

‘Making up for being female’

Work-life balance, medical time and gender norms for women in the New Zealand senior medical workforce



HEALTH DIALOGUE

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Clodie Abbes



Executive summary

This *Health Dialogue* reports on an in-depth semi-structured narrative interview study conducted with 14 women aged between 30 and 40 who, at the time of the research, were members of the Association of Salaried Medical Specialists (ASMS). The ASMS represents medical and dental specialists and other non-vocationally registered doctors and dentists employed primarily by New Zealand's 20 district health boards.

Research published by the ASMS in 2016 found women aged between 30 and 40 had the highest prevalence of burnout, with 71% of those surveyed scoring as likely to be experiencing burnout as measured by the Copenhagen Burnout Inventory. Due to the limitations of the original quantitative methodology, it was not possible to interrogate the reasons for this statistic. Consequently, a qualitative study was designed to probe this finding in appropriate depth. This *Health Dialogue* reports on this qualitative study, which presents an in-depth window into the everyday lives of women in their thirties working in the New Zealand senior medical workforce.

The key question driving this research was to understand why women in this age cohort were disproportionately affected by burnout. Analysis of the interviews revealed commonalities of experience which the research suggests shape their propensity for burnout in significant ways. Against a background of increasing patient demand, growing workloads, and short-staffing, this research examines particular aspects of the culture of medicine and how they shape propensity for burnout. By exploring the lived experiences of these women, this *Health Dialogue* demonstrates how key aspects of medical culture are gendered and continue to restrict equity of experience and opportunity for women as well as circumscribing their capacity to achieve well-being in subtle yet pernicious ways.

This *Health Dialogue* is divided into three main sections. The first section sets out the theoretical framework for the study. It defines key terms, presents relevant literature pertaining to gender and medicine, and explains the research approach to the study.

The second section presents the findings from the research by focusing on three key themes emerging from the qualitative data. These themes are summarised as work–life balance, medical time, and gender stereotypes in medicine. For each of these themes, I briefly summarise pertinent sections of interviews before discussing the findings with reference to key literature and concepts. The themes are summarised as follows: first, participants described significant stress in balancing the expectations of medicine with the practical realities of having domestic commitments, including having children. Discussions in this regard touched upon issues of meeting both work and personal or family obligations, feeling torn between demonstrating commitment to medical work and meeting the needs of family and/or self, and the significant challenges facing doctors who have children. Second, implicit in the discussions concerning the balance between work and home were issues concerning medical workloads, difficulties completing work in allocated working hours, challenges finding time for domestic and personal commitments, and concerns for how working less than full-time was perceived. These issues were collectively summarised as pertaining to time, with analysis focused on how temporal issues were narrated by the women interviewed, and what these accounts serve to reveal of temporal norms in medicine. Implicit in much of these accounts were temporally inflected constructions of medicine as vocation rather than 'job' and associated ideals of commitment and professionalism. Finally, flowing through all the themes were significant yet latent gender stereotypes emphasising the gendered nature of medical culture and the influence of pervasive



gender schemas on professional and personal commitments. This final theme attempts to focus explicitly on the significance of gender in structuring daily interaction with patients and colleagues, the role of gender in perpetuating micro-inequities in medical careers, and how gender continues to shape the lived experiences of women in medicine in subtle ways yet with cumulative consequences for well-being.

The third section concludes by proposing potential solutions and key considerations as to what may need to change to improve the well-being of the medical workforce overall.

This work builds upon ongoing ASMS research which continues to document the extreme workload pressures many of our members are facing (ASMS, 2019a). While these issues are not the explicit focus of this enquiry, this emphasis on aspects of medical culture should be understood as part of a wider matrix of factors which intersect and layer to influence the capacity for well-being of the senior medical workforce. Work conducted

by the ASMS continues to document the significant and growing demand for health services and the significant discrepancy between this health need and future projected specialist workforce numbers (ASMS, 2019b). It is well recognised that New Zealand continues to have a high reliance on international medical graduates as well as issues with poor specialist retention (ASMS, 2019b). The issues detailed in this *Health Dialogue* intersect with these growing structural issues and pressures. This work matters if we are serious about making New Zealand's public health system the workplace of choice for New Zealand graduates and international medical graduates in an increasingly competitive medical skills market. Accordingly, this work is designed as a call for change and an encouragement to address the issues raised with appropriate sensitivity and care. As recent work from the British Medical Association (BMA) supports, addressing cultural change in the workplace will pay dividends in terms of elevating the significance of staff well-being, with respect, compassion, and inclusion recognised as vital cornerstones of high quality patient care (BMA, 2019).

Introduction

Freudenberger (1989) described burnout as the disease of the over-committed, resulting from extreme work demands, workloads, and time pressure. In medicine and other professional settings, burnout is commonly ascribed to high job demands coupled with low control, feeling under-valued or treated unfairly, and a state that can result from a disconnect between individual values and organisational priorities (Kane, 2019). For those working in medicine, there appears to be a confluence of circumstances making this occupational group one of the most affected by burnout worldwide (Rossler, 2012; Shanafelt et al., 2012). What is less commonly articulated are some of the possible cultural drivers of burnout. Against a backdrop of increasing workforce pressures, growing clinical demands, and a burdensome administrative load, what aspects of medical culture may also unwittingly contribute to burnout, and what might need to change?

Recent Association of Salaried Medical Specialists (ASMS) research found that over 50% of senior doctors and dentists surveyed screened as positive for burnout using the Copenhagen Burnout Inventory (CBI). Analysed by gender, women were found to have significantly higher rates of burnout overall, with the highest proportion found in women aged 30–39 (70.5% overall burnout) (Chambers et al., 2016). Being female also significantly increased the odds of scoring ≥ 50 for personal and work-related burnout by 2.1 and 2.6 times respectively. The trend for women to have worse burnout scores than men held when cross-cut with age and self-rated health status.

In addition to this burnout research, two other pieces of ASMS research found that women were also more likely to work through illness when unwell enough to be on sick leave (Chambers et al., 2017) and were more likely to self-report as bullied than their male counterparts (Chambers et al., 2018). Combined, this data suggests that the well-being of women in the New Zealand senior medical workforce is at risk. What is unclear is why.

Common sense explanations?

At first glance, the reason for the spike in burnout for women in their thirties appears obvious; this is when doctors begin to consolidate their years of medical training and make the transition from registrar to specialist. The thirties may also be a key

period of change and upheaval because of personal circumstances around this time, including having children, entering long-term relationships, or taking on domestic responsibilities such as caring for parents. Analysis of the qualitative comments left by respondents in the original study reinforced this notion that burnout rates reflect career and life stage issues. Women may be grappling with pressures posed by their domestic situations, especially if they have children. Other research supported these assertions; the overall conclusion was that the higher propensity for burnout may reflect the pressure of establishing professional careers as well as tensions between home and work life that may manifest at this life stage (Kamal et al., 2016; Norlund et al., 2010).

As others have pointed out, however, not all burnt-out women in their thirties will have children, and not all burnt-out doctors will be women (Greenberg, 2017). Why is it that women in this demographic are disproportionately affected? Alongside ‘common sense’ explanations, other research suggests that connections between life stage, gender, and burnout may reflect issues with the culture of medicine. Comments from the ASMS study on presenteeism, for example, emphasised the ‘hidden curriculum’ in medicine, and tensions between colleagues’ expectations and domestic commitments. As some authors have noted (see for example Ozbilgin et al., 2011; Tsouroufli et al., 2001), assumptions about what constitutes ‘ideal’

medical practice is interwoven with expectations of extensive temporal availability for work which can have significant unanticipated consequences for those who seek space and time to care for themselves or others. This notion was referenced explicitly by one respondent who stated:

“For me, the hardest part of being a female in the medical workforce is resisting the notion that we should work in our own time to keep up with our paperwork. Family and childcare commitments mean that I can’t work from home in my own time and, quite frankly, I won’t allow myself to fall into that habit. This is something that some of my more ‘senior/old school’ colleagues don’t seem to agree with or understand.”

The respondent also stated that the tensions perceived between the need and expectation that she will keep up with work in her own time, combined with burgeoning administrative workloads, resulted in her feeling ‘one step behind’. The focus of this research is accordingly a fine-grained examination of the factors that may give rise to these expectations regarding ideal working practices, tensions between medicine and personal lives, and the role that latent gender norms play.

This work builds upon previous ASMS research documenting the extreme workload pressures many of our members are facing (ASMS, 2019a). While these issues are not the explicit focus of this enquiry, this emphasis on aspects of medical culture should be understood as part of a matrix of factors that intersect and layer to influence the capacity for well-being in the senior medical workforce. Work conducted by the ASMS continues to document the significant and growing demand for health services and the significant discrepancy between health need and future projected specialist workforce numbers (ASMS, 2019b). It is well recognised that New Zealand continues to have a high reliance on international medical graduates as well as poor specialist retention (ASMS, 2019b). The work–life tensions detailed in this *Health Dialogue* intersect with these structural issues and pressures. This work matters if we are serious about making

New Zealand’s public health system the workplace of choice for New Zealand and international medical graduates in a competitive medical skills market. Accordingly, this work is a call for change and an encouragement to address the matters raised with appropriate sensitivity and care. As recent work from the British Medical Association (BMA) supports, addressing cultural change in the workplace will pay dividends in elevating the significance of staff well-being, with respect, compassion, and inclusion recognised as vital cornerstones of quality patient care (BMA, 2019).

Despite what may seem like a focus on a negative set of issues and concerns, it is vital to recognise that women are continuing to have a major positive impact on medicine. Their growing presence is resulting in a long overdue move towards gender balance in the composition of the New Zealand senior medical workforce. While much of this *Health Dialogue* is dedicated to exploring and describing the often negative experiences of the women interviewed, the intent is not to reinforce a sense of women as victims, ‘others’, or irrevocably marginalised. As Pringle (1998, p3) states:

“Women doctors are simultaneously a part of (patriarchal) medicine and placed outside it, their presence in large numbers necessarily a destabilising one ... If the masculinity of the medical profession rests on a binary opposition between ‘women’ and ‘medicine’, then ‘women doctors’ constitute the third term which undermines its functioning.”

Moreover, it is not my intent to suggest that women require special or additional treatment or to inadvertently reinforce the notion that women will continue to face challenges on the basis of their gender (Liang et al., 2019). Indeed, as I will go on to explain, some of the issues that I raise will resonate with male doctors too, particularly if they strive for work–life balance or seek to be an equal participant in domestic and/or parenting responsibilities.

Finally, significant attention is paid in this analysis to the challenges faced by women who are doctors and parents. As Caprice Greenberg

exhorts us to remember, parenting, and work–life balance are critical for all doctors, regardless of gender or parenting status. Moreover, as she emphasises, it is not acceptable to continue to focus on issues of parenting in ways that reinforce problematic gender stereotypes by suggesting these are only issues of concern for women. There are other complex issues at play which are not simply reducible to whether you have children (Greenberg, 2017). Nevertheless, as I will describe throughout this *Health Dialogue*, it appears that there are persistent issues faced by women in medicine that are specific to their gender, and in particular, the way in which medicine has evolved as a professional field with clearly gendered values, expectations, and practices. To situate my analysis, the following section briefly traces the history of women in medicine before outlining key theoretical concepts that ground this research.

‘Lady doctors’

According to the 2017 workforce survey published by the Medical Council of New Zealand, 44.8% of the New Zealand medical workforce are women, up from 43.9% the previous year. In addition, the numbers of women graduating from New Zealand medical schools are reported to be higher than the numbers of men, while the Medical Council of New Zealand estimates that women will outnumber male doctors by 2025. Recent demographic data from ASMS surveys suggests the proportion of women in the senior medical workforce is steadily growing; data from the 2006 salary survey found the proportion of women at around 28%, with this having grown to 39.5% by 2018 (the numbers of specialists and medical and dental officers combined).

These trends for the increasing participation of women in the medical workforce are not restricted to New Zealand; indeed, most countries report a growing number of women working in medical fields. In the United Kingdom (UK), for example, the

number of female medical and dental staff working in the National Health Service (NHS) increased by 74% over the decade from 1999 to 2010 (NHS, cited in Walsh, 2013).

The current growth of women in medicine belies the historical struggles women have faced in medicine. In the past, women were actively prevented and discouraged from medicine. Elizabeth Blackwell’s 1847 entry into medical school in the United States (US) resulted from a practical joke by the male student body at the time¹ (Wietsma, 2014). In New Zealand, Emily Siedeberg was the first woman to enter the University of Otago in 1891, and while her entry into formal medical training was not reported to be controversial, she had to contend with significant negative behaviour from her male peers. As Page (2008) cites in her history of the University of Otago Medical School, a laboratory assistant recalled that the male students “did not want lady doctors and the lady students have to thank Miss Siedeberg for her pluck in making way for them... The young men would throw the flesh at her every chance they got.” (p50).

Women like Siedeberg who paved the way for other women to study in medicine were viewed as ‘lady doctors’, interlopers in a highly masculinised field who refused to take no for an answer but were marginalised by male peers and by society (Australian and New Zealand College of Anaesthetists, 2019). The hostility directed towards those who dared to enter a field where there was ‘no place for women’ is well illustrated in the views of a ‘Dunedin medico’ who wrote in to the *Otago Medical Review* in 1891 querying, “Why should a woman unsex herself by giving way to a morbid craving which can only be likened to an epidemic of insanity?” (cited in Page, 2008, p49).

