

Women in medicine

The challenge of finding balance

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ABSTRACT

OBJECTIVE To examine the experiences of women physicians with regard to the interplay between career and lifestyle choices and to discover how women's experiences have evolved during the past 3 decades.

DESIGN Qualitative study using a phenomenologic approach and in-depth interviews.

SETTING Southwestern Ontario.

PARTICIPANTS A total of 12 women physicians.

METHOD A purposeful sample of women physicians was selected using a maximum variation sampling strategy. Through semistructured interviews, participants' experiences, opinions, behaviour, and feelings were explored. All interviews were audiotaped and transcribed. The analysis strategy was both iterative and interpretive. Researchers independently reviewed and coded each transcript to identify key emerging themes, and the research team met to discuss and compare individual interpretations. Interviews continued until saturation was achieved.

MAIN FINDINGS Three main challenges emerged from the women physicians' comments: lifestyle and career choices, family planning and career trajectory, and seeking balance.

CONCLUSION Despite the increased number of women physicians in the work force, the experiences and challenges faced by these women have not evolved during the past 30 years. Women continue to experience the strain of their dual role as women and as physicians, discordance between career and lifestyle choices, and difficulties with timing pregnancies. Some changes in legislation have been made to benefit women physicians, but these changes have not yet influenced attitudes and behaviour in the workplace.

EDITOR'S KEY POINTS

- By 2015 women will make up about 40% of the physician work force, and both women and men physicians are increasingly concerned about lifestyle issues. How does a career in medicine affect women's practice and lifestyle choices?
- All of the participants in this study of female physicians struggled to maintain balance in the face of competing demands. Most of the participants described a strong link between choice of specialty and lifestyle issues and many believed taking maternity leave was one of their biggest challenges.
- The authors suggest that more on-site day-care centres, more flexible scheduling, the option of job sharing, and replacement staff for maternity leave would help female physicians deal with the competing demands of career and family.

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Féminisation de la médecine

Un équilibre à trouver

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RÉSUMÉ

OBJECTIF Examiner ce que les femmes médecins ont comme expérience des relations entre choix de carrière et de mode de vie, et découvrir comment leur opinion s'est modifiée au cours des 30 dernières années.

TYPE D'ÉTUDE Étude qualitative par approche phénoménologique et entrevues en profondeur.

CONTEXTE Sud-ouest de l'Ontario.

PARTICIPANTS Un total de 12 femmes médecins.

MÉTHODE Un échantillonnage raisonné de femmes médecins a été sélectionné grâce à une stratégie visant un maximum de variation. Des entrevues semi-structurées ont permis d'explorer les expériences, opinions, comportements et impressions des participantes. Toutes les entrevues ont été enregistrées sur ruban magnétique et transcrites. La stratégie d'analyse était à la fois itérative et interprétative. Les chercheurs ont revu et codé indépendamment chaque transcrite pour relever les thèmes clés émergents, et l'équipe de recherche s'est réunie pour comparer les interprétations individuelles et en discuter. Les entrevues ont continué jusqu'à saturation.

PRINCIPALES OBSERVATIONS Trois défis principaux sont ressortis des commentaires des participantes : style de vie et choix de carrière, planning familial et orientation de carrière, et recherche d'équilibre.

CONCLUSION Malgré la proportion croissante de femmes parmi les médecins actifs, les expériences et défis auxquels ces femmes font face n'ont pas changé au cours des 30 dernières années. Les femmes continuent d'être confrontées aux exigences de leur double rôle de femmes et de médecins, aux contradictions entre carrière et style de vie choisi et à la difficulté de planifier le moment d'une grossesse. Certains changements ont été apportés à la législation pour aider les femmes médecins, mais ces changements n'ont pas encore influencé les attitudes et comportements en milieu de travail.

