australia amongst GPs and their spouses/partners I explore the notion that gender as a structural or organising principle impacts on expectations and experiences of roles in the workplace and in the home. Compliance with conventional views of male as provider and female as primary caregiver raises questions about the advantages of conformity and the costs of challenge. Nonetheless, contesting dominant ideas and practices that do not serve the interests of non-dominant groups may well cause conflict but can lead to change.

Bio

Angela Durey's background is in medical anthropology/sociology. She works in rural health education and is interested in the impact of broader structural factors such as the political economy and gender on models of health care in rural settings and the recruitment and retention of rural GPs and their families.

The increasing feminisation of the medical workforce in many Western industrialised countries has widened the lens through which to view and understand medical work practice. Growing numbers of women entering medicine bring with them the social expectation and aspiration that as women, they will assume domestic responsibilities, especially care for family members. As a result, women general practitioners (GPs) are demanding greater flexibility in their working hours to accommodate the responsibilities of home and work (Lapeyre, 2003; Pringle, 1998; Strasser, Kamien, & Hays, 1997; Tolhurst & Stewart, 2004). This is particularly relevant in rural settings where childcare services are often limited. Gendered imperatives associated with women's assumption of caregiving and domestic responsibilities is also a theme in the social practice of female spouses/partners of rural GPs.

In this paper I draw on ethnographic research conducted in rural Western Australia amongst GPs and their spouses/partners to identify how gender as a structural or organising principle impacts on expectations and experiences of roles in the workplace and in the home. I examine the dialectical relationship between structure and social practice and consider Bourdieu's (2002; Bourdieu & Passeron, 1977) notions of symbolic violence and misrecognition important elements in understanding how inequitable gender relations are reproduced.

Connell (1987, pp. 92, 107) explains structure as the recurring pattern of social relations that is informed by a complex interplay of power evident in relationships within and between social institutions. Power is diffused through these institutions such as the State, the health system and the family and can manifest in ideas about social relations that are reproduced to support dominant groups. At one level, structure conditions social practice and lies beneath 'the surface complexity of interactions and institutions' (Connell, 1987, p.93), providing a 'template' for how people relate to each other. At another, social structure acts to constrain behaviour or practice that deviates from the norm. In each of these ways, there is a relationship between structure and social practice.

Connell (1987) suggests that social institutions are informed by a range of beliefs and practices that underpin power relations and help explain the possibilities and constraints for social practice and their consequences. This 'structure' of power is evident when considering gender relations. Gender as a structuring principle in social relations permeates all institutions including the family, the workplace and the State and generally locates men as dominant and women as subordinate (Connell, 1987, 2002). Connell (1987, p.62) argues that the 'structure' conditions practice. Social practice reflects how people constitute their social relations in light of structural principles or general rules that guide action, expectations and experiences. Thus, the social structure informs the interpretation and practice of masculinity and femininity, reflecting the 'norm' of gender relations in specific contexts (Connell, 1987, p.120). Structures endure because they are reconstituted daily in social action.

While structures are reproduced in social practice, they can also be contested. Social action or practice can impact on structure and this process suggests that there is 'an active presence of structure in practice, and an active constitution of structure by practice' (Connell, 1987, p.94). While structures can constrain practices that deviate from the norm, individuals or groups can resist recurring patterns of social relations that do not serve their interests. This resistance can lead to conflict and generate tension with those who support such patterns. However, from this tension, changes to those patterns can emerge whereby older structures are replaced by newer ones. This process suggests a dialectical relationship between those who support the structure and those who resist it.

Whilst recognising the contested nature of the term 'dialectic,' I define a dialectical relationship between structure and social practice as a relationship in which ideas or practices that oppose each other cause tension that can lead to changes either in structure or in social practice. More specifically, I use the term 'dialectical relationship' when referring to relationships between male and female rural GPs and between rural GPs and their spouses where the social practice of groups or individuals may oppose dominant or recurring patterns of social relations. This can generate tension between individuals or groups that can also lead to changes to those patterns.

Bourdieu's (1989; , 2004; Bourdieu & Passeron, 1977; Bourdieu & Wacquant, 2002) extensive body of work adds texture by providing a more nuanced, layered perspective to understanding how social relations are reproduced and contested and sometimes changed. Bourdieu (2002, p.19) discusses the notion of the individual as an agent for potential change rather than as a passive recipient of the ideas espoused by dominant groups. This suggests that ideas supporting the dominant group's interests that are accepted as the norm by subordinate groups can also be contested. In other words, dominant structures or institutions can be influenced by the activities of subordinated people who cease being passive individuals and become agents for change. Bourdieu (2002, p.19) argues that agents think reflexively. When they become conscious and critical of the objective, structural reality, they are less likely to internalise, or accept as the norm, those objective realities that do not serve their interests. Bourdieu (1989, p.15) sees the two, structure and agent, in a dialectical relationship.

Symbolic violence

Bourdieu (2002) suggests that men's dominance is taken for granted and many women accept their own subordination without realising that such patterns of gender relations are not natural. Instead they are socially constructed and reproduced to make the dominance of men in gender relations seem natural. Bourdieu (2002; Bourdieu & Passeron, 1977) introduces the notion of symbolic violence which plays an important role in his analysis of domination in general and is integral to understanding how inequitable gender relations are reproduced. In this context, symbolic violence occurs when the dominance of men is legitimated as part of the normal social order whereby women are treated as inferior and denied resources (Bourdieu & Wacquant, 2002, p.167). Jenkins (1993) suggests that Bourdieu's idea of symbolic violence contributes to a theory of socialisation whereby various ways of thinking and acting are internalised by groups and classes in a way that masks underlying power relations. In other words, symbolic violence is:

> … a subtle, euphemised, invisible mode of domination that prevents domination from being recognised as such and, therefore, as misrecognised domination, is socially recognised (Krais, 1993, p.172).