Understanding the significant sexism and misogyny faced by early women pioneers in medicine provides important context for this work. The extreme resistance faced by women seeking to enter

1 Apparently Elizabeth Blackwell’s application for entry into Geneva Medical College in New York was voted on by the male student body at the time who unanimously accepted her application assuming it was joke.

medicine was concurrent with the construction of medicine as a masculine field and the valuing of specific traits and qualities which were also coded as masculine. Men, not women, were viewed as fit to study and practise medicine because only they were thought to be imbued with the requisite characteristics for medicine, which included rationality, objectivity, authority, physical and mental strength, decisiveness, and competitiveness (Davies, 2003). By contrast, women were constructed as the bearers of feminine qualities, 'naturally' suited to domestic duties, caring, and empathy work.

Nursing in particular was actively constructed as "distinctly women's work", as women were deemed "peculiarly fitted for the onerous task of patiently and skillfully caring for the patient in faithful obedience to the physician's order" (*Hospital* 8 July 1905 cited in Garmanikow, 1978, p110). By contrast, those women who sought medical training were vilified for going against the character of their sex and disrupting the 'natural order'. A petition from male students at Harvard Medical School in 1850 stated, "We object to having the company of any female forced upon us, who is disposed to *unsex herself*" (Perrone et al., 1993, p128, emphasis added). This disturbance of the so-called natural gender order resulted in the likes of William Osler, the 'father' of modern medical training, infamously stating that "there are three classes of human beings: men, women and women physicians" (Lopate and Macy, 1968, p178).

Women no longer face the same degree of explicit gender bias experienced by Siedeberg and her peers, and yet the move towards gender equality in the composition of the medical workforce has not translated into equity of opportunity or experience for women. In her review of the status of 'women doctors' in 1987, Barbara Heslop (1987a) suggested the gendered differentials in specialist qualifications, medical teaching posts, and income opportunities were unlikely to improve significantly in the near future. As she stated:

"The current system of postgraduate training effectively culls many of the women who choose to have children before they have gained a postgraduate qualification by severely limiting their subsequent career options. The same system encourages medical women to have their children late, and almost certainly deters some women doctors from having children at all ... The conclusion seems inescapable that the trainees of the immediate future will continue to be cast in the same mould as their mentors." (Heslop, 1987a, p224)

While Heslop's suggestions included the tongue in cheek recommendation that women who aspire to be surgeons would be well advised to acquire a wife (Heslop, 1987b), her articles emphasised the manner in which women doctors, including those without children, "are to some extent handicapped by domestic obligations" (Heslop et al., 1990, p255). More recent research documents the persistence of other drivers of inequity; for example, research by Files et al. (2017) found that women presenting at Grand Rounds in the US were less likely to be introduced as 'doctor' than their male counterparts. Another study into the representation of women in medical leadership roles found that there were more moustachioed men at US medical schools than women (Wehner et al., 2015). Only six out of twenty specialties were found to have more women than moustaches.

Such research contributes to the wider literature concerning the vertical and horizontal segregation of women in medicine. It documents the persistence of significant gender differences in the composition of medical specialties, underrepresentation in leadership and managerial positions, distinct differences in career progression, and the persistence of gender-based pay gaps,² all of which negatively affect women in comparison to their male colleagues (Boulis and Jacobs, 2008; Riska, 2008; Wallace, 2014). The gendered distribution

2 The ASMS is undertaking work through the Motu Economic and Public Policy Research Unit to establish whether and the degree to which such a gender-based pay gap exists in New Zealand.

of doctors by specialty has been explained in individual, institutional, and structural terms. For example, NHS data from the UK demonstrates that women are well represented in the medical fields of general practice, paediatrics, and dermatology, a differential ascribed because of women seeking medical specialties offering “regular and predictable working hours” which can be readily balanced against non-work activities, including domestic commitments (Crompton and Lyonette, 2011). Data collected in ASMS surveys shows women outnumbering men in the fields of sexual health medicine (77%), family planning (60%) and public health medicine (53%), and findings from the 2017 Medical Council of New Zealand workforce survey show women outnumbering men in the specialties of obstetrics and gynaecology, paediatrics, public health medicine, and general practice (Medical Council of New Zealand, 2017).

By contrast, one specific field of medicine where women remain poorly represented is surgery. In Australasia, for example, the proportion of women fellows of the Royal Australasian College of Surgeons is currently only 12.6% (Lai, 2018). The Medical Council of New Zealand estimated in 2017 that 10.8% of surgical specialists are women. The persistence of this significant gender imbalance is complex, and, as I discuss in my analysis, is at least in part due to the persistence of gendered stereotypes which act as barriers for greater participation of women in the field. Furthermore, despite significant efforts to encourage greater numbers of women in medicine, Pringle (1998, p73) suggests that “equal opportunity measures alone will not be effective until there is a shift in the wider cultural and social meanings of surgery which enables it to be seen as an appropriate field for women”. Combined, the literature suggests that gender bias remains a significant driver of inequality (Files et al., 2017) while remaining a poorly understood and often under-recognised challenge for women in medicine today (Webster et al., 2016).

Theorising gender

Throughout this *Health Dialogue* I refer to the concept of gender. As used in my writing, unless specified otherwise, gender is defined as the ongoing social construction of what is considered female and male in terms of how people identify to themselves and others. Understanding gender as a social construction also brings into consideration power relations and sociocultural norms which tend to suggest innate differences between men and women based on a dichotomous framework (Massey, 1994). Gender is thus used to refer to a dynamic set of social, cultural, and historical constructions of masculinities and femininities which are not stable, but constantly evolving (McDowell and Sharp, 1997). Building upon the work of Judith Butler (1990) and others, gender is theorised in this analysis as inherently mutable, constantly under negotiation and something which is performed within a social context; “an ongoing activity embedded in everyday interaction” (West and Zimmerman, 1987, p130).

Conceptualising gender in this way is important and useful for the current study as it enables attention to the ways gender identities are formed as a consequence of social interactions, in particular socio-historical contexts (Emslie and Hunt, 2009). In the context of this study, using a performative theory of gender enables a closer analytic focus on how gender identities are reinforced by medical culture as well as how constructions of gender have worked alongside and with the formation of the professional identity of ‘doctor’ and with the professionalisation of medicine over time. As with other scholars examining gender in the medical profession, this theoretical approach enables a deeper understanding as to how the professional identity of a ‘woman doctor’ is constantly being re-made and negotiated in response to individual experiences, as well as medical culture and gender schemas (see below) more broadly (Babaria et al., 2012). This theoretical lens enables a deeper understanding of the relationship between gender and medical culture, and in particular, how and why gender in medicine matters in particular ways and with specific consequences.

Gender schemas

The gendering of certain traits, qualities and abilities, and the manner in which these shape expectations as to how men and women ought to behave, are defined in this Health Dialogue as gender schemas. As explicated by Valian (1998), gender schemas are the frameworks for interpreting behaviours and abilities based on the perception of gender-based differences. For example, based on the generalisation from observation of physical sex-based differences between men and women, women are expected to be nurturing, emotional, and communal in contrast to men, who are considered agentic, action orientated, and competitive. Failing to behave in congruence with gender schemas has consequences; both men and women are penalised for failing to act in accord with expectations concerning gender roles. Significantly, as authors such as Valian have sought to demonstrate, gender schemas have served to advantage men and disadvantage women, particularly in professional settings where men are viewed as better suited and constructed as 'natural' leaders. For example, an online review of Valian's work describes the following case in point:

"Even something as ordinarily uncontrolled as who looks at whom during a conversation – at whom does the speaker look? for how long? at whom does the listener look? for how long? – are loaded with gender and other schemas (schemas of power, for example). And even with such simple actions what is approved of in men can be disapproved of in women. In particular, the subtle signals that are interpreted positively as signs of leadership in men are often interpreted negatively in women because of conflicts with the gender schema for women, so it becomes very difficult for women to be seen as leaders." (Roitman, 1999)

Understanding the role of gender schemas in perceptions of gender-based differences is vital; without recognising the social construction of gender schemas, perceptions of gender-

based differences may be deemed 'natural' or 'inherent'. In the context of medicine, for example, suggesting there are inherent differences in the abilities of men and women can translate into problematic assertions to explain differentials in performance, ability, and aptitude (Davies, 2003). In some instances, such perceptions of difference have served women well. For example, there is considerable research to suggest that women may make better doctors because of their ability to be empathetic and listen to patients (Baumhäkel et al., 2009; Berthold et al., 2008). On the contrary, however, consider the assertions from a male surgeon writing in *The Lancet* who dismissed low numbers of women in surgery as a consequence of inferior biological and psychological aptitudes:

"Female house surgeons are not as tolerant of sleep deprivation and are more prone to succumb to exhaustion than their male counterparts ... some aspects of surgery ... demand a certain attitude of mind and level of confidence ... such qualities may be to some extent gender dependent in favour of the male psychological constitution." (Benson, 1992, p1361)

Taken to its logical extreme this can lead to the conclusion that differences in the gender composition of specialties are simply due to gender-based propensities founded in biological difference rather than a consequence of gender schemas or subtle gender bias. Appeals to such biological discourse are further problematic as imputing that such differences are 'natural' rather than culturally determined can remove any imperative to change (Davies, 2003; Pringle, 1998).

The other key perspective from a focus on the social construction of gender and the power of gender schemas is to demonstrate how certain qualities and traits which continue to be valued in medicine today are gendered in their origins and, further, serve as 'silent organisers' (Keller, 1992) of what constitutes appropriate comportment, skills, and practice in medicine. Authors such as Davies and Greenberg have sought to demonstrate how the preponderance of masculine ideals, values,

and behaviours that infuse medicine is one of the key reasons women face uneven advancement in medicine today. As Davies describes:

“One of the reasons why women doctors may find their position problematic [is because] they have to find space in an area that has already been defined by masculinist ideas and where values and behavior, that women doctors may feel are a part of their own constructed femininity, are questioned.” (Davies, 2003, p725)

Perhaps most significantly, given the focus of this study, I follow other scholars in understanding medicine as a professional field inextricably linked with the construction of a specific set of gendered values, traits, and characteristics (Jefferson et al., 2015; Kaatz and Carnes, 2014; LaPierre et al., 2016). Moreover, while medicine has democratised and evolved considerably, it is important to attend to the manner in which certain traits and qualities remain valued and emphasised in contemporary medicine and the consequences of this differential valuation. For example, the change in the proportion of women entering medicine is frequently referred to as the ‘feminisation’ of medicine. It is not uncommon to specify ‘women’ doctors. Implicit in both the reference to the feminisation of medicine and the (pejorative) term ‘women doctors’ are strong power relations which in part may explain why the growing equality in numbers is not readily translating into equality of or equity in experience (Babaria et al., 2012). Again, following interventions of other scholars in this field, I approach this study by taking a sceptical approach to these terms and labels by considering how they may serve to posit women as ‘others’ in the implicitly masculine field of medicine in significant and power-laden ways.

Consequently, given the focus on understanding the discrepancy in indicators of well-being for women in the senior medical workforce, the primary focus of this study is how women themselves articulate their experiences as doctors and what is revealed by their explanations as a form of discourse. A focus on discourse

focuses attention on the language describing individual experiences, while simultaneously understanding such language as both constructed and constructive. Individual experiences and the way they are described are taken to be reflective of broader social processes and the ebbs and flow of power (Foucault, 1972; Pringle, 1998). As a consequence, my approach to individual experiences as articulated in the context of interviews with the women in this study considers how they shape and are shaped by institutional medical culture as well as expectations reflecting standardised associations of how women ‘ought’ to behave in particular contexts (Babaria et al., 2012; Phillips et al., 2016).

Accordingly, a final emphasis underpinning the analysis in this study is a latent focus on power and power relationships in defining, constructing, and shaping the experiences of individuals in medicine. As many others have demonstrated, medical culture is a product of learned behaviours and values; becoming a ‘doctor’ involves far more than the acquisition of technical skills and knowledge, it requires learning how to “play the part of [doctor] in the drama of medicine” (Becker et al., 1961, p4). Again, using the Butlerian lens of performativity, becoming a doctor and, specifically, learning how to perform the identity of a ‘woman in medicine’ is understood in this analysis as a consequence of navigating a complex series of relationships and encounters with peers, patients, and other medical colleagues, all of which involve flows of power (Pringle, 1998). Focusing on the way individuals articulate key relationships and encounters in their personal histories provides a fine-grained understanding of power relations. In the context of my focus on well-being, this is vital to understanding the differential experiences of women in medicine in this research.

Approach to the study

Research participants

Participants for the study were recruited with adverts in the ASMS magazine *The Specialist* and in the then newly established 'Women in Medicine' Facebook page. While the original motivation for the study was exploring propensity for burnout, the adverts sought women in their thirties who were willing to speak with me about their experiences of being a woman in the New Zealand medical specialist workforce. Initially, expressions of interest were received from 30 women, but due to various time-related circumstances and eligibility issues (for example, not all were members of the ASMS at the time of the research), 14 of

these women were interviewed by the close of November 2017.

The women interviewed came from a range of different-sized district health boards (DHBs) and geographical locations and worked in a range of medical specialties, including three surgical sub-specialties. Key demographic information from the participants is detailed below in Table 1. All but two women were of European descent, and one had received their primary medical qualification from an overseas university. Ten women were married at the time of the interview. Participants were not asked about their sexual orientation. Due to concerns for anonymity, I have taken care to not specify place of work or medical specialty in the responses, but for some, their specialty is more obvious than others.