POINTS DE REPÈRE DU RÉDACTEUR

- En 2015, les femmes constitueront environ 40% des médecins actifs alors que les médecins des deux sexes sont de plus en plus préoccupés par les questions touchant le mode de vie. Comment une carrière en médecine affecte-t-elle le type de pratique et le style de vie que choisissent les femmes?
- Toutes les participantes à cette étude sur les femmes médecins s'efforçaient de maintenir un équilibre face à des exigences contradictoires. La plupart voyaient un lien évident entre le choix d'une spécialité et les questions relatives au mode de vie, et plusieurs estimaient que le congé de maternité était l'un de leurs plus grands défis.
- Les auteurs croient que davantage de centres de jour locaux, des horaires plus flexibles, la possibilité de partager le travail et la disponibilité de remplaçants en cas de congé de maternité aideraient les femmes médecins à concilier les exigences contradictoires de la carrière et de la famille.

*Le texte intégral est accessible en anglais à www.cfp.ca.

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A considerable demographic shift has occurred and continues to occur in medicine as older physicians retire and a greater proportion of women enter the profession.¹ In 1961, women made up only 7% of all practising Canadian physicians, but by 2000, this had risen 28%.²⁻⁴ Since 1995, more than 50% of new Canadian medical students have been women, and by 2015 it is predicted that women will make up 40% of the physician work force.⁵ In addition to this changing demographic, both women and men physicians are increasingly concerned about lifestyle issues, and this concern influences their career choices.^{6,7}

Traditionally, women have assumed responsibility for raising families and maintaining the household. Today, women physicians continue to fulfil these roles, while also managing busy medical practices.⁸ To accomplish this, women physicians generally practise fewer hours than their male counterparts, work only part-time, and avoid specific specialties because they might interfere with the way they want to live their lives.^{5,6,9-11} Even now, women still perceive sex-related barriers within certain specialties and feel criticized for taking maternity leave or other family-related leave.^{6,10,11}

Although some research has been conducted into barriers faced by women physicians, more recent studies have focused on demographics and barriers within subspecialties, such as surgery, and administrative roles.^{2,6,12} Other issues noted in past studies have included the strain of playing several roles, the difficulties of getting time off, and life-work balance.¹³⁻¹⁹ In recent years, various legislative and policy changes have been made to protect both residents and practising physicians, but few studies have investigated whether these changes have helped women physicians to achieve balanced lifestyles.

The purpose of this study was to examine the experiences of women physicians, to investigate how medicine affects their careers and lifestyle choices, and to discover how women's experiences have evolved during the past 3 decades.

METHODS

This qualitative study used a phenomenologic approach and explored the experiences, ideas, behaviour, and feelings of women practising medicine. The study was approved by The University of Western Ontario's Human Research Ethics Board (review #12044E).

Drs Mobilos and Chan were medical students at the Schulich School of Medicine & Dentistry at The University of Western Ontario in London at the time of the study.

Dr Brown is a Professor of Family Medicine and Social Work at the Centre for Studies in Family Medicine in the Department of Family Medicine at the Schulich School of Medicine & Dentistry.

Recruitment

A purposeful sample was selected using a maximum variation sampling strategy that aims to illustrate the central themes that emerge from a great deal of variation across a phenomenon of interest.²⁰ Participants were chosen to reflect a range of ages; years in practice; specialties (eg, family medicine, surgery, internal medicine); marital status; and numbers of children.²⁰ Potential participants were identified from a list of women physicians currently practising at the Academic Health Sciences Centre (AHSC) in London, Ont, and through snowball sampling to locate information-rich participants.²⁰ Participants were initially contacted by telephone to establish their interest in participating in the study. Once verbal consent was obtained, an interview date and location convenient to each participant was determined. During the interviews, a letter of information was provided and written consent was obtained. Participants were recruited and interviewed until theme saturation was reached, which occurred by the twelfth interview.

Data collection

Through semistructured interviews, we explored participants' experiences, opinions, behaviour, and feelings. Questions included the following: "How important were lifestyle issues in your decision to enter medicine and your specialty?" "How does medicine affect your personal relationships?" and "How do you balance your personal and professional life?" Interviews lasted until the interviewers thought they had a comprehensive understanding of each woman's experiences. Four medical students, 2 of whom co-authored this paper (S.M. and M.C.), conducted the interviews. All 4 students participated in a training session with the third author (J.B.B.) before the study. All interviews were audiotaped and transcribed verbatim.

