Chapter 1.3.2

DEVELOPING GENDER AND CULTURAL AWARENESS FOR RURAL PRACTICE

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This chapter addresses the following questions with a view to developing a gender and culturally inclusive awareness for rural practice in medical education:

- Is medicine different across place, culture, and gender?
- Does sensitivity to gender or cultural difference shape who we are as doctors and patients?
- How can we best train medical students to live and work in settings where norms, values and expectations are at variance with their own?

Introduction

There I was, the non-native, young physician[1] providing primary care to eight isolated native communities in Canada. In the local language I was the 'nurse doctor' as the word for doctor was 'medicine man'. Even more confusing was the role of the male nurse with whom I often worked and who presumably was referred to as 'doctor nurse'.

I suppose I am part of a global feminisation of medicine attributable to both an influx of women and a 'walking away' from the profession by men. The gender shift has been particularly evident in general/family practice. In Canada female medical students outnumber males, although the ratio of male to female family physicians is about 3:1, reflecting past gender imbalances. This ratio is the same in urban and rural settings, despite a belief that women shun rural and remote practice (1).

[1] A 'physician' here (and in North America more broadly) is another term for 'doctor' or general practitioner, while in countries like South Africa and Australia, a 'physician' is a specialist in internal medicine.

Gender stereotypes: The 'rugged male'

The typical picture of the family physician (2) and, the rural doctor in particular is, nevertheless, the rugged male. Although hardly scientific, a Google search of why doctors choose rural practice unearthed many images of male physicians hiking across fields and forests (often wearing stethoscopes), riding horses, or roasting pigs on a spit. On those rare occasions when women are pictured, they are at work, smiling at children, and wearing those white lab coats most of us abandoned years ago. A recurrent picture is what might be labelled 'The Big Fish', not because the doctor gets to be 'a big fish in a small pond' (a role some might seek) but because the man pictured (the rural doctor) is holding his catch of the day – a big fish!

Such images deter young female doctors from rural practice. If learners do not see themselves in their preceptors[2] or work mentors, they will avoid such practice settings. Yet while the icon of the rural physician is stereotypically male and not inviting for women, Canadian women are drawn to remote practice with the same frequency as men. Perhaps the survey identifying the attraction of the rural setting as 'a place to make a difference' has greater explanatory value than does 'the big fish' for why women physicians might choose to leave the big city (3).

Being female or male is genetic, permanent (I will not discuss transgender here), and not dependent on geography. Combining sex and place of practice does, however, give rise to malleable gendered effects. The realities of rural practice and life will be different for men and women. For example, male doctors will often be seen (and may see themselves) as physicians first, while for females the ambiguity of doctor versus parent may be the more common reality. Communities may view the single male physician as 'a catch' and the single female doctor as a social oddity. Can education remove such differences or even them out? Not really, because they arise from social circumstances rather than aspects of training. However, we can acknowledge the existence of stereotypes and equip all trainees to both adapt to, and work toward eliminating, inequities and biases.

2 A preceptor - or clinical instructor/adjunct faculty – is a clinician (person with core clinical skills) who offers clinical teaching at a distant (rural) site.

Gender roles and expectations

Traditional gender roles and expectations remain, particularly in more rural and isolated geographic areas and especially in less developed countries. Their effect on women physicians is universal and subtle, but real. Women continue to bear disproportionate responsibility for home, family, and balancing these with employment. As medical education is distributed outside the academic centre, rural practices face increased pressure to absorb more learners. The extra time commitment required for this may present a particular strain for practitioners (usually female) already juggling home and work. At the same time, awareness that one way to recruit doctors to underserved areas is to welcome them during their training by being the previously absent icons and role models, creates guilt among those women physicians who just don't have time for mentoring.

Advancement in academic careers is also jeopardised, as it is often men who can find added hours to invest in teaching, and are therefore recognised and hailed as leaders and scholars, while their (often physician) wives are devoting those hours to nurturing them and their children. The very nature of rural practice - that is, the necessity to provide enhanced care and maintain extra skills in a setting where these are rarely used - means that if women do work fewer hours or take leave to have children they will have less exposure to the sickest patients and may lose confidence in their abilities.

Gender and the patient-centred approach

I expect that most medical schools strive to combine knowledge and skills training with a patient-centred approach to prepare graduates for practice in any location. Part of patient-centredness is the ability to form relationships, that is, to be interested in and engage with people in their care over the long term.

The ability of a doctor to connect is particularly advantageous and yet challenging in rural settings where the overlap between patient and neighbour is inevitable. Female physicians appear to be more likely to connect with patients (4). However, one of the associated stresses for all, but particularly female doctors, and especially in smaller communities is 'over-connection' - a sense of never having privacy and often being under surveillance. The fact that one has to always be a physician can be overlooked for a year or two, but may become unbearable after many years. Being the keeper of many secrets can be frustrating and isolating over time. Similarly, deepening connections within the community may lead to more and more phone

calls at home and a loss of privacy for the doctor. Education to build awareness of the need for, and ways to find a balance between, maintaining boundaries while being an engaged community participant might ameliorate this problem. Developing self-awareness during medical training will be a recurrent theme throughout this chapter.