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF RESEARCH PARTICIPANTS

INTERVIEWEE	LENGTH OF INTERVIEW	DEPENDANTS	AGE	FULL-TIME EQUIVALENT (FTE)
1	2:17:40	2 children	37	1
2	1:19:40	2 children	37	0.6
3	1:56:06	None	37	1.67
4	1:39:52	2 children	40	0.65
5	1:04:27	2 children	36	0.9
6	1:09:00	1 child	35	1
7	1:31:56	3 children	40	1.25
8	1:37:21	3 children	34	0.7
9	1:30:10	None	40	0.9
10	1:34:29	2 children	34	1
11	1:32:30	None	39	1
12	1:31:21	1 child	36	0.8
13	1:36:19	1 child	37	1
14	2:07:27	2 children	36	1
Total hours: 22:26:18				
Average length of interview: 1:36:10			Average age: 37	Average FTE: 0.96

Research process

Written information outlining the purpose of the research was distributed to participants in advance of meeting, and written consent was sought for their participation. A formal ethical consent process was approved by the New Zealand Ethics Committee. All participants were required to sign a consent form containing an explanation as to how the data would be stored, transcribed, and used. An independent transcriber was engaged and was also required to sign a confidentiality agreement pertaining to the data she was transcribing.

The interviews were designed as a narrative-based exploration of individuals' personal and professional histories. Interviews were guided by a series of open-ended questions which were designed to elicit in-depth reflections on core issues pertaining to well-being, gender, and medicine. Interviews generally started by asking participants to describe how they came to work in their particular field of medicine, and key decisions or moments they recall that shaped their professional careers. Interviews touched on such issues as choice of specialty, feelings concerning work–life balance, reflections on whether and how gender had shaped career and personal choices, and thoughts concerning high rates of burnout for their gender and age cohort. Additional questions touched on notions of what they felt it meant to be a good doctor in their specialty, advice for future generations of women coming through the system, and what brought them joy and pleasure in their current situation.

Interviews were all conducted face-to-face at a place of the participant's choosing. Locations ranged from the participant's home to cafes in proximity to places of work. Fieldnotes were taken at the time of the interview, and reflections were written up after each encounter. All interviews were recorded on both iPhone and Dictaphone. The recorded interviews ranged in length from one hour to over two hours duration, but in some instances I spent over four hours with the women as they negotiated childcare and domestic affairs.

Interviews were professionally transcribed with in-depth reading and preliminary analysis of available transcripts conducted concurrently with ongoing

data collection. This enabled a sense for issues and areas that needed further attention in subsequent interviews and enabled a sense of when the research was nearing theoretical saturation point. The attainment of theoretical saturation point was defined as the point at which no new thematic issues were arising in the context of the interviews (Saunders et al., 2018, and see below).

The interviews were transcribed in full, with attention paid to pauses, repetition, emphases, and laughter. This approach to transcription focused attention on the non-spoken and implied meanings of pauses and hesitations, giving the reader a sense of the moments of hesitation and emotion. Comments selected for inclusion in the final report were those that best expressed the themes. Comments were transcribed directly, and where sections were omitted, ellipses ('...') were used to signify the break. Any words replaced or altered to preserve anonymity or correct for tense or sense are noted within square brackets ('[]'). Questions asked by me are identified by the initials 'CC'.

Initially, all interview transcripts were read in-depth, with particular sections of text highlighted and coded according to common ideas or themes emerging from the conversations. This initial iterative and emergent coding process was based on an approach to coding where it was understood as a process to "expand, transform and reconceptualize data ... in order to interrogate ... to try to identify and speculate ... [to go] beyond the data" (Coffey and Atkinson, 1996, p29–30). Coding was initially performed by highlighting and annotating key sections of transcript in hard copy form before moving to NVivo (version 11). As the research progressed, this initial wide range of themes was whittled down into broad descriptive ideas (see Figure 1) which were further refined into core themes supported by analysis of relevant literature and key theoretical perspectives (see Figure 2). The material and final analysis was further refined by a series of presentations throughout 2018 on preliminary analyses of the material and feedback from colleagues and members.

FIGURE 1: INITIAL THEMES

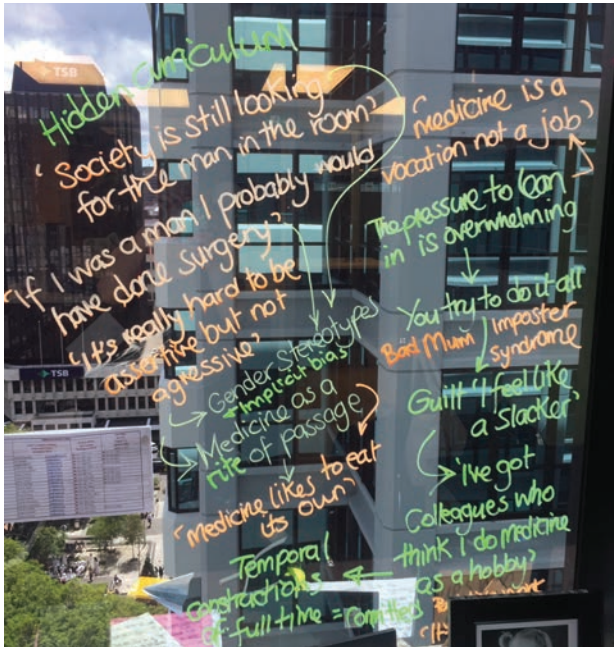
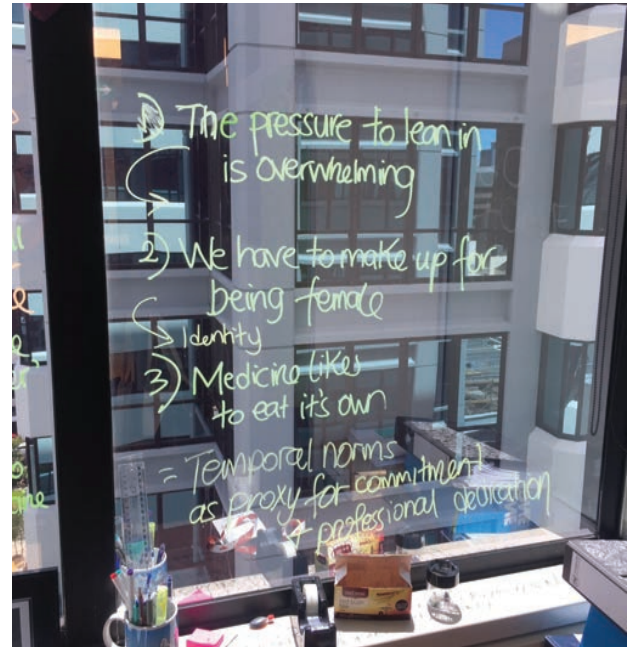


FIGURE 2: REFINED DESCRIPTIVE IDEAS



My role as researcher: “You ask questions like a mum would”

My positionality as a professional woman of the target age group working for the union of these medical professionals was not insignificant to the research process. My own experience combining motherhood with an academic career was particularly helpful in connecting with some of the women who were also parents and enabled me to explore certain issues in significant depth. As one participant commented, “You ask questions like a mum would.”

During interviews, I found myself sharing personal information where relevant to the topic and discussing commonalities of experience. I was also at times deeply affected and found myself reflecting on my own choices and decisions in my professional and personal contexts. The connections and commonalities of experience shaped the research process and outcomes in significant ways, and methodologically it is important for me to acknowledge and reflect on how this research was constructed.

Qualitative research has significant epistemological and ontological distinctions to quantitative

research; in particular, the assumption that in order to achieve ‘rigor’, it is necessary for the researcher to remain objective, disembodied, and ‘neutral’. By contrast, in qualitative research it is imperative to acknowledge and ‘write in’ the way research is produced as a mutual exchange of views and is inherently shaped by the position of the researcher as well as the researched (Grosz, 1987; McDowell and Sharp, 1997). In other words, in qualitative research, it is acknowledged and vital to explore how the researcher’s personal and field life ‘bleed’ into each other to shape the conduct of research. I have decided to write this *Health Dialogue* with greater reference to the personal ‘I’ than I have in previous publications. This simple heuristic device is an attempt to situate myself in the research in a simple but important way.

The other aspect of qualitative research worthy of note is the reliance on the experiences of 14 women. In contrast to quantitative research, the goal of qualitative work is not to attempt ‘representativeness’; rather, the emphasis is on attaining depth of views in a rigorous and theoretically sound manner. I followed established qualitative research methodology where attaining theoretical saturation point was a key principle

in determining whether adequate ground was covered in the interview process and subsequent analysis (Drisko, 1997). The emphasis on theoretical saturation point is a key element of rigor in this approach; first, interviews were deemed to have covered adequate depth when no new theoretical viewpoints or perspectives were emerging, and second, when no new themes were emerging from the data during the analytical process (Saunders et al., 2018).

Limitations to the study

There are limitations to this study, including the reliance on the narratives of 14 women in the target age group, despite the rigorous approach sketched out above. As an exploratory piece of research, however, it lays a groundwork for additional future in-depth research which could include the utilisation of other qualitative research techniques such as focus groups or ethnographic methodology. It would be fascinating to compare the experiences of the women interviewed with the perspectives of men from the same target age group. This would enable greater consideration of

whether some of the experiences are restricted to women on the basis of their gender, or whether gender intersects with other factors such as age.

One significant limitation of this research is a lack of consideration to how other 'isms' of discrimination, such as racism and heterosexism, may intersect with gender to further compromise well-being. While two of the women interviewed were not of European descent, race was not a key analytic focus of this research but may well have other implications for propensity for burnout. For example, research by Dyrbye et al. (2018) found correlations between ethnicity and propensity for burnout and regret for specialty choice. Other research suggests that doctors of colour face significant additional burdens to having their viewpoints accepted as legitimate, and they work harder to comport themselves as accepted and valued members of the medical community (Dyrbye et al., 2007). Future research would benefit from taking a more explicit focus on intersectionality and how gender combines with other forms of discrimination and inequality to shape propensity for burnout and other issues with well-being in significant ways (Acker, 2012).



Results of the study

Analysis of the transcribed material revealed several common themes which connected the experiences and histories of the women interviewed. In what follows, I discuss core emergent themes and associated sub-themes by focusing on their explication in the interviews and discussing the issues raised in light of relevant literature. The themes are all interwoven, but I have attempted to separate them into three categories of experience. First, participants described significant stress balancing the expectations of medicine with the practical realities of having domestic commitments, including having children. Discussions in this regard touched upon issues of meeting both work and personal or family obligations, feeling torn between demonstrating commitment to medical work and meeting needs of family and/or self, and the significant challenges facing doctors who have children. This theme has been summarised as pertaining to *work–life balance*. Implicit in discussions concerning the balance between work and home were issues concerning medical workloads, difficulties completing work in allocated working hours, challenges finding time for domestic and personal commitments, as well as concerns about how working less than full-time was perceived. These issues were collectively summarised as those pertaining to *medical time*, with analysis focused on how temporal issues were narrated by the women interviewed, and what these accounts serve to reveal of temporal norms in medicine. Implicit in much of these accounts were temporally inflected constructions of medicine as vocation rather than ‘job’, and associated ideals of commitment and professionalism. Finally, and flowing through all the themes, were significant yet latent *gender norms* reflecting the gendered nature of medical culture and the influence of pervasive gender schemas on professional and personal commitments. This final theme attempts to focus explicitly on the significance of gender in structuring daily interaction with patients and colleagues, the role of gender in perpetuating microinequities in medical careers, and how gender continues to

shape the lived experiences of women in medicine in subtle ways yet with significant consequences for well-being.

In the following section, I begin by addressing what could be deemed ‘common sense’ explanations for the spike in burnout for women in their thirties, before moving into a deeper examination of the characteristics of work–life balance as they pertain to the question of burnout.

‘A perfect storm’: Burnout and life stage issues

One of the key findings from the original ASMS study (Chambers et al., 2016) was the high proportion of women in their thirties scoring as having burnout. None of the women interviewed expressed surprise at the gender and age disparity. As summarised by one interviewee, the findings of the burnout study were “not surprising at all” because “there isn’t really a group of people who have more competing interests at that focal point”. She continued:

“If you look at [women in their] thirties, you’ve probably just finished ... your training scheme, so you’re burnt out already because that’s brutal ... You’re likely to have a family who are gonna be young and then you’re trying to establish yourself as a consultant, prove to others that you don’t have mummy brain. ... So, yeah, it’s not really that surprising.”

As suggested in the above excerpt, many of the women interviewed had not long completed their training and fellowship examinations, which was uniformly described as a challenging and exhausting period. The women were readily able to describe the stresses and strains this imposed on their personal lives, particularly if they had decided to have children during the intervening period:

“When you look at 30-year-old women as a group, what are we doing? We’re having children and getting to a point in our career

where we're taking that massive step up from being a registrar to a consultant [and] the head space you need for that and the responsibility you're carrying and your decisions you're making – they're really heavy. [And if you have a child at home] if [your child] has had a massive *meltdown* in the morning as you tried to get out the door at 7 o'clock. ... you're just carrying everything." (emphasis in original)

Medical training is widely acknowledged as being one of the longest, most intense and relentless professional training schemes. In New Zealand, basic medical training takes on average at least six years, with graduates then doing postgraduate training for at least two years before applying for a place on a medical college training programme. This period of registrar training requires hospitals to provide training positions, and registrars to pass challenging examinations. As an advanced trainee, the final hurdle is college fellowship examinations. Once attaining fellowship, there may be additional challenges attaining full-time positions, particularly if they wish to work in one of the main cities and hospitals in New Zealand.

What was interesting, moreover, were the participants' reflections on how the challenges associated with training had not readily dissipated since becoming specialists. For the women interviewed, it appeared that in some instances the stresses and time pressures were magnified. The burden of medical work was articulated not just in terms of the extensive hours required to train, work, and prove competency, but also due to the complexity, volume, and mentally demanding nature of the work. As one participant mused:

"I think that medicine is quite different to other careers in that respect in that you are seeing people who are at their most distressed or darkest point in their lives. And you as the doctor have to be the person that holds it all together. It's *exhausting* having to be the light house in the storm. And then you have to hold it all together at home as well. And nobody can be calm like that the whole time." (emphasis in original)

She continued:

"It's not just an emotional load either, but the cognitive load of constantly having lots of balls juggling in your head ... I sort of have three jobs at the moment: I've got some inpatients; I have some outpatients that are clinic, and then I also do a [specific] clinic once a week ... And it's a different style of work for each group of patients. ... It's different staff that you're interacting with, but you feel like you've kind of got to be able to do all three jobs on one day and juggle all the balls at the same time ... it feels like there's no end to any of that work and you're constantly having to shift and change the way that you're approaching things – it's just exhausting."