Connelly and Healey explain further by stating that symbolic violence:

> … represents the way in which people play a role in their own subordination through the gradual internalisation and acceptance of those ideas that tend to subordinate them. It is an act of *violence* precisely because it leads to the constraint and subordination of individuals, but it is also *symbolic* in the sense that this is achieved indirectly and without overt and explicit acts of force or coercion (Connelly & Healey, 2004, p. , p.15, emphasis in original).

Internalising 'the violence which is exercised upon a social agent with his or her complicity' (Bourdieu & Wacquant, 2002, p.167) implies that such actions are perceived as a normal part of gender relations. According to Bourdieu, women's complicity occurs because they accept uncritically ideas constructed by the dominant group as the way things are and ought to be:

> Of all the forms of 'hidden persuasion' the most implacable is the one exerted, quite simply, by the *order of things'* (Bourdieu & Wacquant, 2002, p.168).

Bourdieu (2002, p.73) introduced the notion of 'doxa', describing it as 'an uncontested acceptance of the daily lifeworld'. Dominated social groups, such as women, accept their subordination without realising they are being oppressed and without seeking to change the situation by challenging the so-called conventional wisdom (Webb, Schirato, & Danaher, 2002). In other words, Bourdieu suggests that women's 'doxic acceptance' of their subordination occurs because they accept as axiomatic men's dominance even though they may be treated unfairly and restricted in their expectations or opportunities (Webb et al., 2002, p.25). Bourdieu (Bourdieu & Wacquant, 2002) argues that many women legitimate and reproduce prevailing gender pratices by accepting men's dominance *because* they misrecognise the symbolic violence being perpetrated and instead experience it as something normal and natural within the existing social order::

> … symbolic violence accomplishes itself through an act of cognition and of misrecognition that lies beyond - or beneath - the controls of consciousness and will' (Bourdieu & Wacquant, 2002, p.172)

Misrecognition

Bourdieu argues that symbolic violence typically involves 'misrecognition' whereby relations of power are often hidden and seen 'not for what they objectively are but in the form which renders them legitimate in the eyes of the beholder' (Bourdieu & Passeron, 1977, p.xiii). Actions that subordinate the needs of women constitute 'symbolic violence' when they hide power relations at a structural level that restrict women's choices at the level of social practice. Evidence of this is found in contexts where women accept lower wages than men for doing the same amount of work, where women are employed full-time and also take primary responsibility for the demands of domestic duties and childcare, or where women are restricted in furthering their occupational or educational aspirations.

According to Krais (1993) 'complicity' implies that if someone is confronted with an act of symbolic violence such as being treated as inferior, they may decode relevant signals and sense the violence at some level but not recognise it for what it is, a form of domination. While the notion of symbolic violence may help in understanding how inequitable power relations between groups are reproduced, it fails to explain women's complicity adequately. A more nuanced interpretation puts forward the idea of the consequences for women if they do not comply with dominant expectations.

While some women may be aware of acts of symbolic violence directed against them, they are often constrained to change the situation by the very structures that reproduce the 'order of things'. Women may take for granted men's dominance in gender relations believing it to be normal behaviour or even that it supports the common good. They may accept that gender relations are inequitable but choose not to contest the 'daily lifeworld' because they feel powerless, or may not want to change the situation because of what they may stand to lose if they challenge the existing social order. They may also comply because of the enormous effort it would take to go against their social conditioning and contest male dominance and privilege.

Women may not only accept their subordinate role to fit the so-called 'norm'; they may also choose that role because they are more likely to be valued and gain social acceptance if they conform to dominant expectations and practices, where men are the main provider and women are the primary caregiver, even if women are in paid

employment. Thus, men's position of dominance occurs because ideas and practices supporting their position of power in the social order are seen as normal and natural, and are rewarded.

Women who are married or in a committed relationship with someone from a dominant social group such as a doctor or a lawyer may also acquire social status, material wealth and financial security as a result of that partnership. Rhodes's (2001, p.353) qualitative analysis of wives of professionals in the mining industry shows how a 'good wife' is one who subjugates her professional interests to become a 'consort, helpmate and moral supporter' where she can 'release her engineer from domestic duties, to free him from childcare and to withdraw her own occupational competition in order to promote instead his image through her social skills'. This choice assures her 'financial security and a comfortable lifestyle'. In effect, women may 'misrecognise', or choose to ignore, or feel powerless to change the power imbalance embedded in such relations that, while hidden, is inequitable and can be exploitative.

While Bourdieu's view of gender relations has been criticised as being overly deterministic (Butler, 1990, 1993; Jenkins, 1993), it nevertheless highlights the inequitable distribution of power. Bourdieu claims that, while the dominant group is not consciously duplicitous in reproducing inequitable gender relations, its privileged position within the social order and within social institutions gives it a platform on which to gain the consent of subordinate groups into believing the conventional wisdom it has effectively constructed (Lechte, 1996). That this 'conventional wisdom' is accepted is evident in the beliefs and practices of both the dominant and dominated classes or groups (Bourdieu & Wacquant, 2002).

