President's Message – Gender and rural medicine

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Gender biases and the gender gap; Rural female physicians are not spared from the disparities in income, leadership opportunities, enhanced skills or speciality training seen across all fields of medicine. As a rural female physician, I have lived it in innumerable ways. Being passed over for leadership opportunities, assumptions regarding capacity for involvement in projects, having to limit my scope of practice due to inflexible schedules for life with young children-the list goes on. Sometimes, actions are more subtle, and unfortunately, in other cases, much clearer discrimination occurs. For example, I have seen skilled, knowledgeable female colleagues lose leadership roles to male counterparts at times such as maternity leave.

As outlined by Drs. Cohen and Kiran, 'the gender pay gap in medicine is not explained by women working fewer hours or less efficiently but, rather, relates to systemic bias in medical school, hiring, promotion, clinical care arrangements, the fee schedule itself and societal structures more broadly'.[1] Some progress has been made over the years with respect to the gender divide, and the issue is crucial to address from an equity perspective. However, why should it matter to the SRPC?

Increasingly, medical graduates are women. An Australian study found significantly more females participate in rural undergraduate medical training (70%) compared with males (56%), however, females were 20%–40% less likely to work rurally after completion of their degree.[2] In the US, women are much more likely to leave rural practice than their male colleagues.[3] If we do not address the issues leading to these trends, our rural workforce will be significantly limited in the future. Educational programs, recruitment and retention strategies, clinical team and leadership development must all consider the varied needs of female physicians.

As the SRPC, we must advocate for novel and inclusive approaches from health authorities and governments to ensure the vitality of our rural Canadian physician workforce. We must also look inwardly; our educational programs, such as the Rural and Remote conference, should seek to ensure plenary speakers, presenters and the planning committee reflect the diversity of rural physicians in practice. Our council and executive should be selected based on criteria that embrace philosophies of equity, diversity and inclusion.

Together, let us actively work towards being an organisation considered a leader in gender equity.

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