For others, key stressors associated with this career stage included difficulty attaining permanent positions in their preferred DHBs. This was described as particularly stressful for women with non-medical spouses with jobs that would be hard to transfer to different locations or other geographically determined commitments (for example, caring for other family members in the area). As one research participant described, her attempts to gain a permanent position at her DHB of choice were so fraught that she found herself focusing her sense of disappointment on her baby as she found herself comparing her experience with other peers who, without children, were able to go overseas and gain greater clinical experience:

"I had [my baby] in the last six months of my training [and then I had another] two years later. So I've had two children within the first two years of being a specialist. That meant I didn't go overseas to do an overseas fellowship, which had the potential and still probably does, to have been quite detrimental on my ability to get a job in [city] as a specialist ... [when I didn't get an interview for the post] ... I was *gutted*. I was absolutely gutted. I cried for days about it. Blamed it all on [my baby] ... I'd lost my competitive edge, basically. My impression of how they saw it was that I'd taken my

foot off the accelerator at just the wrong time and in doing so, I'd demonstrated that I wasn't committed to really chasing that job." (emphasis in original)

What is conveyed in this excerpt are her views concerning the unanticipated consequences of her decision around timing her pregnancy and the subsequent limitations she felt this presented for her career opportunities. Whether or not this is objectively the case is in many respects insignificant; for this respondent, the sense of disappointment was so severe that it resulted in her blaming her baby.

This sense of resentment for what was collectively framed as 'life choices' was a recurrent and distressing theme in many of the interviews, particularly with women who had combined their medical training with having children. Some of the women spoke of difficulties getting pregnant with in vitro fertilisation (IVF), and also logistical issues with IVF treatment, particularly while working full-time. Other women spoke of challenges with timing pregnancies; one who had a husband also involved in medical training found it virtually impossible to be in the same physical location, so as a consequence, their plans for children were put on hold because:

"we just need to get through [training] because we know that we won't be able to split-care the child – that'll be too hard. So as soon as we got the exams, got through, we were like, okay, well now we can think about having children. And I was 34, so I was already, you know, old."

Other women also spoke of challenges in managing job opportunities and fellowships with small children; one woman described the quandary she faced after being accepted for a prestigious overseas fellowship with a world expert in her field. Due to a variety of factors, accepting this fellowship was premised on her leaving her baby behind in New Zealand. As she described, this decision was all the more conflicting because upon her return, she was not enabled to apply the skills that she had learned during her six months away:

"[leaving baby with my mum] is something I'm still not sure [whether] I did the right thing ... [I acquired] a skillset that I wouldn't have got that no one else in the country had acquired, no one had got that level of experience or skills with such a world leader, um, and I come back and I haven't been allowed to use [that skill set] ... I still look back and I think, should I have given up that time with my child to go and acquire that skill set when I come back and I've been completely shut down? I was away six months ... [It was] a really long time."

Other women referenced the strain of trying to find a good time to have children with no clear sense of when having children would work without being too disruptive or challenging to handle. As the following excerpt discusses, many felt that this could have significant unanticipated consequences, be it for fertility or likelihood of developing postnatal depression:

"I think most women in medicine choose to have their kids a little bit later than other people, just because the training is so hard to get through. And that just sets you up for more problems with postnatal depression and anxiety, because you're more established in your professional role, that that adjustment to doing something else is even worse. ... and people like [us] really want to do [parenting] right and they read everything and that's the kind of personality that most female doctors are. It just is a perfect storm for creating all of these problems, and it's often when you're taking on more responsibility and starting to transition to being a consultant, like I'm about to do, and it's really really hard."

The trend for early career doctors to be at greater risk of burnout is supported in the wider burnout literature. For example, research by Dyrbye et al. (2013) found doctors who had been practising 10 years or less had the lowest scores for job satisfaction, as well as the highest rate of experiencing work–life conflict. Cheng et al. (2013)

also found women aged 30 to 35 had the highest prevalence of burnout (tool: CBI) and found that women aged 30 to 40 had the highest prevalence of psychological job demands, as measured by Karasek's Job Strain Model. This sense that women in the study were facing the 'perfect storm' in career stage and life choices was clearly articulated as shaping the propensity to tip over into a state where burnout was a risk.

What remains unarticulated in the narratives is why women as a group are more at risk as a consequence of this confluence of life and career. As noted in the introduction to this *Health Dialogue*, many younger men will be facing the same decisions around when to time parenthood and how to balance attaining the best possible career opportunities. Some of the women interviewed had spouses who also worked in medicine. It would be interesting to compare their male counterparts' descriptions of this transition period to see if they articulated similar quandaries. Recent research, however, suggests that the situation for male doctors who have children is significantly different. For example, a study conducted by Hill et al. (2018) found that nearly double the number of women compared with men cited their career as having affected the timing of having children, and similarly, a significantly larger proportion of doctors felt that their decision to have children affected their productivity compared with their male counterparts. Such research, in combination with the findings from this qualitative research, suggests the persistence of a residual gender order where decisions concerning parenthood present qualitatively different considerations for women. This sense was summed up by one participant as follows:

“[Medicine], it's like a calling and it's your life. It's part of your life. You don't clock off at five. It's hard for other people to realise that you do have to put work first, it's quite hard to juggle ... and I know for a lot of women, it's been a juggle to balance having the absolute best opportunities on their fellowships, going somewhere amazing, working really, really long hours, but if they've got kids, what do they do with the kids? How do they balance that?”

With medicine framed as a calling and a 'way of life', there is a sense of medicine assuming a moral primacy with other needs and commitments juggled against this priority. For younger women contemplating having children, as suggested in the above excerpt, there appears to be significant moral and organisational quandaries. What is currently unclear is whether these same quandaries are shared by men. Moreover, despite the gender-neutral framing of the wider impact of career and life stage issues, what emerges from these interviews are subtly gendered concerns and anxieties pertaining to how to balance careers as successful doctors against the unspoken expectation that domestic responsibilities, including parenting duties, remain the concern of the women involved.

In the next section I extend these ideas to consider how the women in my study narrated issues concerning the 'juggle' of work-life balance and the nexus of these issues with the propensity of women to experience burnout.

Narrating work–life balance

“Honestly, it’s like a house of cards. It’s really complex and really fragile and it takes the smallest thing to [send it] completely out of whack ... I feel like it’s a really precarious balance.”

One of the key questions posed to the women in the interviews was how they felt about their current state of work–life balance. Lack of work–life balance was narrated by all women as a core risk factor for burnout, something which was a constant challenge to avoid, and attaining work–life balance was something they strived for in varying degrees. Maintaining a semblance of work–life balance was commonly described as a ‘battle’, ‘precarious’, and overall as ‘a constant struggle’.

In the course of the interviews, work–life balance and difficulties achieving this elusive state was articulated by one doctor as pertaining to the struggle for women contending with “the emotional overlay of managing two roles”. For many of the women interviewed, there was a persistent sense that women would always face the ‘juggle’ of balancing their professional and domestic commitments, irrespective of whether they had children, in ways their male counterparts did not have to contend with. As one woman stated:

“I think [it] hits women much more than it hits men. I think even when you’ve got really great participating fathers, society will give them a free pass if they need to step down from that dual role at any stage.”

The ‘dual role’ references an almost dichotomous view of work and ‘life’ with ‘societal expectations’ as to who should hold primary responsibility for domestic affairs disproportionately targeting women. In this commentary and in other interview excerpts, there was a strong sense of the inevitability of women having to continue to take responsibility for multiple roles (parent, doctor, domestic manager, professional) and needing to demonstrate competence in all spheres of their existence. As she continued, “... women take on all of society’s pressures to manage both roles in an exemplary way”.

On the question of why women may struggle with work–life balance more than their male counterparts, some suggested this may reflect tightly held notions of what women ‘ought’ to do, a theme which I explore in focus in the final section of this *Health Dialogue*. In the context of the discussions of work–life balance, the interviewee argued that:

“society expects women to somehow be early childhood educators and household managers and hold down full-time jobs and not drop the ball with any of those things.”

In this narrative, the risk of burnout was framed as a constant threat because of stress arising from juggling societal expectations of motherhood, the realities of medical work, and the impossibility of not dropping the ball at some point. When I probed her about the differences of working in medicine as opposed to other work, she continued:

“Living medicine, because you do live it, and living the life of a parent, they are at massive loggerheads all of the time. They are not really compatible. And the fact that we even make an attempt at making them compatible, shows how foolish we are.”

Indeed, for the majority of women interviewed, whether or not they had children, the concept of work–life balance was frequently referenced by contrasting the demands of medical work with the challenges and, at times, the peripherality and incompatibility of domestic life. As other literature substantiates, lack of work–life balance, often framed as role conflict, is a strong predictor of burnout (Amofo et al., 2015), and there is considerable research to suggest that lack of work–life balance can have significant negative consequences for the well-being and morale of doctors (BMA, 2005; Walsh, 2013). Lack of work–life balance is commonly theorised as resulting from role conflict, defined as obligations, responsibilities, or duties competing for limited time and energy, or when they are incompatible or challenging to fulfil – in other words, in ‘conflict’ with each other (Guille et al., 2017). Role conflict may also result when the different identities of an

individual come into conflict; for example, doctor/parent (Walsh, 2013). Another associated concept is that of role strain, which is the need to attend to multiple roles of equal importance and to fulfil the various demands effectively (Schaufeli et al., 2009). Using the framework of human capital theory, research in this field suggests that given a finite amount of time and energy, role conflict between formal work and non-work demands may occur when the demands and expectations associated with different domains become mutually incompatible (Schaufeli et al., 2009).

There is considerable evidence to suggest that there are key gender discrepancies in how work–life imbalance can occur and its consequences for men and women working in medicine. For example, research by Mache et al. (2016) found that male doctors without children reported less work–family conflict than females and male doctors with children. They also perceived higher levels of work engagement than their female colleagues. As a consequence, the authors suggest that women in medicine are more at risk of stress and inter-role conflicts than their male counterparts. Klein et al. (2010) further note that work–family conflict was found to be a strong correlate with negative mental well-being for female doctors, whereas this was the least significant factor for men. The literature concludes that doctors who feel exhausted and drained from the challenges of juggling work responsibilities alongside personal or domestic responsibilities are more at risk of burnout than others who do not perceive the same struggles (Ádám et al., 2008). Other research conducted by Elmore et al. (2016) examining the degree of emotional exhaustion, a key facet of burnout as measured by the Maslach burnout inventory, in American general surgery residents found striking differences in the degree of emotional exhaustion experienced by gender and relationship status and by whether the doctors had children. The research found that for male general surgery residents, being in either a committed or married relationship significantly lowered their scores for emotional exhaustion. The same pattern held for those male residents that had children. By contrast, the degree

of emotional exhaustion was the inverse for females; having children or being married or in a committed relationship significantly increased the degree to which they experienced emotional exhaustion.

These trends in the literature combined with the observations from the interviews suggest obvious disparities in the propensity for women working in medicine to experience role conflict and/or role strain. Moreover, the clear differences in the risks faced by women who have significant domestic commitments, including children, suggest the need for greater attention to the role of gender in the development of burnout risk and amelioration strategies. While recommendations from the literature emphasise the importance of fostering opportunities for doctors to increase levels of job engagement, what appears lacking from such analysis is the wider significance of gender norms where decisions around working hours, parenting, and other domestic duties remain strongly linked to societal expectations of what women ‘ought to do’. In other words, propensity to experience burnout clearly reflects the significance of gender norms; strategies that aim to foster well-being in the workplace similarly need to be attentive to the significance of gender while avoiding reinforcing the notion that women ought to hold responsibility for domestic affairs. In the next section, I extend these observations by attending to the role of gender in the narratives concerning work–life balance.

The ‘perfect professional’; gender in work–life balance

Throughout the interviews, there were repeated references to the different expectations and responsibilities assumed of medical women, including lengthy discussions concerning the assumption that women will hold responsibility for domestic duties as well as continuing to succeed in their medical careers. As one interviewee mused:

“I think that women have very, very high expectations of themselves. Having children is an easy example. There’s this expectation that they’ll be the perfect mother. The perfect housekeeper, and the perfect professional, all at the same time.”

There was a clear sense that the pressure to succeed in attaining a work–life balance could be a hugely draining experience. This was felt to be particularly the case for women who were also dealing with young children or pregnancy. As one participant pondered:

“I share an office with a guy who does a *lot* of the childcare in his house. He shares it really well with his wife, but ... that’s not how things are done in every single relationship and women still do the majority of the childcare and cleaning of the family home, all those sorts of things. So I think if you look at this group of women who are having all their babies, because they’ve often left it until their 30s, [and are] taking big steps up in terms of their responsibility at work, it’s just a total recipe for disaster, for crash and burn.” (emphasis in original)

While there was the occasional acknowledgement of the increasing willingness of male colleagues (and/or partners) to participate in domestic affairs, there was a residual sense of the ‘natural’ order where women were still forced to delegate tasks and ‘manage’ their lives in ways that were fundamentally different to their male counterparts:

“I still think there is an expectation that women take on a greater proportion of the home life. Ah, the work, you know the home responsibilities. I think there is still um, well there are frequent comments that if you have a male partner who contributes, even if it’s not 50:50, then that’s somehow unexpected or better than you might expect, or that it’s a bonus.”