Agents of change

If women demand changes to structural inequities present in current gender relations that reinforce their subordinate status in their relationship, they may risk losing the benefits of their position if the partnership or marriage ends (Tavris, 1992). This suggests that women's complicity to conform may also be shaped by their perceptions of the consequences if they resist. Indeed, the costs are more pervasive because of what women stand to lose socially and economically if they challenge the prevailing social

order. According to West and Zimmerman (1987, p.146) it is women who are held to account when they resist hegemonic expectations by 'fail[ing] to do gender properly' rather than the structuring principles that underlie the inequitable distribution of power and reproduce the dominance of men in gender relations.

Gender as social practice

The notion of gender as a structuring principle can be understood when gender relations that serve the dominant group's interests are reproduced at the level of practice. For many years the majority of doctors in the medical profession were male and a male model of work practice espousing long, irregular working hours was the norm. Such practices were often made possible by the gendered division of labour in the home which allocated the main responsibility for childcare and domestic tasks to women (Pringle, 1998; Wainer, Bryant, Strasser, Carson, & Stringer, 1999). This organisational structure has shaped the beliefs and values that inform work practices in medicine where the interests of women doctors are less well served than those of their male colleagues. In such a climate, female medical practitioners have made huge efforts to work within this structure notwithstanding their commitments at home (Crompton & Le Feuvre, 2003). Research on female GPs in Britain and France shows that they conform to conventional social expectations and make choices during their training which assume they will take responsibility for the family and the home, which they frequently do (Crompton & Le Feuvre, 2003). As increasing numbers of women enter the medical workforce in Australia, many of whom are also the main caregivers in the home, they too are calling for more flexible working hours to better meet the demands of work and home life, often creating tension with their male colleagues (Pringle, 1998; Tolhurst & Stewart, 2004; Wainer, 2000).

However, from this tension, change is emerging. Research among Australian medical students and rural GPs, and amongst British medical students and GPs, suggests that men also want to better balance work with family and lifestyle pursuits(Strasser et al., 1997; Tolhurst & Stewart, 2004; Young, Leese, & Sibbald, 2001). This change is effectively challenging the underlying vocational beliefs and practices of medicine as a profession. However, recent research in Australia also suggests that, while interest in

men's involvement in childcare may be increasing, at least in theory, as popular support for the traditional sexual division of labour is on the wane, this shift is not reflected in practice. Instead, conventional models of gender roles persist where men's priority is to be the breadwinner and women are cast as the main caregivers. Despite organisations in Australia introducing family friendly provisions such as flexible hours for childcare, few fathers are taking this up (Bittman, Hoffman, & Thompson, 2004).

In Australia, most female spouses of rural GPs are the primary caregivers and are often supported financially by their GP partners (Nichols, 1997; Wise, Nichols, Chater, & Craig, 1996). Nichols (1997) and Wise et al. (1996) suggest that in relationships where the female works as a rural GP, male spouses often conformed to expectations of their role as provider, generally working full-time in their original profession (Nichols, 1997; Wise et al., 1996). Such findings were reflected in ethnographic research I carried out in rural Western Australia.

Methods

I chose an ethnographic approach to understand, using a variety of methods, how participants experience and attribute meaning to aspects of their life that influence their decision to stay or leave rural general practice (Spradley, 1979). Ethnography combines the perspective of both the researcher and the researched and requires that the researcher participate in and observe participants' actions and behaviour in everyday contexts rather than in experimental conditions (Hammersley, 1990). Methods included participant observation in a range of contexts such as surgery waiting rooms, hospitals, social events and chance meetings as well as informal discussions, semi-structured interviews and the use of archival material such as government and historical documents and media reports. I also chose ethnography to locate participants' expectations and experiences in a broader social context and 'subject the insider's view to critical analysis' (De Laine, 1997, p.124). The role of structural issues in social practice could then be examined, relationships of power identified, and the presence of symbolic violence recognised.

Gathering information

Following university ethics approval, I conducted a pilot project to test interview questions with six GPs and three spouses, all of whom had lived and worked in a rural area. The main research was carried out in a rural Division of General Practice supporting 60 GPs covering an area of 87000 square kilometres in Western Australia.[1] Every GP in the Division was invited to participate in the research. As personal contact details were unavailable on the Division data base, letters were sent to all GPs and their spouses and addressed to the surgery. Follow-up phone calls and visits were also made to each surgery. GPs participating in the research worked in either solo or group practices in regional, rural and remote settings. Rural and remote practices were located from 50 to 530 kilometres from the regional centre.

Gaining access to participants was an ongoing relational process involving negotiation and re-negotiation (Feldman, Bell, & Berger, 2003). I devised various strategies to encourage GPs and their spouses to engage with the research. These included presenting the project to potential participants in various stages rather than 'going in cold' to minimise the possibility of outright rejection. I also established relationships with practice managers given their position as gatekeeper to accessing the GP.

Spouses were generally informed about the project by their GP partner or I requested spouses' contact details from GPs whom I interviewed. While this was usually successful, the request nonetheless placed the GP in the position of gate-keeper. If GPs were not involved in the project, then opportunities to contact their spouses were significantly reduced.

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[1] Divisions of General Practice were set up by the Commonwealth Government in 1992 to forge better links between GPs and other health agencies. They represent GPs in the hospital and community including negotiating GP access to hospitals, providing continuing medical education for GPs, organising peer review and quality assurance; facilitating undergraduate teaching and vocational training, and participating in primary care research, health promotion and education (NHS 1992 cited in General Practice Strategic Policy Development Unit 2000, p.11).