Data analysis

Two fundamental techniques of qualitative analysis, immersion and crystallization, were used throughout the analysis. Immersion involves researchers' complete engrossment in the data, allowing them to become sensitive to the tone, range, mood, and content of the findings during the analysis.²⁰⁻²² Crystallization is the progression and ultimate clarification of important common themes described by participants.²⁰⁻²²

In the first stage of the analysis, the researchers independently reviewed and coded each transcript, identifying key emerging themes. Next, the team of researchers met to compare coding and to develop a coding template. Thereafter, at the completion of every 2 to 3 interviews, the research team met to discuss and compare individual interpretations. Thus, both the analysis and interpretation of findings were ongoing throughout the period of data collection, which is consistent with interpretive methodology and allows emerging themes to

be identified early. Interview questions were then tailored for subsequent interviews to further expand on all themes identified to ensure they were completely understood. This process continued until saturation was achieved, which occurred by the twelfth interview, in that no new emerging themes or disconfirming evidence was coming forward by that time.²¹

Various qualitative techniques were used to ensure the credibility and trustworthiness of the analysis. The transcripts of all the interviews were analyzed individually and then by the team. Investigators kept field notes on all transcripts to outline the general perspectives of each interview. Finally, *bracketing* (a technique where investigators consciously examine personal and professional preconceptions that could influence their analysis of the data) was used.

FINDINGS

While numerous issues surfaced during the interviews, 3 dominant themes were identified: lifestyle and career choices, family planning and career trajectory, and seeking balance. The average age of participants was 42 years (range 29 to 58 years). Nine physicians were married, 2 were divorced, and 1 never married. Eight had children, ranging from 1 to 3 children, and 2 were expecting babies. The 12 physicians reflected 10 specialties (eg, family medicine, surgery, internal medicine). All were working in southwestern Ontario, and 9 were practising at the AHSC.

Lifestyle and career choices

Most of the participants described a strong link between choice of specialty and lifestyle issues. Commitment to maintaining a balanced lifestyle required certain career decisions.

When I started medical school I thought I was going to be a surgeon, and it was cardiac versus plastics I was doing electives in them and I figured out ... I wanted more in my life than just my career ... those kinds of specialties were not going to be compatible with it. So lifestyle was a huge influence.

This often meant a sacrifice in either family life or career.

So you make sacrifices as a result of [demands at work] without question, and I guess I'm okay with that because that's sort of what I really chose to do, and I guess I never really truly expected that I would have a completely normal lifestyle as a result of it.

Participants appeared to accept these sacrifices with resignation, seeing them as just a reality given the

responsibilities inherent in practising medicine: "If you're part of this noble profession you have to act nobly and ... it does mean giving up some of the things that you may have wanted to do, and I'm okay with that, for the most part." Sacrifices were often perceived as necessary at the beginning of a career: "So you have to sacrifice I think in the beginning to get where you want in the end." Participants perceived that their male colleagues were required to make fewer sacrifices and experienced less pressure to make allowances for family life.

Women spend more time thinking about their career choices as an integral part of their lifestyle, where I don't believe men do so much. They will choose ... their career almost independent of what their expected lifestyle [or] family would be.

In order to achieve balance in their professional and personal lives, some participants reduced their hours of work to increase time for parenting. One physician explained why she chose a specialty in which she could change her work schedule to fit into her life schedule, which was her first priority:

We got married just after medical school, and I knew I didn't want to be away from my husband for hours on end ... we wanted to have children ... knowing that I could choose to not be on call regularly, and I could do whatever hours I wanted Lifestyle was definitely important.

A flexible work schedule was a desire, if not a requirement, for many participants when choosing a specialty.

Lifestyle benefits, that really was probably half the reason I went into family medicine ... I can set my own office hours If we have a pool and kids, I can only work 8 to 12 in July, whereas if I was a surgeon ... OR time is dictated by the hospital, and I don't have that flexibility.