There was a sense that the time required to attend to domestic commitments, especially for those who had children, was gendered in ways that made it a challenge for women specifically. It was felt that their partners or male colleagues did not have to face the same expectations or decisions as to how to split their time. As one interviewee mused:

“Just because the era has changed and we are able to work – it’s not like [men have]

stepped into the domestic area. They still continue to be fixed *that way* and we have to keep asking and it’s as *good* as doing it ourselves. So it’s like having two full-time jobs and doing everything at home – even though you’re delegating it. You still have to delegate, and that’s the most tiring thing because you have to keep chasing up on it.” (emphasis in original)

In this excerpt, the significance of the societal change that has resulted in far more women participating in the medical workforce is noted, but in her opinion, this leaves unchanged the wider societal view which continues to be ‘fixed’ where men have failed to adequately step up into the domestic field. This frustration combined with a sense of inevitability was echoed by two women who had children who referenced a sense of carrying the mental load of parenting in very specific ways.

“That whole sort of mental load of parenting almost always falls to women and it’s really hard. I’ve been trying to train [my husband] to do a few things [chuckles] and um, I can get him to do ... He’s actually pretty good, but ...”

“I feel for women there’s that hidden, all those little jobs, like making sure the bag’s ready with all the stuff in it with the nappies and the wipes, even if my husband has the week off work and I’m working, I would be still filling the bag, making the lunch, doing all that kind of stuff, not because he doesn’t wanna do it or because he’s lazy, just cos he doesn’t think about that kind of thing [laughs].”

The concept of the ‘mental load’ was discussed frequently in the course of interviews. At the time of the interviews, the work of the French cartoonist ‘Emma’ was circulating on social media, and there was considerable interest in her work on the ‘mental load’. In her cartoon, this concept is articulated as the societal expectation that women continue to assume a primary sense of responsibility for the domestic sphere with participation of men usually a consequence of the

woman delegating tasks in her role as household 'manager'. As she sums up, the mental load is the implicit responsibility of women who always 'have to remember':

"While women are more and more present in the workforce, they still remain the only ones in charge of the household. When we become mothers, this double responsibility blows up in our face ... most of us feel resigned to the fact that we are alone in bearing the mental load, nibbling away at our work or leisure time just so we can manage everything." (Emma, 2017, p16)

While the work of Emma is premised on a number of assumptions (for example, heterosexual relationships, parenthood), her idea of the mental load served in the interviews as a useful discussion point concerning the impact of the hidden labour associated with assuming responsibility for domestic duties and the implications of this for well-being.

Others articulated their feelings concerning the mental load in the context of discussions which conveyed a residual anxiety that there was always work waiting, always more work that could be done. Many expressed concern their work-life balance was in constant jeopardy because of expectations (not only self-imposed) that they ought to be doing more not only in their professional capacity but also in the roles they held outside of work. As one woman mused:

"I wonder whether – because I'm spending more time at work, whether I'm doing well enough in that role, and that to be a good mum, do I need to be spending more time with the kids and not working? And I guess that's a conflict that I feel, but then if work is something that I enjoy, then actually maybe that's ok?"

Research has found distinct differences in the nature of the family-work interface by gender. Men and women doctors were found to hold distinct degrees of responsibility for domestic tasks and the domestic realm as a whole. Recent

longitudinal research on US doctors found that women spent more time on household activities than their male counterparts and that those female doctors with children spent significantly longer time on childcare activities (Ly and Jena, 2018). This research suggests that little has changed since Carr et al. (1998) studied the domestic responsibilities of a single medical faculty in 1998, which found that nearly 50% of women usually or almost always held responsibility for household tasks compared with 4% of the men, and that nearly 50% of women had scaled back their work commitments for their children, whereas the same applied to only 16% of their male colleagues. Other research conducted by Ly et al. (2017) found that both marriage and parenthood were associated with a decline in the number of hours spent practising medicine for women doctors, and for those women with children, the amount of time dedicated to domestic duties was double that of their male counterparts.

Interestingly, however, much of the literature dealing with strategies to ameliorate the risk of burnout focus on the need to reduce role conflict and/or role strain, with practical suggestions including the importance of fostering interests and activities outside of formal work hours and reducing the spill-over of formal work commitments into personal time. Interestingly, research into the gender balance of doctors who play golf in the US found that 89.5% of doctors who played golf were men, compared with 1.3% of women (Koplewitz et al., 2018). Overall, such literature and suggestions are curiously gender-neutral despite obvious disparities in terms of the propensity for women to experience role conflict and/or role strain as well as the apparent gender discrepancy in the ability for men to take up hobbies such as golf. Moreover, the gender-neutral language which tends to pervade the burnout literature fails to account for highly gendered patterns of working and living where decisions around working hours, parenting, and other domestic duties remain strongly linked to societal expectations of what women 'ought to do'.

In terms of the goals of this study, moreover,

there is little research exploring how discourses of work–life balance assume a gendered neutrality where men and women doctors have equal opportunities to participate in medicine and equal choices regarding their commitments outside of formal work time (Smithson and Stokoe, 2005). What emerges from these interviews is a clear sense of how the issues that women in medicine face are gendered. Significantly, these appear to apply to women whether or not they have children, particularly when they are trying to balance demanding domestic circumstances against professional workloads and expectations.

A key aspect of balancing domestic commitments against professional expectations that arose in the interviews related to the management of the boundaries between work and home life. Analysis of relevant sections of the transcript suggested a sense that while work was expected to regularly spill over into domestic and personal time, there was little tolerance for instances where personal circumstances or domestic commitments might bleed into formal work time. In the next section, I discuss the significance of these boundary-making practices and what they suggest for the propensity of women in medicine to experience burnout.

Permeable boundaries

“It’s like you leave this job to do your other full-time job as a mum and it’s like they’re not allowed to collide. They just have to be two separate roles. Yeah, and that’s where we struggle.”

As suggested in this opening segment of an interview, many of the women narrated a sense of medicine being a role that competed against their other ‘lives’. What I found particularly interesting in these discussions was a sense of clear boundaries between work and the women’s other spheres of existence. Discussions touched on various boundary-making practices and consequences for the women’s physical and emotional well-being. Analysis of the interview transcripts suggested that the permeability of the boundaries was not equal; women’s other commitments were not “allowed to collide” with work, and yet there was a clear sense

that performing medical work was predicated on finding space and time for work to bleed into home life.

As an example of the first, instances where childcare arrangements had fallen over at the last minute, such as having a nanny fall ill, were described by some of the women interviewed with dread and trepidation. As one participant considered, if her nanny was ill and unable to look after the children, she would face a significant quandary in notifying her work that she would be unable to complete her clinics. As she described:

“If I sort of said, ‘I can’t come and do my operating because the nanny’s sick’, I actually don’t know how that would go down. Like I’m a fairly robust and confident person, but that makes me nervous – the concept that I would have to cancel the list because my nanny’s not gonna be there.”

Similar reflections were made by those women in the context of how to structure their maternity leave (see case study in next section) as well as breastfeeding practices (see *ASMS Research Brief* for an extended consideration – ASMS, 2018). As one woman mused, her decision around whether to continue breastfeeding her infant upon return to paid work was strongly influenced by feeling that she wouldn’t be pulling her weight if she took the time to pump off breast milk during her clinics:

“I pumped last time and it was just too hard. My secretary had a fit because I’d told her I needed 20 minutes in the middle of my clinic to pump and she said, ‘How am I going to fit your patients in?!’”

CC: “Really?”

“Yeah [laughs] ... it’s just that pressure because the clinics are always full, and to take out two follow-up appointments out of every clinic ... I mean I felt bad about not pulling my weight ... not seeing new patients because I was having that time off to pump.”

CC: “So what does pulling your weight mean, what does it look like?”



“Doing as much work as everyone else. Seeing as many patients. It’s everyone’s job to help keep it down and you want to do your bit as much as everyone else. I guess it’s all time! It’s all how much time you’re actually in the hospital, doing work, and...”

Other research in the field of work–life balance has noted the significance of boundary-making practices between domestic and professional fields. As Emslie and Hunt (2009) state, the construction of these boundaries is likely to be gendered in subtle yet significant ways. As they argue, understanding the intersections between work and ‘life’ requires careful attention to the role of gender, particularly as the domestic sphere continues to be constructed in a way that cleaves responsibility for the emotional and physical labour of domestic commitments along gendered lines. What is interesting in the context of these

interviews was the clear sense that the boundaries between medicine and ‘life’ were not equal; there was a sense that it was unacceptable and, at worst, deeply unprofessional to allow ‘life’ to bleed into paid working time.

One example of the differential in permeability between the borders of home and work were discussions concerning the residual pervasive anxiety associated with never being able to fully switch off from work. As one woman described:

“[I] wish that I could just switch off when I go home and completely spend my time with my daughter and be the best mum, but that doesn’t happen. You can’t leave the worries that you have from work, and I often don’t realise that [I’m bringing them home] till my husband is like ‘You need to calm down’... So I don’t balance it. I still struggle with it. Every day.”

While the ‘worries of work’ were acknowledged as pervading her domestic time, this woman felt keenly that the inverse was unacceptable:

“When you come to work, leave out the responsibilities as a mum, parent, partner, whatever it is – we don’t want to know about it. It doesn’t matter. You got into this profession knowing fully well what it holds, so keep that up. Keep that out the door and come in’ is the way the culture is. And, you know what, we’ve accepted it, because a lot of us have gotten into medicine knowing fully well this is what it is going to be and that’s what we’ve been doing: keeping everything out of the door and walking in and trying to behave like everything’s fine.”

The idea that women had to keep their other lives and responsibilities ‘out the door’ before they came in was also manifest in women’s reflections concerning how they felt they needed to comport themselves following their return to paid work after parental leave. For example, this interviewee reflected on her self-imposed discipline not to speak of her baby for fear that she would be thought of as unprofessional:

“I was mindful when I first started back – when I had a five-month-old at home, not to speak about my child to my colleagues, because I didn’t want to be that new mother who’s jabbering on about her five-month-old’s sleep and poo, because I – that’s not seen as professional. So I tried to take care that I didn’t mention my child ... because I was trying as well to make an impression. ... So I tried not to mention him, to maintain people under the false illusion that I was completely dedicated to my work, when in actual fact behind closed doors, of course, I’m dedicated to being a mother as well. But that’s not the impression I wanted to make to my colleagues who would be the ones thinking of hiring me permanently.”

At its most extreme, the inability of some of the women to attend to their professional

commitments in what they felt was requisite depth and attention resulted in some describing feelings of resentment, not only for choice of career, but perhaps at the most distressing, decisions over whether they should have attempted to combine parenthood with medicine in the first place. For example, one interviewee in the context of work–life balance opened up about feelings of resentment concerning the impact of her children on her clinical work. She stated:

“I am often quite resentful actually, of the impact of children on my clinical practice. And on my non-clinical workload and I feel that I’m not quite the doctor that I was and could be, and I feel that my clinical practice has slid as a result of, not really from the maternity leave, but from the constant grind of having children at home.”

What is interesting in this statement is her reflection that having children has impeded her ability to dedicate herself totally to her professional career in medicine, due to the ‘grind’ of her domestic responsibilities on her day-to-day existence. As she went on to discuss, her resentment was specifically in response to not having time to keep up-to-date with extra reading in the evening that she feels are necessary in order to “feel really competent”. Significantly for this interviewee, there was no question whether it was necessary to work in her own time to maintain competence. Nor was it questioned why her sense of being a competent clinician required this subjugation of her domestic circumstances. Rather, for this interviewee there was a sense that her domestic situation posed a clear impediment to her ability to continue ascending the path of clinical excellence. Despite acknowledging there are “ebbs and flows in clinical knowledge”, she conceded that:

“unrealistically I sort of have this expectation that if it hadn’t been for children, I’d be pretty hot in multiple areas rather than just sort of holding on by my fingernails.”

The inner turmoil which this woman was able to articulate and the conflicting emotions she felt are

inextricably intertwined with what other authors have described as ideal medical practice and how adhering to these norms is perceived as a key way of demonstrating competence and commitment to medicine. As Ozbilgin et al. (2011) have explored, competence and professionalism in medicine are constructed in a way that requires “extensive temporal commitment that sweeps personal time, leisure, domestic life and family responsibilities” to the side in favour of unswerving dedication to medicine. This tension between her obvious love for her children and yet her desire to be the doctor she feels she could have been was a source of conflict and inner turmoil.

What is particularly troubling about this quote is the close alignment of success and competence with undertaking extra tasks in personal time, such as extra reading, which is viewed as crucial to success and competence. The normalisation of extensive time commitments that go well over the allocated FTE of respondents was a persistent theme in my research and has also been explored extensively in other literature. At its most distressing, it is not hard to perceive how feelings of resentment at choices to have children can have a significant detrimental effect on emotional well-being, particularly when aligned with feelings of self-doubt and frustration. The complexity of these emotions was also explored in an interview with another participant, where she described her inner turmoil concerning her abilities as a doctor and as a parent:

“I don’t think I’m doing a good job as a mum. I think I’m a bigger failure as a mum than as a doctor. And I’m not saying that I’m good as a doctor. But at least I am where I am. If I could at least keep up with my reading then I’d be a little bit more at peace from a doctor’s point of view. But I don’t think I’ll ever see that I’ve done a good job as a mum.”

In conclusion, the women interviewed in this study framed the elusive holy grail of work–life balance as a constant struggle which often left them feeling stressed, precarious, and anxious that either their home or their work life could suffer. The women interviewed readily accepted that they

had challenges balancing medical work with their domestic situations. This was particularly acute for the women interviewed who had children, but the women who didn’t have children also acknowledged the dominance of work in their lives, often at the expense of maintaining relationships or interests outside of formal work. Similarly, the women interviewed felt that men, particularly male doctors, were not faced with the same challenges, at least in part due to engrained societal norms that cleave responsibility for domestic duties along gendered lines. This was felt to be irrespective of whether partners or husbands were in medical work or non-medical jobs.

