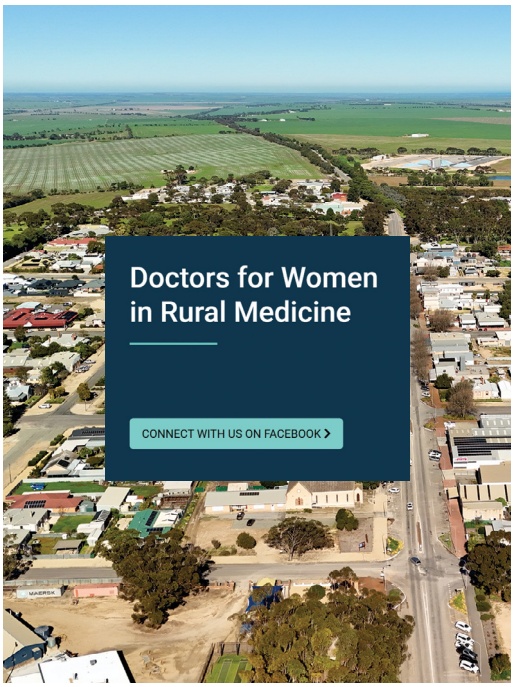
Doctors for Women in Rural Medicine: A model for creating connection, wellbeing and career sustainability



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Background
The traditional Australian rural general practitioner (GP) archetype has shifted. Women now represent a substantial proportion of rural GPs and trainees.

Objective
This article outlines some of the personal and professional needs of female rural GPs and describes the approach of a voluntary group of rural clinicians, the Doctors for Women in Rural Medicine, to help meet these by providing professional connection, support and advocacy.

Discussion
Rural female and gender diverse GPs have specific personal and professional needs that must be met in order to sustain their careers. These clinicians have a strong desire for connection with colleagues, peer support, mentoring and leadership-development opportunities. They seek diversity, flexibility and control over their careers that aligns with their non-professional lives and responsibilities. Promoting wellbeing by achieving pay equity and recognising gender-specific needs is central to sustainability of the rural GP workforce.

THE ARCHETYPE of the typical Australian rural general practitioner (GP) has shifted. Historically, the typical Australian rural GP was more likely to be male,[1] continuously available, embedded in a single community for decades and supported domestically by a partner who absorbed much of the unpaid care burden.[2]

In 2024, 53.5% of medical students identified as female and 0.5% as non-binary.[3] The proportion of Australian full-time-equivalent female GPs is projected to increase from 46.9% in 2023 to 55.8% in 2048,[4] and the growth of the female medical workforce has outpaced male medical workforce growth in all regional and rural areas in Australia in the past 5 years.[5] Women seek flexible working arrangements,[6,7] sustainable career pathways,[7] the ability to share care responsibilities and pay equity. Expectations regarding constant availability, unstructured after-hours work and informal boundary negotiation are no longer aligned with contemporary professional norms.

As the demographic composition of rural general practice shifts, workforce structures and supports must evolve accordingly. A person-centred approach to rural GP recruitment and retention that recognises and responds to gender diversity is central to workforce sustainability and individual wellbeing.

This article outlines some of the personal and professional needs of female rural GPs and describes the approach of a voluntary group of rural clinicians, the Doctors for Women in Rural Medicine (DWRM), to meet these by providing professional connection, support and advocacy.

Addressing new needs

In 2022, The Royal Australian College of General Practitioners' (RACGP's) Rural Faculty established the DWRM Committee.[8]

The objective of DWRM is to unite rural and remote GPs and rural generalists from around Australia by:

- facilitating a connection to share experiences, challenges and solutions
- delivering educational activities for Continuing Professional Development (CPD)
- highlighting valuable resources and tips to improve daily practice
- capturing the voices of and issues affecting RACGP members to provide clear recommendations to the RACGP Rural Council, RACGP Board and Federal Government.

The current committee comprises voluntary RACGP Fellows and medical students with experience in rural practice. Although all RACGP members are welcome to join

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activities facilitated by DWRM, most who participate are women.

DWRM employs a range of techniques to engage RACGP members including social media discussions, interactive online member meetups, in-person events and facilitation of conference workshops.

Challenges for women: Listening to the membership

DWRM activities have yielded rich insights into a range of themes concerning women working in contemporary rural general practice. It is likely that some of the challenges described by female clinicians are also experienced by male and non-binary colleagues.

Professional isolation remains a defining challenge of rural and remote practice and has been described as significant by female clinicians both in the literature[7] and in DWRM discussions. Although rural clinicians often experience the benefits of strong community integration,[9–11] structured professional connection can be lacking,[9] particularly for early-career doctors or those returning from periods of leave, such as after the birth and care of children.

In small communities, blurred boundaries between professional and personal roles can amplify the strain of professional isolation.[10,11] Constant, subtle boundary negotiation with patients and community members can erode wellbeing, increasing the risk of burnout or departure from general practice.[9]

Women and gender diverse clinicians face additional pressures related to the disproportionate distribution of emotional labour,[10] which is frequently under-recognised and poorly remunerated. Rural female GPs often lead teams informally, provide pastoral support to colleagues and spend more time with patients than male GPs.[2,10,12] Relational expectations may extend beyond the consulting room to informal advice-seeking from community members and stepping into non-medical leadership roles.