Seven of the 15 female GPs working in the Division, agreed to be interviewed and ranged in age from early thirties to late fifties. All were married or in long-term relationships, but none to other doctors. Three had adult children, three had young, or school-age children and one had no children. Of the 45 male GPs working in the Division, 25 agreed to participate. Nine worked in practices in the regional centre, eight in group practices in rural towns and eight were solo GPs in smaller rural communities. Twenty three were married or in long term relationships, all except one had children and most worked full-time. Two were not in committed relationships. Twenty one spouses, 16 female and five male, were also interviewed. Of the female spouses one worked fulltime, five did part-time or casual work and ten were not employed outside the home. Two were also involved in higher education study. One male spouse had recently started full-time employment having previously reversed roles with his wife, one worked part-time, one operated a business from home and two were looking for paid employment[i].

A semi-structured interview schedule was developed from the one presented to GPs and their spouses in the pilot project. Questions sought information on expectations and experiences of rural general practice and how participants met the demands of home and work. Interviews lasted between 20 minutes and two and a half hours and were tape recorded and transcribed, subject to written consent. Some participants agreed to be interviewed more than once.

Analysis

Sorting, analysing and interpreting information effectively began on entering the field. The locations in which GPs and their spouses lived and worked became the backdrop against which ongoing analysis of interviews and fieldnotes and interpretation evolved. Writing field notes constitutes a central focus of ethnography (Hammersley & Atkinson, 1995) and offers documentation of observations, impressions, interpretations and experiences of people, settings and events (Emerson, Fretz, & Shaw, 1995). In order to provide useful descriptive information as well as important analytic leads, I recorded my reflections of meetings, interviews, social events, informal interactions and 'ideas, fears, mistakes, confusions, breakthroughs and problems' (Spradley, 1979, p.76) This process provided early identification of emerging themes and patterns that were

subsequently expanded, corrected, modified, summarised, and revised. Interview transcriptions were imported into QSR N6, a qualitative analysis software package. Using the principles of grounded theory, information was coded and categorised into themes, ideas, concepts, hunches and patterns (see Strauss & Corbin, 1994; Wolcott, 2001)

Index trees were used as a model to organise and code information from interviews. The top level or dominant tree node represented a main theme such as gender, under which are placed related themes such as male and female GPs. These generated sub-themes such as work practices, role expectations, which led to further sub themes of conformity and resistance, and so on. Themes, ideas and concepts were regularly reviewed, modified, developed, refined and summarised as part of the analysis process. Patterns in responses within and between groups, individuals and settings were identified and analysed for similarities and differences. Conclusions began to form about how knowledge was constructed and shared and how power was organised. Data could be then be interpreted with a view to examining the dialectical relationship between broader structural issues and their impact on social practice.

In order to respect the privacy of participants every effort was made to ensure confidentiality and as far as possible specific information such as names and workplaces were de-identified and pseudonyms or generic terms were used.

Limitations

Information gathered for this paper from GPs and their spouses is localised to a specific rural area and does not offer a comparative analysis with GPs in other rural areas or urban centres.

Findings and Discussion: Female rural GPs

The dominant social position of male rural GPs enables them to exert their authority and gain consensus for their work practices by subordinating those of female GPs who want to work fewer hours. One rural male GP commented that:

> …the female GPs are never there when they need to be, when there is a rush on. There's a bit of a grudge thing because the male GP has to run the jolly practice while females flit in and out like fairy wrens.

At one level, the quotation above paints a picture of a male rural GP who resents seeing the patients of his female colleague because it means extra work for him as she works part-time and is not available. At another, it suggests tension between two models of work practice. The conventional model of Western medicine and rural general practice has always been male centred where an 'unacknowledged convergence between "medicine" and "male-practised medicine"'(Wainer, 2003, p.69) has over-ridden the different needs of women doctors. This hegemonic approach to work practice involving long working hours is currently being challenged by female medical practitioners who want to strike a better balance between home life and the demands of their profession. They prefer to work within a model that allows more flexibility in working hours (Kilmartin, Newell, & Line, 2002; Lippert & Tolhurst, 2001; Pringle, 1998). Pringle (1998) argues that, by virtue of women highlighting the need to question current practices, and their increasing numbers in the medical profession, they are making a difference to the culture of medical work practice which is slowly being restructured. This suggests a dialectical relationship between structure and social practice as any tension caused by female medical practitioners resisting conventional work practices is opening the door to change.

Despite the increasing numbers of women entering the medical workforce most male rural GPs held conventional views of the gendered division of labour and assumed women GPs would be responsible for childcare:

> A few female GPs are full-time but they make a certain sacrifice to do that by not having children. It is children who really create the problem for female doctors. So for every child [a female GP has] there is a good 18 months [off work].

Male rural GPs often showed little appreciation of the added workload at home for their female colleagues. Instead, female GPs who worked part-time were more likely to be disparaged for not taking their professional role seriously enough—'(flitting) in and out like fairy wrens' (Durey, 2004, p.166). There was a sense of resentment amongst some rural male GPs that their female colleagues did not adequately share the workload like 'real doctors', because of the hours they worked, with the implication that most female GPs 'have it easy'. Rather than address inflexibility within the institutional structure to

better meet the needs of working women with children, responses of rural male GPs in interviews focused more on the detrimental effects to themselves of increased workloads when female rural GPs work part-time:

> I very much support the feminisation of the workforce but if that means I have to work longer and harder, and it does look like it, then I will be putting pressure on those women to work more.