Some of the stress and feelings of exhaustion were clearly articulated as pertaining not only to the physically demanding and arduous nature of medical work, but also from its emotionally demanding nature. Combined with responsibilities in the domestic sphere, some of the women described feelings of exhaustion and being overwhelmed to the point where some spoke of feeling resentful of the impact children have wrought on their careers.

Implicit in many of their discussions and anxieties was reference to the temporal primacy of medical work – in other words, the feeling that medical work not only takes up considerable amounts of time, but further, it carries the implied expectation that it should come first. In the next section of this *Health Dialogue* I extend these observations to tease out latent constructions of medical work and time, and consider how such constructions may inadvertently serve to compromise well-being. In what follows, I discuss varying constructions of medical time and discuss what these suggest about the risk of this cohort for burnout as well as issues for well-being overall.

Medical time

Concerns for burgeoning medical workloads were one of the initial key themes emerging from the original burnout research. Comments left in the survey noted challenges associated with clinical creep and implied expectations of significant effort in non-work time in order to keep on top of things. In the course of these interviews the primacy of medical work and the sheer volume of it was a consistent theme. The women interviewed spoke of stress and anxiety concerning whether their work was ever fully 'done', having to work regularly in their personal time to keep up with emails and administrative tasks, and feelings of fatigue and exhaustion as a consequence of long hours. In this section, I probe these entanglements of medical workloads and expectations regarding time, in light of discussions pertaining to medicine as vocation, choice of specialty, feelings concerning working less than full-time, and the implications of these for well-being. To begin, I consider how the women interviewed described their typical working day. One senior medical officer described a day in her life as follows:

"You're just so busy. And suddenly next thing you're on your emails still at midnight and you think, oh crap, I've got to be up at 6.00 and I've still got to do the washing or whatever. I do every now and then stop and go, why do we do that? Why do we say, yes, I'm superhuman and can work nearly two people's jobs? ... As a profession lots of us are working lots of hours and just expect that as a norm, and it's ridiculous."

Others referenced the normalcy of taking work home and articulated a sense of ongoing pressure to find time to complete their work. Many of the women interviewed spoke of the long and unpredictable hours of their medical work as a necessary evil; something which they had to fit their other commitments and responsibilities around with varying degrees of success. As noted in the previous section on work–life balance, these discussions emphasise the challenge of 'juggling' life around work. Many conveyed a

sense of struggle to stay on top of their work, and particularly so if they also sought to have time for personal activities, spend time with their spouses or have quality time with their children. As described by one interviewee:

*"I was emailing letters back to my registrar till 11.30 last night ... I think it would be much easier if I could stay at the hospital until I was finished with my work every day ... [but] I have my email on my phone, so there's no filter – it's *completely* messy. And, to be honest, when I get home ... that time in the evenings is unproductive anyway, just because I have *completely* exhausted my emotional resources for the day by the time my little one is in bed." (emphasis in original)*

In addition to the considerable workloads, the lack of filter between work and domestic life suggests a blurring of the boundaries between the spheres of work and home, with the ensuing sense that life is "completely messy". As noted in the previous section, when the barrier between work and home is porous, it can be extremely challenging to draw a line between work and non-work time. As a consequence, doctors can feel constantly overwhelmed by the demands of their work. What is significant, however, is the fact it is not just tacitly acceptable for work to bleed into other parts of life, but the sense that allowing work to have temporal primacy is a necessary and defining feature of being a good doctor.

Working long hours, particularly hours worked outside of normal daytime working hours, and failure to take significant breaks between periods of work have been emphasised in research as strong risk factors for burnout (Chou et al., 2014; Shanafelt et al., 2012; West et al., 2016). The original ASMS study on burnout found strong correlations between burnout and the absence of taking a 24-hour break between work, as well as working more than 14 hours in a single stretch. There was also a strong linear association between increasing hours of work and scoring positive for burnout (Chambers et al., 2016). Working long hours thus appears to be a key risk factor for burnout and yet one which is common, normalised,

and as the following excerpt suggests, a key factor in constructing medicine as more than just ‘a job’:

“People say it’s a vocation, not a job. I think it’s like a calling and, it’s your life. You don’t clock off at five. Of course you don’t. If you’ve got a patient that’s doing badly at 4.45, you’re not gonna say, ‘Well I’ve only got 15 minutes and then you’re in the hands of someone else.’ You’re gonna want to see how your patient goes. And I’ve always found it hard for my family, none of whom are medical, if you’ve organised a family dinner and it’s at 6.30 and it’s 6.30, I’m still at work and I’m texting saying, ‘I’m really sorry, I can’t leave for another 15 minutes’ and they’re kind of, ‘Oh, that’s terrible,’ you know, ‘you’re selfish’ or whatever, it’s hard for other people to realise that you do have to sometimes put – not put work first, but if you’ve got a patient that’s unwell, they have to come first. So that can be – it’s quite hard to juggle that, I guess. That is hard to juggle.”

The emphasis in this quote on medicine as a vocation, a calling, and being ‘your life’ was a theme repeated constantly in many of the interviews. Framing of medicine as a vocation, ‘not just a job’, serves to emphasise the primacy of medical work with key implications; medical work as vocation requires the subjugation of all other time – family time, personal time – as secondary. As the interviewee notes, this reflects the core duty of doctors; the need to ensure that the patient ‘comes first’. Nevertheless, the corollary of this view clearly comes with risks. As the following quote suggests, this need to ensure the patient comes first has associated expectations of availability and extensive temporal commitments, with associated ‘costs’:

“I think there is an expectation that you are available ... and contactable. And I think there is a necessary expectation that you don’t go home until the work is done. That you don’t leave someone who needs your care without the care. I think that’s necessary ... I couldn’t conceive of a world

where we let doctors just leave their patients alone. But that comes at a cost if there’s no one to take over from you.”

As described in the introduction to this *Health Dialogue*, medicine has a particular gendered history and association with time. Unlike other clinical fields such as nursing, doctors have always maintained professional pride and a source of professional identity in the expectation and ability that they do not ‘clock off’ at the end of a shift (Pringle, 1998). William Osler, for example, who played a key role in the professionalisation of medical training, expected his entirely male student body to immerse themselves in the 24-hour cycle of an illness, and coined the term ‘resident doctor’ for students expected to stay at the hospital overnight to do so (Pringle, 1998). Pringle notes, however, that it is not insignificant that Osler was able to create such a training programme given that all his students were men who, as unencumbered doctors in training, could wholly dedicate themselves to their medical training in the absence of other responsibilities.

To this end, the work of Ozbilgin et al. (2011) has been significant in demonstrating the ‘cost’ of these entanglements of time and professionalism as they inhere in medicine. Their work explores doctors’ reactions to specific policy changes, such as the European Safe Working Hours directive and the broader significance of doctors’ nostalgia for ‘the good old days’ when doctors could ‘play hard and work hard’. As they argue, temporal availability is used in medicine as a proxy for commitment with those who are unable or unwilling to abide by an ‘all-hours’ work mentality at risk of subtle denigration as lacking a professional ethos. As they outline, the ‘cost’ of these entanglements of time, work, and professionalism have a clear gendered history not least because the ability to follow medicine as ‘a calling’ has at its core the assumption of an unencumbered worker. Remember, for example, the commentary of Heslop cited in the introduction to this *Health Dialogue* that to get through postgraduate medical exams, “a wife is clearly a prime requirement for

a man with children. For a woman with children... she needs a wife too" (Heslop, 1987b, p233). The point of Ozbilgin et al. is that the ability to perform medicine as a way of life has always differed depending on other commitments, expectations, and demands that doctors shoulder, and who else is able and expected to assist with these.

In many of the interviews were hints to how these temporal expectations mattered differently for women, particularly for those women who had domestic commitments or were seeking to work less than full-time to manage their other responsibilities. As one woman considered, with medicine as more than a job, having children could manifest as a particularly risky decision:

"Medicine is not just a job. It is a profession ... being a doctor; it's part of my identity and, I think that part of that identity as a doctor is you are expected to have a dedication of your life to your patients and your profession, and when you then have children there is the potential for this splitting of your obligations and a reduction in what's seen as your dedication to your role."

As she continued, she herself felt conflicted and torn about how her need to be with her child could compromise perceptions that she was dedicated to her role, particularly as an early career specialist where she was trying to 'prove' herself as a worthy colleague:

"I remember one time when I totally snapped at the end of a list and said, 'If I don't get home I'm not going to be able to breastfeed my child and ... it'll be 36 hours since I've seen my child.' And I was so embarrassed afterwards that I had said that to a theatre room at 6 o'clock at night. I know half the nurses there. They all wanted to get home as well but I, I – yeah, I snapped ... But I was so embarrassed afterwards that *I had made my work about what my home commitments were* because that's not, that's not the impression I wanted to make." (emphasis added)

As Acker (1990) notes, working long hours continues to be a defining feature of commitment and dedication to a career. For both men and women who also have other commitments outside of formal work, the demanding nature of medicine as 'your life' can manifest in considerable feelings of anxiety and stress. At worst, this can result in feelings that carving out time to attend to other commitments can be perceived as demonstrating a lack of commitment compared with colleagues who for various reasons may be better able to focus on medicine entirely.

This tension was referenced explicitly by one interviewee who acknowledged that she was likely on the precipice of burnout. In the following excerpt, she describes her feelings of conflict, and in particular that her burnout could be viewed as the ultimate let-down to a close colleague who worked in accord with the unspoken temporal norms in medicine, in contrast to herself, who made time for her family:

"... most of the time I'm leaving and saying I want to just spend time with my family, and she's staying here and working till 11.00 at night. She comes in the weekends and weekdays ... if anybody should burn out, it's her. She doesn't stop. And here I am thinking I'll be letting her down ... how [can] I expect her to understand me when from where she's standing I'm actually doing it. I have everything. You know what I'm saying, as in I'm, I'm not coming in or I'm not working late. I'm actually going home to a family that loves me and I think – you know, it, it looks like I have everything. How can I be experiencing burnout when it looks like I'm just not strong enough, like my threshold's really low. I could give an appearance of ... a weakling who whines."

Case study: Unencumbered workers and the gendered nature of work

The scholarship of Jean Acker has been critical in demonstrating how the very notion of 'work' is premised on a gender-based division of labour which relies upon a "particular gendered organisation of domestic life and social production" (Acker, 1990, p149). As Acker and others discuss, this division of labour has simultaneously served to shape the construction of the 'ideal' worker as one who is able to work unencumbered, full-time, and continuously (Lewis, 2001). Acker (1990) uses the concept of the 'unencumbered worker' defined as one who can turn up to work every day and stay as long as the work requires them to stay. The 'unencumbered worker' is, in other words, unfettered by constraints on their availability for work and is free from other commitments that might impede their ability to work. As Acker states:

"The worker' under capitalism is implicitly defined as unencumbered by any obligations other than those to the job, and work is usually organized on the basis of this assumption. Historically, women have been seen as encumbered wives and mothers and thus not real workers and not entitled to the rewards and rights of real workers." (Acker, 2010, p11).

Acker explains that the consequences of this construction of the 'ideal' worker are clear: those who are able to work full-time and unencumbered are deemed 'naturally' more suited to responsibility and authority.

The relevance of this notion was discussed tacitly in an interview where propensity for burnout was aligned with the notion of professionalism. As this interviewee pondered, she felt that at least part of the reason why women in medicine were more prone to burnout and other negative indicators of well-being was because of the doubt that ensued from the sense that they didn't fully belong in the profession. She stated:

"I think despite what we like to think ... professional careers, almost irrespective of what the careers are, start from a male-centred view of the world and so women always have one foot into that world and one foot out because we're not men. And I think we therefore always doubt ourselves, and I just don't think men doubt themselves in the same way. I think if you are constantly, I'd like to say self-reflective, that would be a really positive way of terming it, I think it's more like self-critical, and thinking that you're not good enough for the job, then it takes much less to push you over the edge. Because I think, I dunno, men seem to, take the hit, go 'Oh yeah, oh well' and move on. And women don't do that."

As I go on to describe later, part-time work in particular exists as a deviation from a broader workforce model which cleaves a clear distinction between 'work' and home, with the latter implicitly gendered as feminine. Lewis (2001) further argues that part-time work is gendered also due to its particular history with enabling women to enter into the paid workforce while also maintaining primary responsibility for the domestic sphere.

This is another example of the close association of core temporal norms with professionalism and commitment; they can actively serve to negatively affect well-being in pernicious ways. Internalising feelings of guilt for deviating from unspoken norms of appropriate temporal commitment has resulted in this doctor feeling that her risk of burnout is because of a weakness in strength and character rather than situating her risk of burnout in the wider pressures she faces in her work. Perhaps most perversely, for this doctor, she felt that despite her own struggles, she would not have any advice or perspective for others coming through facing difficulties:

“And I think I’d be the same towards somebody else. ... I don’t know if I’d be – because this is the expectation. This is the standard. This, this will fit everyone, so if somebody else is in the same situation as me, we’re like, ‘We just have to buckle up and deal with it.’ I don’t know if I can do anything else, because I don’t see anything else that’s done.”

This woman’s reflection that she doesn’t ‘see anything else that’s done’ and her framing of burnout as representing some sort of an inner weakness prevents her from supporting others who may be at risk. Burnout in this framing is suggested as evidence of a poor fit for medicine; as she states, the standard is clear and those who are unwilling or unable to abide by it are perhaps unsuited to medicine.