Family planning and career trajectory

All the mothers in our study believed taking maternity leave was one of their biggest challenges as they struggled to plan families and career trajectories simultaneously. The strategic planning and logistics of pregnancy were critical: "We literally took out a calendar and sort of timed it. Okay, so if we could have a child within this span of 3 or 4 months that's great If it worked here, great, and if it doesn't, then we'll stop trying." Delaying pregnancy could have an effect on future dreams of a family: "I wanted to have several children but ... it wasn't as easy as I thought it was going to be ... I had an issue with infertility. And that probably was related to the fact that I had delayed becoming pregnant."

There was no consensus among participants regarding the best time for a woman physician to get pregnant. For example, some were reluctant to become pregnant during residency owing to demands on their time: "I would never have considered having children during residency I just think it would have been very difficult ... it would just have been too much on my plate." For others, both time constraints during residency and the demands of practice were deterrents to starting families: "It's really hard to start a family as a resident; it's even hard to start a family once you're in practice. It's just hard to be pregnant and operating. It's hard to be pregnant and on call." In addition to these time barriers, participants also described the reactions of program directors during residency and colleagues once in practice: "I ended up getting pregnant just after getting into the [residency] program, which didn't make a lot of friends among the program directors ... so I certainly didn't try to become pregnant again."

Participants also described how women going on maternity leave "were ostracized basically within their program for taking time off to have children." Despite current policies and legislation supporting maternity leave, participants felt "a silent disapproval." Five of our participants completed residency training after policies entitling residents to maternity leave had been implemented. Despite this, all 5 consciously chose to postpone pregnancy until they had completed their training. As 1 of these 5 women stated, "It wouldn't have even crossed my mind People do it, but I don't think personally I would have been able to handle it." Another participant reflected on her decision to postpone pregnancy: "It's all being delayed by it I'm reproductively old, and I just wonder if it was worth it."

Once in practice, participants noted how often women physicians were judged not by their competence and knowledge as physicians, but by their sex: "Some women aren't looked at well in their professions because it's assumed that they'll be taking time off for maternity leave, that they're never really as committed as their male counterparts." They also described how news of a pregnancy, which should have been celebrated, was often met with resentment: "On the surface the news of my pregnancy went over very nicely ... but I think that there was really also an undercurrent of resentment."

Seeking balance

All the participants clearly articulated that their main struggle was how to achieve a balance between their personal and professional lives. They often faced multiple demands: "There are family demands, professional demands, academic demands. It's really hard to be good at everything." Failure to achieve balance was reflected in emotional distress: "A lot of the time there isn't balance. It's sad to say, but it's true ... I get really stressed, and frustrated, and upset." Some participants expressed

deep concern about what might happen if balance was not achieved.

I think that's what leads people to drinking, to drug abuse, to depression, to suicide ... because we all forget about ourselves, we get so caught up in the job and everyone else's expectations, and you know, you lose yourself and that's not healthy.

Other participants described their perpetual struggle to manage their conflicting demands and roles. One said, "I'm running myself ragged trying to keep both going at the same time." Another explained, "It feels like being on this big gerbil wheel of just go, go, go." Balancing their numerous roles was a continuing struggle:

If we're 80% good at everything, 80% good mother, 80% good doctor, and 80% good wife, add it all together, that's working 240% of the time instead of just 100% ... in my household, I do carry a bigger weight of child care, of wife-ing, of mothering, getting the groceries, of doing the laundry.

Participants thought that their male colleagues failed to appreciate the multiplicity of roles faced by female physicians.

It's such a male-dominated group ... they'll come up to me and ask "How was your weekend?" and I'll tell them, well I did laundry and I did the groceries, and they don't know how to respond to that because they're not doing that, they have a wife at home who is.

DISCUSSION

The findings of this study clearly demonstrate the challenges faced by women in medicine. Participants' stories revealed 3 central and interconnected themes: lifestyle and career choices, family planning and career trajectory, and seeking balance. While a greater proportion of women are entering Canadian medical schools these days, the fundamental challenges facing women physicians remain unchanged since the mid-1970s.¹³⁻¹⁸ Our findings suggest that 3 decades later there have been few changes in the type and amount of strain female physicians experience in their multiple roles.