Yet female doctors' resistance to working long hours is often predicated on their wish to fulfil the demands of their role as main caregiver in the home suggesting that resistance to hegemonic beliefs is contextual. Indeed, structural constraints on the social practice of gender are problematic when transferred across contexts. This seems particularly relevant when few female rural GPs with families can meet the expectations of a male model of rural general practice when the conventional wisdom regarding the gendered division of labour in the home allocates the main responsibility for childcare and domestic tasks to women. If they become full-time rural GPs, do they forego having children, reverse roles with their partners or negotiate gender practices? In this context, to what extent are male spouses willing to re-structure their work practices to allow negotiation of responsibility for childcare and domestic tasks in order to combine the professional and career aspirations of both members of the couple in a way that is experienced as fair?

Tension arises because conventional expectations of rural GPs' work practices are incompatible with expectations of being the primary caregiver in the home. Change occurs when female medical practitioners may choose to work fewer hours in the workplace so they can meet social expectations to be responsible for childcare and domestic tasks, thereby reproducing the dominant belief of women as the primary caregiver. However, their male colleagues are frustrated that they have to 'pick up the slack' when female GPs go home.

GPs who respond to the inter-personal nature of the issue where they see female GPs as 'not pulling their weight' in the workplace, fail to address the problem at a structural level. Instead their repsonses reflect dominant ideas of gender relations and support the work practices of male medical practitioners. Women medical practitioners

have adapted to a male model of work practice that has demanded 'a vocational commitment [and] a readiness to be available 24 hours a day, seven days a week' (Pringle, 1998, p.2). They have also tried to meet their domestic and childcare responsibilities. Expectations to conform to a male work ethic in medical practice and meet the demands of home-maker are unjust particularly when women doctors may be treated as inferior by their male colleagues and not be considered 'real doctors' (Pringle, 1998, p.10) if they are unable to fulfil the 'vocational commitment' (p.2) to their work.

While women medical practitioners may not be victims to their circumstances, a broader interpretation of the problem does reveal how power relations within the social structure inform ideas about 'normal' practice in gender relations in specific contexts (see Connell, 1987, p.120). Dominant ideas that essentialise or reduce gender relations to a clearly defined division of labour based on male as provider and female as primary caregiver are not recognising the complexity of the issue nor addressing the effects of these beliefs across contexts. If female GPs are disparaged and treated as inferior for not conforming to hegemonic ideas of rural medical work practices, this constitutes a form of symbolic violence despite complying with dominant gender expectations in the home.

Role definition for female GPs who are also spouses and mothers suggests that multiple femininities operate where meeting the demands of one role can compromise meeting the demands of the other, often causing tension. Female GPs often struggle to balance work and family life particularly if they had dependent children. One commented how 'guilty' she felt working when her children were young even though she 'juggled' work and family 'as best I could'. For some female GPs their role as a spouse and mother was central to their sense of identity:

> For women doctors, what they do is not part of their core identity. Most women doctors would say their core identity was as wife and mother and GP would be third.

One part-time female GP stated that 'medicine is not my life, family is.' This was compromised for those who worked full-time:

> I have always been very involved with the children and I couldn't do everything any more [when working full-time]

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While not all female GPs agreed that being a wife and mother was central to their identity with one stating that '[Medicine] is my life. This is everything I ever wanted', nonetheless, the centrality of gender in rural general practice was reiterated given the cost to women doctors of finding a suitable solution:

> Not many women do obstetrics because it ruins your home life. Not many females want to do it because there is this need to want to have children and you can't do both. It's hard to do both. A lot of my friends who are female GPs choose to work far less hours.

According to Wainer (2004, p.52), female GPs who carry the main responsibility for their children 'cannot be on-call for their practice and their family at the same time without support'. Yet in rural settings, childcare services are often limited.

While female GPs are reproducing hegemonic patterns of gender relations in a domestic context they are also challenging dominant ideas of work practices in rural general practice. They may seek changes to their work practices in favour of flexible working hours in order to accommodate their responsibilities as main caregiver in the home. It is the desire to spend more time with the family that is motivating them to instigate changes at work to better meet their needs rather than wanting to transform the organisational structure of medical work practice, even though this is occurring as an effect of their actions. Effectively, they are acting as agents for change in the workplace while conforming to dominant expectations of the division of labour in the home. While their calls for change in the workplace are not new, they are becoming louder as women enter the medical profession in greater numbers. This development is having a significant impact on medical work patterns in Western industrialised countries (Lapeyre, 2003; Wainer, 2001), a trend that is expected to continue (Riska & Wegar, 1993). Gendered imperatives associated with women's assumption of caregiving and domestic responsibilities is also a theme in the expectations and experiences of spouses of rural GPs.

Gender relations in the home

The power and high status accorded male GPs in their role as rural doctors and their position as providers for their families often leads to their spouses subjugating their

own career aspirations to assume the role of primary caregiver in the home. However, female spouses can also act as agents for change and resist structural constraints in the context of work practices by expressing and acting on their own sense of entitlement to seek occupational fulfilment. Acting as agents, they have the potential to transform rather than reproduce dominant ideas and practices by supporting their own interests.