Other researchers have emphasised the perniciousness of viewing burnout as a form of an individualised failing, representative of individual weakness, lack of toughness or ‘fit’ for the job or profession at hand (for example, commentary by Krishnan and Sarkar, 2017). Nevertheless, as the excerpt above demonstrates, the nascent sentiment that could frame burnout as another ‘rite of passage’ is worrying, particularly if the solution to this is to ‘buckle up and deal with it’. Other researchers have sought to demonstrate the wider significance of the ‘rite of passage’ mentality as it inheres in medicine (for example,

Veazey Brooks and Bosk, 2012) and how seemingly innocuous rhetoric of nostalgia for a ‘work hard and play hard’ mentality is inextricably linked to constructions of professionalism and ‘fit’ in medicine, as demonstrated in the scholarship of Ozbilgin et al. (2011) and Tsouroufli et al. (2001).

Elements of this sentiment arose in the context of other interviews, where some of the doctors were able to articulate feelings of an unresolved tension regarding their willingness to assist younger doctors coming through who sought different ways of working to what they had been afforded. One specific example of this was discussed in the context of registrars seeking greater flexibility in their working schedules in order to breastfeed, which is discussed in depth in the ASMS *Research Brief* on breastfeeding (ASMS, 2018). In the following excerpt, one woman describes her sense of dissonance between wanting to make medicine a better place, particularly for women coming through, but described feeling conflicted as she wasn’t afforded the same advantages:

“I also find it fascinating that even now, understanding all that, I can’t 100% go into bat for all my colleagues who are following me through it. And I’m not entirely sure why. If we as women can’t support our female colleagues to traverse the challenges better than we did, if we can’t, if our juniors can’t rely on us to help them, if we can’t provide that support, to give them a better journey than we had, I mean, we can’t expect the men to do that? I mean life’s lost. I find it really disappointing when I realise that I’m not really prepared to make life easier ... I’m prepared to make it as straightforward as I had it, but make it one step easier? Is actually quite challenging. ... I don’t want to make life easier for [them], because I didn’t get those advantages, and it’s unfair. And it is unfair, to feel that way about your colleagues coming through.”

Her reluctance to make life easier was in part due to the advantages she felt her ‘rite of passage’ had bestowed, particularly in terms of exposure to challenging situations:

“Yeah. The rite of passage thing. The stories we have. And, the learning that I got from, you know the case that I stayed on for. The child with tetanus that we operated on at 2am in the morning when my shift finished at 9, the near catastrophes, that I managed with fewer staff, in the middle of the night, when there were fewer people on the floor; they do make you as a doctor, they make you as a clinician and they provide you with a level of experience that is very difficult to get in the timeframe that you are asking people to get that experience.”

While not directly relevant to the question of burnout, the resistance to different ways of working and the dissonance articulated between wanting to make things better but feeling that to do so would be ‘unfair’ has key implications for medical culture. On a positive note, the research of Veazey Brooks and Bosk (2012) into the manner in which duty hours restrictions were received by surgeons in a UK study suggests that these moments serve to disrupt occupational cultures in medicine. In the process of doing so, they ‘create space’ for those who seek different ways of working and different types of medical identity.

As other research has demonstrated, the interplay between temporal constructions of medicine with the need to put work first and other commitments, particularly family, second, has often dissuaded women from entering certain specialties which are renowned for having acute and unpredictable workloads (Siller and Hochleitner, 2015). In the following section, I explore how temporal constructions of medicine apply in shaping choice of specialty and patterns of work.

Specialty choice and temporal norms

In the course of the interviews, interviewees emphasised a range of factors that influenced their choice of specialty; for example, variety and excitement in emergency medicine and getting to know patients in greater depth in psychiatry. In addition to why the women interviewed chose their specialties, it was also revealing to hear what

specialties they had chosen not to pursue, and the reasons why. In the following interview excerpt, one doctor explained how her choice of specialty was largely premised on needing to be realistic, given that she already had a husband and didn’t want to choose something that, as she framed it, would cause ‘regret’:

“If I did not have a husband or a family, I think I [would have chosen] something that would just put me all into my work field. Because I was married by the time I was a trainee intern ... I knew my life [laughs] was going down a different path. And so I had to be realistic ... and there was always going to be family, and so if that’s the case, there’s no point in [choosing] something that will make me regret. As in, you know, you’re – at work you regret that you’re not with your child. You’re with your child and clearly you cannot be a good surgeon because, you know, duty call – it’s just so *demanding* of you. There’s no set time. It’s not, ‘I can go off now’, yeah.” (emphasis in original)

As the interview continued, I probed this woman as to what she meant by her sense of regret. What emerged was an emphasis on the lack of temporal control where her ‘pull as a mother’ meant she would always have competing demands on her sense of obligation and duty. She continued:

“There’d be after-hour calls, overnight calls, you just cannot say, ‘Okay, I’ll just get in theatre now and get out in five hours.’ ... It’s not something you can control. If I did not have the *pull* of being a mother then I [could] give it my all and not worry about time. And, yeah, it’s mainly time and, and the amount of effort you put into it. But if I had a child in the picture, my first priority was always going to be her and there was never – I could never say, ‘Oh, I can’t do the surgery because my child is ill.’ It’s a sense of duty. It’s just you’re never going to be happy ... I know there are women who do it and they’re *amazing* people, but I just know from my personality – I would struggle with guilt for the rest of my life.” (emphasis in original)



What is fascinating about this framing of surgery is the emphasis on the temporal factors that make it ‘so demanding of you’. The emphasis on the uncontrollable nature of surgery with ‘no set time’ gives heed to concerns for being ‘realistic’ with a choice of specialty in light of existing and possible future domestic circumstances. The expectation to accept the ongoing imposition of work into personal time is a key element in this construction of the ‘good surgeon’. The emphasis on the after-hours calls combined with the inherent lack of control of surgical work constructs surgery as somehow deeply incompatible with motherhood, despite the recognition that there are some ‘amazing’ women who manage it. Without marriage and children, this respondent would not have to “worry about time” and thus surgery could have been a choice if she were truly able to put herself ‘all into her work’.

Research by Smith et al. (2018) found that women and men in medical training are likely to consider fundamentally different factors in considering how their choice of specialty may affect their future lives; in particular, their ability to achieve work–life balance. In their research into choices of men and women medical students, they found that women were more likely to cite concerns for future domestic commitments, including responsibilities associated with childrearing, even if they did not have children, whereas men “described balancing work with adventure and the pursuit of personal interests” (Smith et al., 2018, p39). This tension between certain specialty choices and future lifestyles was described by one participant as follows:

“I think, like, if you want to do it, do it. Make the most of every opportunity. Um, I think if you plan to have a family, then I would just advise people to be mindful of what – the specialty they’re choosing. I know lots of women who have just done an awesome job in various kinds of surgical or anaesthetic training and made it work, but I think about there are some specialties which lend themselves a bit better to, to have that balance – [between] work and family life.”

While it is not made explicit in this excerpt, there remains an implicit sense that these choices remain acute for women entering medicine, despite the recognition that many younger male doctors coming through the system are now also seeking greater opportunities for work–life balance (Heiligers and Hingstman, 2000). One respondent who had chosen surgery also noted that she felt she had to make an explicit choice between surgery and having children. As she pondered:

“Surgery is 100% yourself, plus probably someone supporting you if you had kids. Like, you just can’t – the concept of starting work at 7.00 in the morning and finishing at 5.30 guaranteed, just does not exist. And, therefore, I, I felt, yeah, I didn’t want that kind of stress of having to juggle those two lives. And so, ironically at the time that made things very easy [to] pull a 60- or 80-hour week or just go the extra mile or get called back in, even if you’re not rostered on, that’s just how it was because you kind of expected that.”

The gendered constructions of the surgeon is something I attend to in greater depth later in this *Health Dialogue*, but it is interesting to note how framing women in surgery as ‘amazing’ can serve to elevate them as the rare exception rather than as a readily achievable role model to which women can aspire. It is also interesting to consider how surgery continues to be constructed as inherently demanding, and specifically for women, fundamentally challenging if they also have (or wish to have) domestic commitments. As a result, the presence of more female role models is likely to assist only in a limited way, unless the temporal norms which remain hallmarks of particular specialties are addressed directly.

What is significant in these sections of the interviews is how extensive temporal commitments are normalised as hallmarks of medicine in general but emphasised as prerequisites for certain specialties such as surgery. What emerges from the interviews is a sense that the ability or willingness of individuals to comply with these temporal expectations is used as a proxy to assess

suitability for particular specialties. With domestic commitments remaining in societal norms the expected responsibility of women, their place in medicine and suitability for specific specialties with acute temporal demands may be judged differently to their male counterparts. What is significant, moreover, is how women in turn have internalised these norms and assess their suitability for various specialties accordingly. As I go on to explore, in this regard medicine shares much with other professions where “long hours culture is the norm and long hours spent visibly at the workplace are valued because it is assumed that they represent commitment and productivity” (Lewis, 2001, p23).

One specific example of the impact of the ‘all-hours mentality’ of medicine which arose in the interviews was highlighted in reflections on the challenges of attending meetings and other non-clinical events outside of the normal working day. For example, a recent decision to change the time of a department meeting was recounted by one interviewee as follows:

“I went to my clinical director last Friday, I said, ‘Why are we starting at 7.30 in the morning?’ He said, ‘Oh well, I thought it would be really good to start the day fresh.’ And I was like, ‘Right, so I’ll bring my kids in so my nanny can pick them up from there, shall I?’ And he was like, ‘What do you mean?’ I said, ‘Well, unlike the rest of you mofos, [laughs] I can’t just walk out the door and expect my wife who stays at home will just pick up everything...’

In this instance, not only was there lack of consideration as to whether the other members of the department might find this time change problematic, but also the assumption that work should come first and other commitments second. For this woman, her role as both a doctor and a parent meant she had significantly different commitments and responsibilities that made adhering to the new meeting times a real challenge. Despite the push to recognise parenting as issues for both men and women, there was a sense in the interviews of a prevailing gender order

where, as one interviewee summed up:

“And the men, it doesn’t affect them the same way. They have an ability to just walk out that door and go. And largely, the reason they can walk out the door is cos she’s still inside.”

In 2004, Professor Carol Black made a clear connection between the dominant gender order in medicine and such temporal issues when she stated that the decision to:

“practise medicine in a male way ... when meetings happen at 8am, 6pm, it is a driven profession to do it all hours of the day ... If we continue to do that, then women will not be able to participate as fully. And if you are not at the table, if you are not participating, if you are not leading the departments, then you can’t have the same professional influence.” (Black, cited in Ozbilgin et al., 2011, p1588)

Unfortunately, Black’s comments were drawn into wider debates concerning the growing numerical representation of women in medicine with the unintended consequence that many used her argument to suggest the growing gender balance may threaten the professional standing of medicine because women are unwilling to work in certain specialties which have unpredictable workloads, and on average work fewer hours than their male counterparts.

More recently, Gary Tigges, an internal medicine specialist from Plano, Texas, suggested that the existence of a gender-based pay gap was fair because:

“female physicians do not work as hard ... as male physicians. This is because ... they don’t want to work the long hours. Most of the time, their priority is something else ... family, social whatever. Nothing needs to be ‘done’ about this unless female physicians actually want to work harder and put in the hours.” (Tigges, 2018, p11)

Not unexpectedly, his statement generated significant outcry and created considerable

media interest, with the result being an apology from Dr Tigges for his comments (Telford, 2018). Unfortunately, however, other commentators have echoed the substance of Tigges' claims by suggesting that as women on average work fewer hours and retain primary responsibility for domestic affairs:

“...women should consider the conflicting demands that medicine and parenthood made before they accept (and deny to others) sought after positions in medical school and residency. They must understand that medical education is a privilege, not an entitlement, and it confers a real moral obligation to serve.” (Sibert, 2011, para 16)

The inference is that women who for a variety of reasons choose to work fewer hours are somehow less committed than those who choose or who are able to work full-time. What remains unacknowledged and unquestioned in commentaries such as Sibert's are the tightly held norms which couple dedication and professionalism to medicine with extensive temporal obligations. The other problematic assumption is the mutually exclusive framing of parenthood and medicine as well as the reliance on problematic gender stereotypes which frame responsibility for parenthood as firmly women's work. As Greenberg (2017) succinctly refutes, the answer is not as Sibert suggests to “keep more female doctors working full-time by setting up child care centres with long operating hours, on site” (Sibert, 2011, para 14) at hospitals, but rather to start unpicking and addressing the latent assumptions that inhere in such statements pertaining to women's suitability for medicine as opposed to their 'natural' suitability for parenthood, and the notion that the only legitimate way to work in medicine is to work full-time.

In the next section, I explore these themes in the context of how some of the women interviewed narrated their decisions to work part-time in medicine. I discuss their comments in light of broader debates concerning the increasing numerical feminisation of medicine and trends for

female doctors to work on average more part-time roles than their male counterparts.

Part-time medicine and constructions of the 'ideal' doctor

In the context of this particular research, I was interested to understand how the women who worked part-time explained their decision and how they felt this mode of work was received by their colleagues. Subsequent analysis of discussions pertaining to part-time work revealed key discourses reflecting contradictory cultural norms concerning how to demonstrate commitment, competence, and a sense of legitimacy in medicine. One woman I spoke with had recently returned to paid work at the hospital after a period of maternity leave. She articulated her decision to go part-time as a necessary strategy to avoid burning out, given her identity as the primary caregiver to her children. She noted that she was relieved that two of her colleagues had recently reduced their FTE to less than full-time, “so [she] doesn't feel quite so much of a slacker”. I asked her what she meant by feeling like a 'slacker', and she said:

“I feel that, everyone else is there more than me and working more than me and working harder than me, which they are because they are paid to do that extra bit.”