The rural calling

Although often from large cities, and with limited experience of living or training outside of an urban centre, the women physicians I consulted in preparing this chapter were drawn to Canada's rural north. Rather than their place of birth or rural exposure during medical education it was an awareness of personal values, sense of service and altruism, and a spirit of adventure that called these women.

Literature from a search of rural medical education is disappointing, full of stereotypes, unsupported conclusions, and articles on why physicians don't choose rural practice, rather than why they do or how education might encourage such a choice. Suggestions proposed include advanced skills training (despite absence of documentation that young physicians lack necessary skills) and financial recruitment incentives (despite failure of such incentives to 'solve' the underserviced problem in, for example, Canada). Much mention is made of non-medical impediments such as being female, finding employment for spouses, quality of education for children, or lack of familiarity with rural settings prior to graduation, all anecdotal and lacking evidence of validity.

There is no clear documentation that those who grow up in smaller communities return or remain in such communities as physicians. Most Canadian doctors working in the periphery are from the big city and have chosen rural practice (assuming that government contractual constraints have not forced them into isolated communities) because of some combination of: 'it's an adventure', there's an aspect of altruism and 'missionary' work that's appealing, they can 'hide' or escape, there's a perception of greater control, autonomy and independence as well as the chance to extend one's scope of practice. For some whose commitment is often only short-term, the attraction may be financial incentives.

Does this play out differently for men and women? Can medical education foster the values and characteristics that make remote practice appealing?

Self and cultural awareness

There is a whole literature on the importance of self and cultural awareness in promoting excellence in medical practice and flexibility in caring for patients across cultural, ethnic, or religious diversity, that is, caring for anyone whose background or values is at variance with one's own (5). Betancourt describes how socio-cultural dimensions and an understanding of these shape symptom recognition, communications, patient compliance, trust and satisfaction, and clinical decision-making (6), while Taylor writes that 'in the medical context . . . this extends to an understanding that physician's medical knowledge is no less cultural for being real, just as patients' lived experiences and perspectives are no less real for being cultural' (7).

To become excellent practitioners of evidence-based medicine, students require training that extends beyond knowledge acquisition and incorporates elements of self- and cultural-awareness. Comfort with working across difference, while required in rural settings, is of benefit everywhere. Training in cultural awareness will open students to difference and to being inclusive and sensitive to the person, rather than just knowing the disease.

With physician self/cultural awareness may come a fear of how rural folks, who are conceptualised as being more traditional and conservative, will deal with heterogeneity. And so doctors may hesitate to move away from their cultural community to a town where they perceive themselves to be outsiders. In most countries physicians anywhere will, at times, feel marginalised and the objects of excess scrutiny or even overt discrimination because of real or presumed differences between themselves and patients.

An education that acknowledges this and prepares students to know themselves, and, at the same time, to be inclusive and open to others will help physicians understand and minimise difference while recognising how these same social characteristics shape patients' health. Trainees may also discover that those who live in remote settings often manage to combine traditional values with an acceptance of diversity, welcoming doctors who are different rather than being wary of them.

Sensitivity to gender and culture in practice

Among women in those eight remote indigenous communities where I first practiced, there appeared to be an epidemic of abdominal pain, relieved only by rest. Even with limited access to investigations, I could rule out many diagnoses. However, my Canadian medical education seemed to be failing me. How could non-infectious abdominal pain be contagious? With thought, discussion and time I came to understand that women's work in communities with no electricity or plumbing included hauling wood for fires and collecting water for drinking and washing. My patients felt unable to ask their husbands to help, but could use my advice 'to rest' as a way of redistributing an unequal workload. These patients taught me the difference between knowing the evidence and practicing evidence-based medicine (see Figure 1).

> 'Any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied.' (8)

Figure 1

What is Evidence Based Medicine?

Source: Cochrane Collaboration

More than a technician – and the limits of evidence-based medicine

Both patient and physician are more than proteins, cells and organs. Each has a context, values, vulnerabilities, in other words, a humanity that caregivers must integrate with the pattern recognition of medical science. There is no doubt that even with increasing communication technology, doctors practicing in rural settings need expanded skills relative to their urban colleagues, and require a higher level of comfort with independence and self-reliance. However, it is only by being more than a good technician that a family physician will respond to the uniqueness of individuals in their settings:

> 'An important part of GPs' work consists of attending to the everyday and existential conditions of human being. In these life world aspects, biomedicine is often not the relevant theory to guide the GP ... [there exist two] perspectives of medicine: medicine as the science of biomedicine or medicine as a clinical practice of moral and relational origin, which uses biomedicine as a tool.' (9)

Inclusiveness and working across difference

Concepts of gender, inclusiveness, self-awareness and place are all part of who the patient is, what the doctor brings to care-giving, and patient-centred care.

Physicians are not immune to both the opportunities and constraints of individual culture and gender. In the heterogeneous urban centre, every physician can 'fit in' somewhere. Often this fit evaporates in rural areas where there may be only one acceptable set of behaviours linked to, for example, being female or male, and many ways to feel different. Such differences are often easily diffused but only if one has the insight to recognise them and the skills to talk across culture, race, or gender. These are skills we can and should provide to all medical trainees to build comfort in practising in all settings.

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