However, one reason prevailing ideas of gender relations are reproduced is the persistence of influential cultural stereotypes about what constitutes a 'good' wife where 'the subservient female [is] dedicated to the satisfaction of her husband's needs' (Oakley, 1985, p.157) over and above her own. Hakim's (1995, 2003a) more recent studies in Britain revealed that one third of women experienced home and childcare as their main focus in life and believed that women should not combine a career with a family. Two thirds of women agreed that a job was necessary to gain independence though many saw themselves, not as career women, but as contributing to the household income. They worked outside the home partly because of current instability in the job market where their paid employment was considered an 'unfortunate financial necessity' (Hakim, 2003a, p.52) taking them away from their central role in the home. Across Europe, women continue to be 'heavily dependent' (Hakim, 2003b: 50) economically on their male partners. De Vaus' (1997, p.6) analysis of findings from the 1989-90 National Social Science Survey and the 1995 Australian Family Values Survey show that 75 per cent of respondents supported the role of women as the main caregivers in the home and men as breadwinners and protectors of their families.

Gender in a rural setting

Alston (2005) argues that gender is a defining feature of Australian rural community life. However, while dominant expectations of gender relations are open to contestation, their prevalence within the institutional structures and practices in rural communities is normalised rather than resisted, effectively marginalising women in roles outside that of caregiver. Dempsey's (1990, 1992, 1997a) research shows that rural marriages are often so 'palpably one-sided that we are justified in describing them as exploitative' (Dempsey, 1992, p.64). He also found that men *and* women living in rural locations often regard 'wifehood and motherhood as the natural and ultimate roles for

women' and men are the 'family providers' (Dempsey, 1992, p.171). Such essentialist views of gender are reflected in expectations that a wife supports her husband, not just in his occupation but also in his leisure pursuits and altruistic activities such as public service in the community (p.64).

British and Australian research into women in rural communities offers numerous examples of women's careers taking second place to their mothering role (Alston, 2005; Halliday & Little, 2001; Little, 1997). Women who are highly educated and trained who move to a rural location often downsize their career aspirations by taking on unskilled work in order to fulfil their role as caregiver (Alston, 2005; Little, 1997). While limited opportunities for childcare in rural areas are a factor constraining women's employment choices, so also are expectations of women's role and identity. In a rural setting, expectations of women as primary caregivers impact on the gendered division of labour in the home and on women's ambitions in the workplace (Little, 1997). While it is important to recognise that multiple femininities exist in a rural context, Little (1997) nonetheless argues that certain characteristics are shared. Women's roles as wives/partners and mothers are considered a defining aspect of their identity which is given priority over their career.

Women's doxic acceptance of their role as caregiver is reflected in the assumption that 'their employment necessarily took second place to their childcaring role' (Halliday & Little, 2001, p.430). Women's reluctance to seriously challenge and change inequities in gender relations was reinforced in a British study where women considered men's employment more 'fixed and non-negotiable' (Halliday & Little, 2001, p.434). Few women suggested their husband/partner change his working day or week to help with childcare. According to Alston (2005, p.154) '[h]egemonic masculinity ensures that men have a stronger negotiating position around domestic labour and therefore may make themselves unavailable for household work' thereby sustaining and reproducing dominant ideas and practices.

Women's responses not only indicate complicity with dominant views on gender relations, but also misrecognise the symbolic 'violence that is wielded' (Bourdieu & Wacquant, 2002, p.168) where power is inequitably distributed to benefit men more than

women. Seeking a clearer understanding of women's complicity warrants a deeper investigation. Women in their subordinate role are more likely to gain acceptance and be valued in the current social order if they conform to dominant practices. In the case of doctors' spouses, benefits may include social status, material wealth and financial security, which they could stand to lose if they demand change to the structural inequities present in the prevailing social order. According to Finch (1983, p.28), the wives of men who undertake 'noble endeavours' that curtail time spent at home, often do not express any relational conflict this may generate. Instead, they give their husband even '*more* space to get on with great work' (italics in original). Such evidence is reflected in findings from interviews with several female spouses of rural GPs who placed high value on the GP's work and justified the importance of their own role to support his work and leisure pursuits.

> Everything revolves around Aiden. [GPs'] jobs are so important and their physical, psychological and emotional wellbeing are so important. I cannot compare the job they do to anyone else's in the world in terms of the demands placed on them. The public lacks insight that they sit up all night with a sick child and then go to work the next day. They need to debrief at the end of the day and [the spouse] has to have the time and energy to support that. … Wives are so essential especially in remote areas. If the wife isn't there the whole thing crumbles.

It is this conservative belief system that shapes the role of many female spouses of rural GPs. Women who accept their role as primary caregiver as 'normal', even if it means relinquishing their own professional or educational aspirations, are reproducing dominant beliefs about gender relations.

> I was very happy where we were, working [in my career] which was fantastic. … I dug my heels in initially. … But when I saw how unhappy Graham was, I thought, well, what have we got to lose, we may as well go. … Ultimately if Graham is not happy then it affects the whole family.

Such a view highlights the power of structural forces in influencing social practice. Women's choice to conform may well be linked to their wish to avoid conflict and secure a good family life and future for their children (Dempsey, 1997b), particularly if they are economically dependent on their partner.

Unpacking this idea to reveal a more complex, nuanced understanding is also warranted. It is important to acknowledge what women stand to lose if they do not conform to dominant expectations of their role. In the context of rural general practice, female spouses who are not employed, and/or who choose not to continue their education or training and who are dependent financially on their GP partners, run the risk of losing their professional or occupational skills that may jeopardise their employment prospects should their circumstances change. According to Baxter and Western (1998), women with fewer resources stand to lose more if the marital relationship is disrupted because of the constraints on their options. Dempsey (1999) suggests that when women gain more economic power their sense of gratitude lessens and their sense of entitlement increases and they are more likely to perceive injustice in the division of labour. However, women who have fulfilled their role as the primary caregiver in the marriage and have not worked outside the home, yet are dissatisfied and unhappy, have limited choices and are often unable to leave their relationships without significant socio-economic hardship (Connell, 1987). For most women, 'the contrast between the standard of living that they enjoy while married and that which they can expect after divorce simply redoubles the pressures in favour of marriage' (Delphy, 1992, p.139).