Achieving personal and professional balance is a difficult task for all physicians. For women, however, it is made more difficult by their responsibilities at home.²² Most participants in this study perceived that male physicians do not carry the same amount of responsibility at home, making it much easier for them to succeed in a time-demanding field such as medicine.

To help women deal with these multiple demands, participants emphasized the importance of flexibility on the job. As several participants stated, and as found in previous studies, the flexibility offered in family practice is one of the reasons more women physicians than men physicians enter the discipline.^{23,24} Expectations vary tremendously within specialties, and many women choose specialties based not only on their passion for that field, but because of the lifestyle it offers. This is also illustrated by the fact that the number of women applying to surgical specialties has not increased proportionally in relation to the increase in the number of women entering medical school.^{25,26}

A pervasive problem documented since the 1970s is the timing of pregnancies, the challenges of maternity leave and child care, and the effects of these responsibilities on mothers' career trajectories.^{3,19,27-32} Academic institutions do not support pregnant physicians adequately, and, as a result, parents take insufficient leave, despite current legislation.^{33,34} A survey of Ontario's medical faculty members showed that women felt guilty about taking maternity leave because it would increase their colleagues' workloads.³⁵ It is noteworthy that all 5 of our newly graduated participants consciously chose to postpone pregnancy until they had completed their training because they still thought that pregnancy and maternity leave would receive silent disapproval from most of their colleagues. A potential solution to this problem might include guaranteed temporary replacement staff for physicians on maternity leave.

Most participants in our study perceived there was a lack of resources for child care. Despite the substantial increase in the number of women physicians, hospitals have yet to provide adequate support for female physicians with children. Most institutions fail to acknowledge today's dual-career parents; they rarely have on-site day-care centres, and they offer little opportunity for flexible scheduling or job sharing for their staff.¹⁹

All our participants described the constant struggle they experienced to balance their personal and professional lives. This is worrying because research demonstrates that a lack of balance is associated with decreased job satisfaction and leads to stress both inside and outside the workplace.³⁶ This stress can result in burnout, illness, and relationship difficulties.^{36,37} All these have important implications, as women physicians have been more likely than their male counterparts to report addictions or to commit suicide.³⁸


Limitations

Since only 1 AHSC was sampled, our findings might not be similar to those that would be found in other centres. Readers need to be cautious in interpreting the findings because our sample had only 3 community-based family physicians. All our participants, however,

shared the common experience of having been medical students and residents. While we had only a few doctors from each type of specialty, saturation of themes was achieved by the twelfth interview.

Future research could compare the opinions of female medical students and residents with those of practising women physicians. Having identified some of the issues faced by women physicians in this qualitative study, a more comprehensive study using a survey design might be warranted. Such a study could access more physicians and could allow for comparisons across specialties. A more in-depth analysis investigating how new policies on maternity leave and benefits affect the timing of physicians' pregnancies is also required. Male physicians' perspectives on their balance between work and family life should be explored, as maintaining a balanced lifestyle has become more important in society as a whole.

Conclusion

Our findings illustrate how, despite the increased number of women medical students and practising physicians, the experiences and challenges faced by these women have not evolved accordingly during the past 30 years. Women physicians continue to experience strain in their many roles, discordance between career and lifestyle choices, and difficulties in timing pregnancies. Changes to legislation regarding maternity leave have been made; however, it is the profession's responsibility to ensure that its members are given the opportunity to benefit from these changes. Given our findings, it is clear that female physicians require more on-site day-care centres, more flexible scheduling, the option of job sharing, and replacement staff when they are on maternity leave. 

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Contributors

Dr Brown supervised the conception and design of the study, contributed to data analysis and interpretation, and helped prepare the manuscript for submission. **Drs Mobilos** and **Chan** conceived and designed the study, conducted the interviews, contributed to data analysis and interpretation, and prepared the manuscript.

Competing interests

None declared

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