In addition, female GPs juggle professional roles with a higher burden of personal caregiving responsibilities.[13] Equitable leave entitlements and flexibility within workplaces have not evolved rapidly enough to meet these needs in a changing cultural environment, which may diminish an individual female clinician's sense of autonomy and precipitate financial disadvantage. Periods of family leave also exacerbate the procedural deskilling and decreased confidence already hindered by difficulty accessing CPD when working in rural or remote locations,[9] risking individual scope-of-practice reduction over time.

Women experience financial disadvantage when compared with male colleagues, with a GP gender pay gap resulting from myriad factors.[14] Women spend longer on average with patients per visit because they see higher rates of complex disease, women's health and mental health, which is financially penalised by a Medicare system that rewards shorter and bulk-billed consultations.[12] Female GPs are less likely to be practice owners[12] and have lower lifetime income and superannuation earnings as a consequence of working fewer hours[14] because of family leave and caregiving roles. Some data suggest that the GP gender pay gap may be wider in rural areas.[14]

Female and non-binary role models are less visible to rural clinicians, and mentors are less accessible, because of historical gender inequities persisting into current formal leadership representation[15] as well as geographical barriers. Fewer female colleagues combined with metro-centric organisational structures, in which city clinicians are privileged,[16] can result in fewer networking opportunities, reducing the prospect of a 'tap on the shoulder' or sponsorship into leadership and representation roles.

Creating connection

A sense of belonging, mentorship, peer networks and structured professional support reduces burnout and improves retention in rural settings.[7,9–11] For women and gender diverse clinicians, professional networks and mentoring with an intersectional approach can provide psychological safety and career affirmation.[17]

Recognising this, DWRM has responded with initiatives that create connection and a sense of professional belonging among female rural clinicians. Online member meetups, held three or four times per year, usually feature female guest speakers followed by an open discussion among attendees, providing an opportunity to share experiences and learn of others' approaches to issues in a similar rural context. Topics have ranged from the overseas-trained doctor experience to women in practice ownership, tackling toxic masculinity and creative writing for self-care.[8] An interactive virtual International Women's Day event is hosted annually with an address from a high-profile female role model.

In 2025, DWRM hosted a full-day workshop at the RACGP's annual conference specifically addressing a desire expressed by female rural GPs for professional skills training. This featured peer-facilitated interactive sessions on leadership, chairing meetings, effective use of social media, advocacy, mentoring and diverse career planning. A panel session featuring female leaders from within the RACGP recounting their own experiences of leadership provided an opportunity for attendees to relate their own journeys to that of colleagues from a similar background.

In itself, the DWRM Committee has also provided a rich environment for rural female GPs to put these concepts into practice. A strong sense of belonging and purpose drives committee members who share values around supporting women, the profession and rural colleagues. Peer-to-peer mentoring and role modelling, as well as opportunities to learn skills in representation, advocacy and leadership, are inherent in committee work and are supported by the Rural Faculty's commitment to the purpose and objectives of DWRM.

More can be done

Although DWRM continues to facilitate activities that connect its members and offer a sense of belonging, it constitutes only part of the solution needed to sustain female rural and remote GPs today and into the future.

Health system settings need to better recognise and remunerate relational labour burden through increased Medicare rebates for longer, complex consultations and mental health items, in addition to adequate funding for quality supervision and education, equitable leave entitlements and flexibility in workplace and training conditions.

Professional medical organisations and colleges have a role in providing structured leadership pathways and training that account for the geographic, travel and financial burdens

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intrinsic to rural careers. These are essential to ensure that rural female and gender diverse GPs have a voice not only within communities but also within health systems and that a diversity of representation exists where decisions are made. Appropriate opportunities are needed for upskilling or reskilling in procedural and rural practice[18,19] for clinicians returning after periods of family leave or shifting from urban to rural practice.

Medical training has a role to play. Early rural exposure, positive gender diverse rural role models and visible female leaders increase confidence in choosing rural careers,[7] and these should be actively provided to students, early-career doctors and general practice registrars. When potential future clinicians witness rural GPs practising with skill, balance and community respect, rural medicine becomes an opportunity rather than a sacrifice.

Communities are also partners in sustaining rural clinicians. Welcoming employers with flexible work arrangements and trials of innovative models that maintain continuity between patients and doctors working part time are needed. Communities must step up to support partners' work opportunities and provide flexible childcare and education options, which are essential for clinician retention.[7]

Further formal research is needed to identify gender-specific needs of rural clinicians in order to direct future actions to support these GPs. This must be backed with evaluation of policy settings and existing activities, including a review of the efficacy and utility of DWRM activities, to ensure focus and investment are directed effectively.

Conclusion

Recognising and addressing the needs of women and gender diverse rural GPs is essential to a sustainable rural workforce. Supporting career flexibility, pay equity, professional connection, mentoring and leadership development enhances clinician wellbeing and strengthens long-term engagement in rural practice. Embedding gender-specific needs into policy, training and workplace structures enables women to thrive and contributes to a stable, high-quality general practice workforce across rural Australia.