Nonetheless, female spouses of medical practitioners often feel they take second place 'in relationship to both the status and the time demands of their husband's work' (Fowlkes, 1980, p.82. See also Wise et al., 1996), particularly when it comes to meeting their own needs. One female spouse I interviewed commented that:

> My whole study experience was quite lonely. It was very much my thing where the family, even Simon, were not involved. I did [my study] in between the washing and the cooking and the bringing up the children. I didn't really feel supported by the family. They came first and if I got my study in, that was good. I think Simon saw it as a hobby, a nice little hobby. A little patronising really even though he knew it was important to me. … I actually feel like I have sacrificed a lot of myself because of Simon's role. I get frustrated because I feel like I have got my wings clipped all the time.

In rural medical marriages or long-term partnerships the structure and organisation of a male model of rural general practice often constrains the choices of their female spouses, particularly those who are financially dependent and are expected to fit

in with the demands not only of their husband's occupation but also his leisure activities (Dempsey, 1990, 1992; Finch, 1983; Rhodes, 2001):

> He plays sport all the time and he has to do that to relax. He is not really a lie around home sort of person.

Indeed, women may misrecognise that inequity in the division of labour, limited opportunities to meet educational or occupational aspirations outside the home can constitute a form of symbolic violence. Yet women's reluctance to seriously question inequities in gender relations helps to sustain and reproduce such patterns. In order to adopt the role of primary caregiver, female spouses of rural GPs may choose not to work at all. They may subjugate their own aspirations for fulfilment outside the home and take responsibility for childcare and domestic tasks in order to support their male partner in his role as provider.

Feminists have attempted to show how women are subordinated and exploited in the gendered division of labour at home and in the workplace (see Bernard, 1982; Hochschild, 1989; Oakley, 1985). Marxists might assume that exploitation can lead to resistance and revolution (MacKinnon, 1997), yet more recent research has shown that many women refute the claim they are being exploited. Instead, they view their husband's treatment as just and their own contribution to childcare and domestic tasks as fair (Dempsey, 1992, 1997a; Hakim, 1995, 2003b). Indeed, many wives of professionals, rather than seeing themselves as 'helpless victims of patriarchy, masculine oppression or marital inequality' (Rhodes, 2001, p.352), embrace their supportive, caregiving role where their 'subservience is reinforced culturally and ideologically endorsing [their] withdrawal from the search for personal fulfilment beyond the home' (Rhodes, 2001, p.353). Wives of rural GPs often reflected their 'doxic' or uncontested acceptance of the social order as something normal and natural and misrecognised the symbolic violence present in the inequitable distribution of power in gender relations that subordinated their needs and aspirations beyond those of wife and mother:

> I feel at a loss as to what can be done about it. It is [his] lifestyle choice. He wants to do what he wants to do and I want him to be happy and that is important. It is important for him to know what he wants out of life.

As long as the marriage or relationship is maintained and/or women reap the benefits of their conformity to dominant expectations such as social acceptance, financial security and social status the effects of women's subordination remain hidden. The experience of one rural GP's wife suggests a growing awareness of the cost of this choice:

> A lot of the doctors' wives have been submissive to the extent they will give up their career, travelling, anything they may want to do on their own and bow down to their husband's wishes because he is superior, because he does this wonderful work, and they can't actually match him.

If the relationship breaks down and separation occurs, the cost of conformity is revealed as the standard of living, social status and career prospects of women drop while those of their husbands often rise significantly (Delphy, 1992).

Resistance to structural constraints

However, resistance does occur, often causing tension when social practice conflicts with structural expectations: some women, whilst supporting their husband's work, created and maintained an identity separate from that of rural GP's wife. While opportunities to work locally in their chosen profession were invariably limited or non-existent, a reality that often led to frustration, one spouse spent many weeks every year travelling away from home to pursue her career. She had moved to a rural centre to support her husband's work and was reluctant to stay long-term:

> There is a time limit to how long I can stay here. Fine for my husband…but for me I have tried every possible way [to meet] people because I hate just sitting at home and doing housework because that is not my life. I get very frustrated and angry. He used to go to work and have things to tell me, but I had nothing to talk about. … There is nothing for me here. I want a purpose in life. Not the purpose of getting up and doing the housework and waiting for the husband to come home for lunch. I would like to have [the choice] to do things.

Some women in their role as the main caregiver were unwilling to subjugate their educational or occupational aspirations indefinitely. Some resented their partner's sense of entitlement when their own needs or identity, separate from those of 'doctor's wife,'

were not honoured in their own right, often leading to tension in the marital relationship. Spouses 'fitted in' their work or study after they had met the needs of the GP and the family. One spouse had switched careers and given up the opportunity for post-graduate study by accommodating her partner's wishes and moving to a rural area:

> I sort of resented that. I'm over it now and I couldn't go back. Well, I could but it would mean I would have to move to the city to do it. It's pretty hard to do external studies.

