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Women, general practice, and gender roles

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Since 1988, Canadian women have, year after year, outnumbered men in general (family) practice (CAPER, 1989; CAPER, 2018). While factors such as family medicine having more standard working hours (Michas, 2022) and requiring less rigorous training (Boulis & Jacobs, 2008) may be part of their decision to become family physicians, the main reason for women to be constantly choosing family practice is heavily influenced by societal expectations of care. Women are believed to be naturally motherly, which causes society to direct women towards more care-oriented careers such as family medicine or nursing instead of more "uncaring" fields such as specialty medicine. There are many parallels between women's expectations and the role of family physicians: women are expected to know how to care for others longitudinally and holistically, be more empathetic towards others, and have a wide range of knowledge; family physicians look after their patients over many years, have strong relationships with their patients, and are seen as the first point of contact for medicine-related questions or concerns.

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After medical school, there are two routes of patient care that medical students can choose: general practice or speciality practice. General practice, also known as family medicine, focuses on caring for the overall health of the entire family unit. This is a dedicated field of medicine, where doctors consistently see their patients over the course of many years (OECD, 2022). In contrast, specialist doctors focus on one specific area of medicine, be it a particular illness, condition, or mental health disorder (OECD, 2022). Once the medical issue has been corrected, the doctor will cease caring for the patient.

Women have always outnumbered men in family medicine. In 2006, CAPER (2018) found that 65% of students studying general practice were women as opposed to 35% of men. Though there is still a gender gap in the field, it has narrowed in recent years as more men have begun to pursue general practice—compared to 2006, the 2016 medical student demographic was 58% women and 42% men (CAPER, 2018). This is one of the only medical areas where women doctors have been more common than males since women were allowed to practise medicine. While, in

recent decades, there have been more men entering general practice and more women entering specialty practice, women still outnumber men in family medicine and remain a large minority in speciality medicine (CAPER, 2018). This is due to societal influence and perceptions of women's abilities; as such, women are more likely to become general practitioners than specialised doctors due to stereotypes of them being naturally maternal.

Care

Society equates femininity to caring for others, where dedication towards caring for a sick family member or ensuring the well-being of the household is a woman-centred duty (Khazen & Guttman, 2020). This is due to societal stereotypes about the role of women as the primary carer. This expectation causes women, even those without medical experience, to be seen as 'home doctors' (Khazen & Guttman, 2020), because they are expected to know how to care for the sick. Similarly, general practitioners focus on the health of the family—they care about the developmental journey and long-term health of the patient (Joschko & Busing, 2016). This is in contrast to specialty medicine, where specialists do not see their patients longitudinally due to the focused area of medicine (Joschko & Busing, 2016). In fact, because general practitioners care for their patients over an extended period of time, general practitioners spend more time on interacting with or caring for their patients than specialists (Michas, 2022) in order to build a strong doctor-patient relationship.

The women's perceived responsibility of care affects their career as well as how they are seen in the household: they are believed to be more adept at providing patient care as they are stereotyped as better listeners, better communicators, and more empathetic (Boulis & Jacobs, 2008). These stereotypes reflect many important aspects of general practice and patient care: listening to their patients' concerns, communicating and advocating for their patients' needs, and using empathy to better understand and connect with their patients (Robinson, 2021). Additionally, studies have found that women are more likely to focus on more flexible and less intensive programs so they can still remain focused on caring for the family (Boulis & Jacobs, 2008). As general practice requires fewer working hours (Michas, 2022), women are more likely to choose this profession.

This difference in masculinity and femininity is not only bound to gender norms and society, however, but even in infrastructure. This is seen in Wajcman (2001), where Kennedy notes that the more 'feminine' architectural structures are made with an easier, holistic, social, and flexible design in mind, whereas the 'masculine' aspects focus more on more imposing, fixed, profit-oriented, and specialised design. This contrast shows that the belief of women being more welcoming and multi-purpose and men being more rigid and specialised exist everywhere in society—not just in medicine and gender stereotypes. Like women,

'feminine' structures are user-oriented, ergonomic, and social, where they are made to provide a source of comfort and companionship as well as serve others' needs before their own. Wajcman (2001) further points out that this binary divide in structure is reflective of societal beliefs, where women are only better able to care for patients due to this view that they are well-suited for communication, empathy, and general knowledge—aspects that are prevalent in general practice.

Labour and general knowledge

Weber (2006) points out that women are often seen not as people, but as the services they can provide—empathy, maternal instinct, emotional labour, and care. This labour is only associated with women; a Google Ad for the new Google Home Hub shows children constantly calling for their mother, asking them questions, relying on them for help, and seeing medical advice (Made by Google, 2019). In the video, mothers are seen as a 'knower of everything'—whenever the child needs something, they go to their mother (Made by Google, 2019). Similarly, general practitioners, who are considered the first line of defence in healthcare, also serve as the 'knower of everything'. They are the first point of contact to answer any medical concerns and illnesses patients have (Joschko & Busing, 2016) because it is expected that they will have the knowledge necessary to diagnose their patients. It is only when general practitioners are unable to adequately provide a medical diagnosis for the patient that they refer their patients refer them to a specialist (Joschko & Busing, 2016). Part of serving as patients' first point of contact is that they approach medicine from a more holistic view (Fineschi et al., 2020): they know all their patient's past and current medical issues and they see their patient as a whole rather than as part of a whole. This is similar to how women are expected to care holistically for the entire household; they focus on caring for all aspects of their family—their mental, emotional, and physical well-being—instead of just certain parts. Specialists, on the other hand, focus on caring for specific aspects of the patients (Fineschi et al., 2020) and thus do not have extensive knowledge about their patient, leading them to view their patients from a narrowed lens.