Key points

- The archetype of the typical rural GP has shifted.
- Rural female GPs seek diversity, flexibility and control over their career that aligns with their non-professional lives and responsibilities.
- Rural female GPs express a desire for connection with colleagues, peer support, female role models, mentoring and upskilling in leadership and advocacy.
- Promoting wellbeing, achieving pay equity and recognising the diversity of gender-specific needs are central to sustainability of the rural GP workforce.
- More can be done to meet these needs by medical colleges, government, communities and further research.

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References

References are available online only.

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References

1. Strasser RP, Hays RB, Kamien M, Carson D. Is Australian rural practice changing? Findings from the National Rural General Practice Study. Aust J Rural Health 2000;8(4):222–26. doi: 10.1046/j.1440-1584.2000.00305.x.
2. Kilmartin MR, Newell CJ, Line MA. The balancing act: Key issues in the lives of women general practitioners in Australia. Med J Aust 2002;177(2):87–89. doi: 10.5694/j.1326-5377.2002.tb04675.x.
3. Medical Deans Australia and New Zealand. Medical School Outcomes Database: National data Report 2025. Medical Deans Australia and New Zealand, 2025. Available at https://medicaldeans.org.au/md/2025/05/MSOD-National-Data-Report-2025_FINAL.pdf [Accessed 13 August 2026].
4. Australian Government Department of Health and Aged Care. Supply and Demand Study – General Practitioners in Australia. Australian Government, 2024. Available at https://hwd.health.gov.au/supply-and-demand/gp-supply-demand-study.html [Accessed 13 August 2026].
5. Australian Government, Department of Health, Disability and Ageing. General practice workforce providing primary care services in Australia. General Practice Workforce (2020 to 2025 Calendar Years). Australian Government, 2026. Available at https://hwd.health.gov.au/resources/data/gp-primarycare.html [Accessed 13 August 2026].
6. Harris MG, Gavel PH, Young JR. Factors influencing the choice of specialty of Australian medical graduates. Med J Aust 2005;183(6):295–300. doi: 10.5694/j.1326-5377.2005.tb07058.x.
7. O'Sullivan B, McGrail M, May J. Responsive policies needed to secure rural supply from increasing female doctors: A perspective. Int J Health Plann Manage 2022;37(1):40–49. doi: 10.1002/hpm.3363.
8. The Royal Australian College of General Practitioners (RACGP). Doctors for women in rural medicine. RACGP, 2022. Available at www.racgp.org.au/the-racgp/faculties/rural/boards-and-committees/doctors-for-women-in-rural-medicine [Accessed 13 August 2026].
9. Wieland L, Ayton J, Abernethy G. Retention of general practitioners in remote areas of Canada and Australia: A meta-aggregation of qualitative research. Aust J Rural Health 2021;29(5):656–69. doi: 10.1111/ajr.12762.
10. Stutzman K, Ray Karpen R, Naidoo P, et al. Support for rural practice: Female physicians and the life-career interface. Rural Remote Health 2020;20(1):5341. doi: 10.22605/RRH5341.
11. Ozolins IZ, Greenwood G, Beilby J. Keeping women doctors in the country. Rural Remote Health 2004;4(2):268.
12. The Royal Australian College of General Practitioners (RACGP). General practice: Health of the Nation 2025. RACGP, 2025. Available at www.racgp.org.au/FSDEDEV/media/documents/Health-of-the-Nation-2025.pdf [Accessed 13 August 2026].
13. Australian Government. Status of women report card 2025. Australian Government, 2025. Available at https://genderequality.gov.au/status-women-report-cards/2025-report-card [Accessed 13 August 2026]
14. Ochre Health. Insights into gender paygap amongst GPs. Ochre Health, 2025. Available at https://ochrehealth.com.au/insights-into-gender-paygap-amongst-gps [Accessed 23 August 2026].
15. World Health Organization (WHO). Closing the leadership gap: Gender equity and leadership in the global health and care workforce. Policy action paper, June 2021. WHO, 2021. Available at www.who.int/publications/i/item/9789240025905 [Accessed 13 August 2026].
16. Partanen R, Eley D, Ostini R, McGrail M. Identifying the experience of geographical narcissism during medical education and training. Adv Health Sci Educ Theory Pract 2026;31(1):125–43. doi: 10.1007/s10459-025-10440-9.
17. Prathivadi P, MacPherson N. Supporting intersectional mentoring of women in medicine. Med J Aust 2024;221(2):83–85. doi: 10.5694/mja2.52358.
18. Glazebrook RM, Harrison SL. Obstacles and solutions to maintenance of advanced procedural skills for rural and remote medical practitioners in Australia. Rural Remote Health 2006;6(4):502. doi: 10.22605/RRH502.
19. Young L, Peel R, O'Sullivan B, Reeve C. Building general practice training capacity in rural and remote Australia with underserved primary care services: A qualitative investigation. BMC Health Serv Res 2019;19(1):338. doi: 10.1186/s12913-019-4078-1.

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