Few spouses had seriously considered the option that rural GPs, who 'work so hard' might modify their work arrangements to enable the career aspirations of their wives to be fulfilled. Instead, women implied that there was little room to negotiate beyond their accommodating role, not least because 'he makes more money so it is obvious that he works and I look after the kids'. Any sense of inequity was over-ridden by rationalising the need to support the important work carried out by the rural GP:

> Spouses often don't get a look in for their career. If their partner is happy in medicine, well, you accept that. That's all you really need. You wouldn't want icing on it. Just a nice cake will do very nicely.

Female spouses who did not conform to their prescribed roles were often marginalised. Should the marriage break down, the wife, rather than the institutional structure of rural general practice was more likely to be held to account. According to one male GP:

> A lot of doctors want to come to country areas. Most doctors will go anywhere. It is their wives. It's always the same. If you want to come to the country you can't marry a city girl. It is just a no-no. It is really terrible. … If your spouse is happy, you can go anywhere. We have had so many spouses down here who have made their husbands' lives miserable and have either left or separated. Or they lead funny, separated lives where the wife stays with the children in Perth and the GP stays down here. A funny sort of existence.

From this response, negative judgements ensue about rural GPs' spouses if they allow other priorities to conflict with their supportive role.

Multiple masculinities

Male spouses of female GPs who were interviewed for this project also conformed to dominant expectations by earning an income or looking for employment, even if they were the main caregiver. Wise et al (1996), in their study on the extent to which being a rural doctor's spouse in Australia determined their occupation, found that female spouses' lives and activities revolved around their partners' medical practice far more than the lives of spouses of urban GPs which often led to their own professional or educational interests being subjugated. Male spouses of rural GPs were more likely than female spouses to be employed full-time earning an income outside the practice and to be working in their original professions.

However, as Connell (1977) suggests, dominant ideas can be contested and changed. In the context of gender relations, expectations for male spouses to meet the role of main provider were offset by a counter-hegemonic belief in the importance of their role as caregiver:

> I guess I underestimated how [the demands of Margaret's work] would affect having children. So I much prefer to spend time with the children than be at work. … That time with children you can never get back. Friends with older children missed out on that because they were working too much.

Another male spouse was well aware of the importance of GPs to rural areas, and commented wryly that, as a male spouse, the community expected him to work outside the home, unlike his female counterparts. He had reversed roles with his GP partner, happily worked part-time so she could fulfil her career aspirations as a full-time rural GP and he could have more time to pursue non-work activities.

However, other men found coming to terms with reversing roles more difficult despite their choice often being a temporary arrangement where there was 'an end in sight'. One spouse felt his sense of masculinity was compromised in the caregiving role and struggled not to withdraw socially and isolate himself from the community. Despite valuing the extra time being a caregiver gave him to spend with his children, he consoled himself with the knowledge that, 'deep down, I knew I was a lawyer'. However, once he found full-time work his spouse reduced her hours to become the primary caregiver. One female rural GP considered that her husband's sense of masculinity was compromised

when he was without paid employment. She expressed her discomfort that her spouse had been unable to find work while she was employed full-time; she felt responsible for his predicament:

> He is very clever. I am nothing. I am just a small doctor here to treat some people. He has so much knowledge. … I would not have come to a [rural area] if I had known my husband getting work would be this difficult.

Participants' responses indicated that dominant expectations for men to earn an income were strong and tied up with notions of masculinity, even though some men contested this position by reversing roles with their GP partner. Nonetheless, all men either provided economically for their families, or planned to, with none taking on full-time the role of caregiver.

Conclusion

This paper has identified how gender, as a structural principle affects social practice. The dialectical relationship between structure and social practice is revealed when conventional gender roles of male and female rural GPs and their spouses are both reproduced and contested at the level of practice in the workplace and in the home. Bourdieu's notions of symbolic violence and misrecognition help in understanding how inequitable gender relations are sustained and recur. A deeper analysis also reveals that women's reluctance to challenge existing relations may be influenced by what they stand to lose if they fail to comply with conventional expectations of the primacy of their caregiving role.

Hand and Lewis (2002) suggest that women's disinclination to challenge dominant ideas about gender relations in the home is shaped by a lack of social acceptance of their role as breadwinners and men as the main caregivers. Men too are reluctant to compromise their dominant role. This is evident in Australia where '[a]nything which smacks of the 'feminisation' of men is likely to evoke the image of wimp; clearly, the domesticated New Age man is steering dangerously close to femininity' (McMahon, 1998, p.150). Drawing on Beagan (2001), until male GPs see their own biases in the gendered division of labour in the home, female GPs their

inclination to accommodate conventional gender practices in this context, and female spouses their tendency to conform to social expectations rather than voice their concerns about the costs of subjugating their own needs outside that of primary caregiver, change will be slow.

Nonetheless, change is occurring: female GPs are contesting a male model of work practice to one that better suit their needs. This is noteworthy as more women than men are entering medical school and general practice training in Australia. In effect, the organisation of medical work practices is being shaped by changing social relations in which gender is a key factor. Indeed, male GPs and medical students are now also calling for more flexible working hours. Interestingly, it is female GPs complying with social expectations and identifying with the role of caregiver in the home that is often the premise on which to challenge and slowly transform prevailing work patterns that have supported a male model of rural general practice. Consenting to dominant expectations in one setting may require resisting them in another, revealing not only the complexity of social relations but also the power of gender as a structuring principle supporting men's role as provider and women's role as primary caregiver in the home.

Endnote

[1] Many doctors in rural practice are international medical graduates who bring their own experiences of gendered culture. I have addressed this issue elsewhere (Durey, 2005)

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