Bravo!

Bravo for your article "Smile! Women as family doctors" in the July issue of *Canadian Family Physician*, Dr Dhara![1] As a fellow female family physician I wholeheartedly agree with many of your statements. I would like to add that I often feel patients have different expectations of female family doctors in terms of time spent per office visit, as well as explicit expressions of warmth and empathy from physicians. I wonder if there is also a different expectation in terms of payment for noninsured services. Thank you for your article, Dr Dhara. It is a valuable contribution to the discussion on women in family medicine.

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Competing interests
None declared

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Women and family medicine

Dr Dhara, I was moved by your gutsy and heartfelt article "Smile! Women as family doctors," which appeared in the July issue of *Canadian Family Physician*.[1] I was moved enough to respond with an acknowledgment of your experience to mitigate the risk of minimizing an everyday experience for most, if not all, female physicians.

I suspect you debated whether it was even worthwhile to put your thoughts down, let alone think them. After all, you are a practising family physician and a faculty member who is a role model and who teaches future physicians. Why make a fuss? we might all ask.

Well, I for one am glad you did. First, you decided to reflect on why this incident with the nurse who called out for you to smile got under your skin.[1] That is notable when we as female physicians have become quite accustomed to what Beagan[2] refers to as *microaggressions* throughout our training. These daily transgressions that communicate that we do not belong, or are not equal, have a cumulative effect that whittles away at self-image. Virtually every female physician experiences these events—none of them "big enough" or egregious enough to comment on or complain about. Just many ... daily.

The coping strategies we employ include self-blame (I could read this all through your statements[1]), disengagement, desensitization, and finally resignation. We call them *coping,* but with the evidence that female medical students become less confident as their training proceeds (compared with our male colleagues whose self-confidence increases with training),[3,4] can we really sit complacently and ignore the effects these experiences have on more than 50% of our trainees? You and other readers might find a newly published book, *Female Doctors in Canada. Experience and Culture,*[5,6] to be informative and engaging.

You tie your experience of marginalization as a female physician to the issue of career choice and a restriction or narrowing of the career choices of female medical students. I concur that this is a very important consideration in the choices that female students make and how the not so "hidden curriculum" of medicine is a gendered experience.[7] Female and male students have considerably different experiences in their medical education. The result is a horizontal segregation of female students into a narrower career choice than our male colleagues have. Moulton and colleagues refer to this as *paradigmatic trajectories* and suggest that female physicians are absent from many disciplines because they lack opportunities to see and experience that discipline owing to gendered exclusion, and they think that they are not welcomed as legitimate participants in that discipline's community.[8]

Female medical students when making career choices have a complex and conflicted task. In our 2018 study about medical students' career choices published in *Teaching and Learning in Medicine,* colleagues and I identified differences in how male and female students articulated the factors in their career choice.[9] Male students appeared to have a very harmonious integration of their personal and professional goals. Female students on the other hand experienced numerous conflicts between the personal and the professional. These contextual factors that created dissonance we identified as part of the culture of sexism, including lack of mentorship; inequitable treatment on clinical teams; stereotypes of "appropriate" specialty choices perpetuated by faculty, friends, family, and the students themselves; expectations of and commentary on their appearance and choice of dress; and partner and future family influence.

So women do choose family medicine more often than men do, and this is partly because of the factors

articulated above—perhaps because they "see" themselves in family medicine and the fit feels good.

Certainly, society benefits from having so many capable, competent, and compassionate female physicians providing exemplary care. We should be loud and proud about what we bring to the practice of medicine and the care of our patients. Indeed, we know the evidence about how health care systems are best when supported by excellent primary care. However, choosing family medicine because it is what we want is different from choosing it because other doors are not open to us. Equity in medical education will only come when we begin to address the gendered experiences of female students. Speaking out, as you have, will foster a most needed dialogue about all students feeling welcome, included, and respected for what they bring to the practice of medicine.

Thank you, Dr Dhara, for your candid comments and your willingness to put them out there.

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Competing interests

Dr Bethune was a contributing author for *Female Doctors in Canada. Experience and Culture.*

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Failure to acknowledge inequities in the social determinants of health

The article entitled "Lice infestation causing severe anemia in a 4-year-old child" in the July issue of *Canadian Family Physician* explores a case in which social determinants of health and health inequity produce severe illness in a child.[1] However, rather than highlighting these factors, the article propagates stigma that is in direct contradiction to the principles of the College of Family Physicians of Canada, namely "family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power."[2]

The 4-year-old patient in the article is noted to be First Nations and living on reserve with her family.[1] She was transferred to an urban care centre for treatment. The authors explain concern for neglect given the extent of the lice infestation, for which providers contacted child protection services. The article notes that the "family complied with social services, who conducted an extensive review including home visits in conjunction with the local Aboriginal liaison team."[1] Despite this "extensive review," the team fails to acknowledge the inequities in the social determinants of health contributing to this case and instead places emphasis on the possibility of parental neglect. Furthermore, the voices of neither the parents nor the child are represented in the piece. Failure to adequately contextualize this case perpetuates societal stigma against Indigenous people.

When we as health care providers present research regarding Indigenous patients and frame it with the lens of, for instance, potential parental neglect without expressly acknowledging the contexts and oppressions that the families face we are perpetuating stigma and colonization. When we state that an "extensive review" was conducted but do not discuss the barriers and strengths that were discovered, we are failing to adequately represent and advocate for our patients.

It is well known that inequities in the social determinants of health result in an increased burden of health problems, and often restrict affected individuals, communities, and nations from accessing resources that might ameliorate the issues.[3] In this way, the individual determinants are not isolated beings, but rather threads that build a common web. Ironically, the President's Message in this same July issue of *Canadian Family Physician* explores the social determinant of health of wealth inequality, as well as the development of the Poverty Tool.[4] There is no mention of Indigenous health or the disproportionate burden of wealth inequality among Canada's Indigenous people within the President's Message.

Inequities in the social determinants of health of Indigenous people result in health disparities in early childhood development, maternal health, community health, mental health, and chronic disease, among others.[5] In order to address these disparities, it is essential to identify and understand the historical, social, political, and ethical contexts.[5]

The ancestors of the 3 Indigenous groups recognized in Canada (First Nations, Inuit, and Métis) all underwent colonization, including the imposition of colonial institutions and systems.[3,6] These processes have resulted in losses of lands, languages, and sociocultural resources for the Indigenous people of Canada.[3] The ensuing racism, discrimination, and social exclusion continue to permeate Canadian society, including the health care system.[3]

Assimilationist policies relied on measures proposed to "civilize" Indigenous children by removing them from their community, family, and culture.[6] This continues to occur in the current Canadian system, as