Due to these 'maternal instincts', women are also more stereotyped to be better at practicing medicine from a holistic, general perspective rather than speciality medicine, which is often rigid and unchangeable—something that also goes against social stereotypes of femininity (Boulis & Jacobs, 2008). Furthermore, as speciality medicine relies on technology rather than 'maternal instinct' (Boulis & Jacobs, 2008), women are thought to be inept in specialty medicine due to this contrast between their 'naturally caring' nature and the requirements of the job.

Incompetence and inferiority

With maternal instincts come a perception of technological and medical inferiority. Technology—and the jobs associated with or reliant on technology, such as specialty medicine—are often equated to ‘masculine’ jobs (Weber, 2006). As mastery of technology (and technology itself) is seen as ‘masculine’, women are perceived to be technologically illiterate (Weber, 2006), causing people to believe that they will struggle in specialty medicine (and thus specialty research) due to its high use of technological devices. Without research and publications, two aspects which often help advance careers, women further are faced with difficulty disbanding societal perception that women are inferior (Spector & Overholser, 2019).

Additionally, women are seen as emotional or weak (Spector & Overholser, 2019) due to their femininity; they are often discouraged from specialty programs due to concerns that they will not be able to handle the mental or emotional pressures of the job, or that because they will not be as disciplined (Boulis & Jacobs, 2008) as their male counterparts. This difficulty in finding a residency spot will influence women to choose general practice instead as it is deemed more ‘suitable’ for women’s ‘maternal side’, as opposed to the ‘cold’ profession of speciality medicine that is perceived to be ‘unfit’ for women (Boulis & Jacobs, 2008). This pattern is seen in countries other than Canada and the US—Ecuadorian women studying medicine are pushed towards medical jobs that require less ‘strength’, such as trauma (Bedoya-Vaca et al., 2016).

Western societal norms dictate that men are to control femininity and dictate inferiority (Weber, 2006); traditional roles believe women are inferior and therefore must submit to and serve men (Weber, 2006). Similarly, general practice is often seen as ‘inferior’ to other, more specialised, aspects of medicine (Joschko & Busing, 2016). This is for many reasons, including but not limited to the previously mentioned masculine need for ‘strength’ in specialty medicine, but also because of the amount of education needed. General practitioners need a medical degree and a one-year internship to become certified, whereas specialists need a medical degree and completion of their residency (OECD, 2022), which often takes an average of five years (BeMo, 2022). Due to this difference in training, specialities are believed to provide better-informed care than general practitioners, despite studies saying that both types of doctors provide equally high-quality care to their patients (Smetana et al., 2007). Regardless, this belief causes specialist doctors to be socially, and medically, more respected (Joschko & Busing, 2016) and valued (Boulis & Jacobs, 2008) than general practitioners due to this perceived higher knowledge (Smetana et al., 2007). This lack of value and appreciation towards the field of general medicine parallels people’s view towards women’s labour in the household: their work is often unnoticed or taken for granted.

Serving the patriarchy

The current make-up of society perpetuates the oppression and submission of women, where women are expected to stay home and not be part of the workforce, but rather rely on men for knowledge, financial support, and the maintenance of society (Wajcman, 2001). Khazen and Guttman (2020) agree; the gender roles of care extend even when the income roles are switched: fathers who do not work are not expected to care for the family; the working mother remains responsible for the income and family. Thus, women's labour is always taken for granted, similar to how the work of general practitioners are taken for granted, because general practice and caring for the family are seen as lower-skilled work. This adherence to the societal expectation of women being the carers of the family contribute to the perpetuation of a patriarchal society, one where women are told, and not able to choose, this stereotype as carers (Khazen & Guttman, 2020). Similarly, women are believed to be incompetent at more focused, rigid medical jobs, and that they are better at work that is similar to their perceived duty as women inside the home—long-term carers for families.

Women are expected to focus on the family whereas the men's only task is to focus on one specific thing—money (Khazen & Guttman, 2020). Even though having both men and women work is normalised in today's society, working women are still solely responsible for the well-being of the family. This is reflected in the still-existing gender pay gap: women are paid less than men (Spector & Overholser, 2019), with women being paid even less in women-dominated medical fields such as general practice (Cohen & Kiran, 2020). This disparity in wages for the same job can be explained by the fact that as women are expected to focus on the family, their work—and therefore their pay—is not as important as men's work and pay, the latter of which is expected to financially support the family. Khazen and Guttman (2020) agree, saying that this is because women are seen to exist to serve the needs of the family, gender roles mandate that they must sacrifice their needs and wants, such as pay, to ensure the household's well-being. Due to these expected duties of care, they are pressured into choosing medical professions that allow them to adhere to the societal roles they were given.

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