CC: “Does that create any tensions for you?”

“Um, it certainly doesn't create any tensions with anyone else in the department. Just me and myself. I feel a little bit second-class I guess. But that's just definitely my take on it. It's definitely not what anyone else thinks. And just on that, there are some other new consultants who have started around the same time as me, male, who are working full-time, and I do sorta get the feeling that they are getting experience and are seeing more, more various conditions and have more experience in managing them than I have because they see more patients. And they are getting experience more quickly.”

While this woman didn't sense any overt pressure from her colleagues, she had internalised a sense of feeling 'second-class' in comparison to her colleagues who are present and visibly working more than she. The conflation of part-time work with concerns for 'slacking' or feeling 'second-class' suggests a construction of working patterns that deviate from a full-time norm in medicine as less than ideal. Moreover, part-time work is constructed in this narrative as potentially risky; as the woman reflects, there are obvious career-related consequences if her male colleagues, able to work full-time, are attaining greater opportunities and a wider range of clinical experiences.

Around half of the women interviewed in this study were currently working less than full-time, defined as less than 1 FTE, which is generally equated with 40 hours of paid work per week. One was considering dropping her hours due to concerns for her own well-being and to enable her to spend more time with her daughter. Statistics from the 2017 Medical Council of New Zealand workforce survey show 41% of females are working fewer than 40 hours, compared with 17% of males. Of those males working part-time, only 51 responded that they were doing so due to family commitments (cf 554 female respondents) (Medical Council of New Zealand, 2017, p18). Research finds that female doctors are more likely to decrease the number of hours spent working in medicine if they are married or if they have children (Wang and Sweetman, 2013). A recent literature review by Ly et al. (2017) found hours of medical work decreased by on average 11 hours per week for medical women in relationships with other doctors if they had children, but the same trend did not hold for the men. One possible explanation for this trend posed by the authors was the persistence of societal expectations where it is more appropriate for women to reduce their work hours in order to care for children than it is for men (LaPierre et al., 2016; Lewis, 2001).

The sense of part-time work as risky or lacking dedication or commitment to work was narrated by other women as an ongoing struggle to prove

competence which could intensify once women also had children. As one woman described, she felt her decision to 'do mothering stuff' made her fear being treated by her colleagues as someone who only 'dabbles' in medicine:

“...as a female, if you want to be part-time, but take care of the kids and actually do some mothering stuff and still be a good doctor, your colleagues look down on you because you're not contributing as much – even though when you are there, you are doing twice as much as them but they still look at what you're doing as *dabbling in it* rather than actually participating.” (emphasis added)

Again, as with the previous comment, there is a sense that part-time work deviates from a full-time norm. Being visible in the department is framed as important because it is assumed to represent commitment and dedication to the role. Despite this woman reflecting that when she is present at work she is “doing twice as much”, this increase in productivity and effort is not readily recognised because she is not considered to be participating as a full-time member of the team.

Similar sentiments were expressed by another participant in the context of her work at different hospital sites; while working close to full-time, she felt that her lack of visibility combined with her gender led to the assumption that she was off doing other non-work related tasks:

“I work across three different sites. And a lot of my colleagues, if they can't physically see me at work, they think I'm at home doing nothing. Just cos you can't see me, doesn't mean I'm not working. And just because I don't see you doesn't mean I think you're not working. But it's a different way of thinking. I assume they're working, whereas they assume I'm at home painting my toenails or whatever it is.”

The consequences of this lack of visibility were articulated directly by another research participant in the context of her decision to return to paid work full-time following the birth of her child:



“[For me] it was important not to come back to work part-time, and that’s about proving that you don’t need to treat me differently. Um, cos quite a few of my female colleagues come back part-time, and that’s fine. I don’t have a problem with that. But – the less time you spend in the department the less likely you are to be treated as part of the department. You know, ‘Oh, she only works three days a week’ or ‘She works two days a week, two and a half days a week, so she can’t really do that portfolio.’ You’re seen as being a bit of a lightweight, maybe. So when the lists are rostered, you’re less likely to get the good – the more challenging lists. You feel like you get marked as being less capable, less committed.”

CC: “Do you think that’s fair?”

“Mm, no. No, because lots of my department work 0.6, as men. It’s just that the other days of the week they’re doing private, but that’s legitimate. It’s legitimate to be doing private. It’s not legitimate to be hanging out at home. Doing nothing, yeah. Getting pedicures and having massages.”

What these observations demonstrate is how visibility matters and how lack of visibility can be read differently depending on gender and working practices. As the first example suggests, as a woman working in a male-dominated field, working at different places results in her lack of presence being read as absence from work. For those working part-time in their DHB but also working in private, their lack of visibility is read differently because they are still deemed to be working. For those who are less present at work because of their domestic commitments, their lack of visibility is read as absence from work, which in turn is regarded by some as signalling a lack of commitment to their medical work. The consequence of these differentials around visibility are very real; as the last quote describes, it can result in being ‘marked’ as less able. As Lewis (2001) and others note, those who work part-time are often resigned to accept this subtle denigration

as one of the necessary consequences of their decision to deviate from the norm of full-time work in order to fit in their domestic responsibilities. What is perhaps most concerning given the focus on well-being in this research is the subsequent internalisation of these norms, which results in women self-describing their choice to work part-time as equating to slacking or feeling second-class.

One of the consequences of this feeling of deviation from the full-time working idea was frequent expressions of guilt. Some of the women expressed feelings of anxiety that as a part-time worker, they were regarded as not pulling their weight while at work. Some described how their feelings of guilt were bi-directional, feeling guilty when they were at work that they weren’t with their children, and when at work, feeling guilty for not doing as much as their full-time colleagues. As the following comment illustrates, this sense of guilt drove one of the women to volunteer for extra duties so that she could ‘prove herself’ as committed as her other colleagues working full-time:

“Yeah, it’s really hard and I don’t think I know a single woman that doesn’t feel guilty about one thing at times – like not all the time, but you’re always ... I think you try to kind of almost do a better job at work. Well, not a better job, but you wanna, you don’t wanna be seen as slacking off. Because I know that I’m only part-time and I wanna spend time with my kids ... And so I feel like when I’m at work, I don’t wanna say no to any requests for any help with things from others and that kind of thing, because yeah, you’re al-, you’re already feeling guilty that you’re doing stuff with your kids.”

These complex feelings of guilt evidence the nexus between the domestic and professional fields; on the one hand women must deal with gendered expectations concerning how to perform as a ‘good mother’ while on the other hand simultaneously trying to demonstrate commitment and competence in their professional roles as a ‘good doctor’ (Wallace, 2014). As this interviewee continued, this

feeling of guilt also transmuted into feeling less than a 'real' doctor, with again, reference to the notion of part-time work equating to a lack of passion, or treating medicine as a 'hobby':

CC: "So what is it about part-time work that makes you fear slacking or looking like a slacker?"

"Yeah, that's – it's silly isn't it? Because you're only getting paid for part-time. So you should just be working the same proportion of your part-time that other people are working of their full-time, but I guess you feel like if other people are working full-time, they'll be like, oh well ... you're only doing 50% of the job ... It seems like you're not passionate enough about your job or whatever or you're – yeah, it's only a hobby."

CC: "Do you think that's what it is?"

"I don't think it means that you're not passionate about your job, but I wonder if that's how you feel. And it does – you feel like you might be judged by the people that perhaps don't have kids or aren't working part-time or have put more of the energy into the work, yeah."

This sense of being judged is very real; concerns for the increasing rates of doctors choosing to work part-time in medicine have been raised often in recent years. These debates tend to conflate the growing gender balance of the medical workforce with threats to the continuity and quality of medical service provision due to trends for women to more often work part-time hours and retire earlier than their male colleagues. Newspaper headlines from the UK such as "Part-time women doctors are creating a timebomb" (*The Telegraph*, 24 March 2013) and "Part-time women doctors are a risk to the NHS" (*The Telegraph*, 16 September 2012) explicitly frame part-time work and women doctors as a threat to the norm of full-time medical work as business as usual. Debates in the BMJ around the question of 'Are there too many female medical graduates' (McKinstry, 2008; Dacre, 2008) again conflate the increasing gender balance in the medical workforce as a development which is inherently 'bad for medicine'.

These arguments fail to consider wider societal reasons that may see both men and women seek part-time work opportunities, and perhaps most concerning, imply that as the medical profession becomes increasingly feminised, it risks losing professional standing ('More Doctors Needed, without Discrimination', 2004). As Riska (2008) describes, this discourse around 'feminisation' suggests that the growth of women in medicine presents a 'threat' to the "inherent (male) ethos" of medicine where having a female majority is conflated with de-professionalisation and an associated decline in the status of medicine. As Riska counters, such simplistic arguments construct medicine in several important but problematic ways. Firstly, describing the 'feminisation' of medicine implies a gender-neutral field of medicine which only becomes gendered with the entry of women. This will be discussed further later in this *Health Dialogue*, but as I go on to explore, this construction of medicine fails to attend to the way in which medicine as a professional field has been gendered from its inception. Secondly, this discourse reproduces problematic gender essentialisms which construct women as somehow less suitable for professional work. In this discourse, professionalism and authority are reinforced as masculine characteristics directly linked to the proportion of men in a profession. Finally, and again relying on problematic gender essentialisms, this discourse implies that the greater proportion of women in medicine will change the way medicine is practised because women are assumed to bring qualitatively different values and behaviours based on their gender (Riska, 2008). The latter may have benefits; for example, there is evidence to suggest women can have better clinical outcomes (Tsugawa et al., 2017) and are more focused on communication (Roter et al., 2002). Nevertheless, the corollary of this argument is that women may be viewed as inherently unsuited to certain fields and specialties in medicine, particularly surgical specialties, which have been constructed as demanding more agentic modes of behaviour and comportment – behaviours constructed at odds with the feminine gender schema.

The positives of part-time

Despite the negative framing of decisions to work less than full-time, a significant number of studies suggest that working fewer hours may result in significant positives for both doctors and their patients. For example, a study by Panattoni et al. (2015) found patients reported significantly better satisfaction with their encounters with part-time primary care doctors despite acknowledging issues concerning continuity of care and access. Similarly, research by Mechaber et al. (2008) found those working part-time reported less burnout, higher satisfaction, and greater work control than full-time physicians. Other research by Yong et al. (2015) suggested that doctors working part-time reported a greater enthusiasm for their work and better overall morale.

The latter benefit associated with working part-time was affirmed by one of the doctors involved in the study. She spoke of the serendipitous circumstances which led to her attaining a part-time training position following the birth of her first child, and the significance of being encouraged to seek a part-time role by a senior male colleague. As she noted, she felt there were significant benefits associated with working less than full-time, particularly in terms of her ability to stay passionate about her work in light of her domestic commitments:

“I’m definitely passionate about my job and I think it’s because I feel like I have that opportunity now, which I didn’t have. When I was doing my training I would not have said I was a slightest bit passionate about my job. I often thought of quitting my training. I definitely thought I’m in the wrong job, I’ll do something different. But now that I’m only working a couple of days a week, you know, I can really enjoy it while I’m there, enjoy the adult time, enjoy the satisfying interactions with patients.”

“If someone came to me for advice I would definitely say, ‘Be part-time if you can.’ And I would also say, ‘Don’t worry about taking time off to have kids during training.’”

As she noted, the wider benefits of her decision to work part-time resulted in her feeling that she had greater enthusiasm for her work, that her clinical skills were better and that her employer was getting more value for money because she was more willing to stay later if required because she really valued her time in the hospital:

“I definitely do a *much* better job when I’m part-time. I really do. Much more relaxed. Much more enthusiastic about the stuff I’m seeing ... I think when you’re *not* burnt out you remember to look back and treat each patient – you find their life story quite interesting ... [also] you’re going to spend longer. Like, I would be happy to, to be later at work on my day. So I reckon I – they get more out of me for the money than they would if I was full-time because I’m happier to stay ... So, actually I think you do go above and beyond much more, even though you’re being paid less.” (emphasis in original)

A study by Heiligers and Hingstman (2000) found 44% of male specialists working full-time would prefer to go part-time and more than 50% of all specialists desired a reduction in their working hours. As a consequence, they suggest that medicine is gradually shifting towards accepting other modes of working where medical work no longer holds the same level of life centrality than what they define as the “dominant standards of dedication and availability” (Heiligers and Hingstman, 2000). Satiani et al. (2011) similarly suggest there are greater numbers of both male and female surgeons coming through the American system who are seeking less than full-time working opportunities. Their research suggests that embracing the trend towards greater part-time work would represent at least a partial solution to predicted workforce shortages in the future because of the likelihood of retaining these doctors as a consequence of higher job satisfaction. Similar findings have been made in studies by Mechaber et al. (2008) and Pollart et al. (2015).

In conclusion, given the propensity for this age group to experience burnout, the internalisation of feelings of guilt and the sense of deviation from

ideal practice for the women who were working part-time are significant. What is clear from the current research is how pervasive the full-time norm is in medicine, and how deeply the women in this study have internalised views that working less than full-time is potentially risky and a threat to their own sense of belonging and legitimacy in their professional role. This was particularly the case for the women in this study who had chosen part-time work because of their children, but also appeared a concern for those working full-time who recognised that they might like to pull back their working commitments. As a consequence, despite the widespread literature signalling that working long hours can lead to burnout, the decision of these women to decrease their paid working hours in order to move towards a sense of balance between paid work and domestic responsibilities is unlikely to be protective if it is also accompanied by feelings that they are not demonstrating adequate passion or commitment to their medical careers.

As other ASMS research has demonstrated, concerns for working in ways that differ from a full-time temporal norm can also influence decisions pertaining to sick leave and can lead to the feeling that one must continue to work through illness for fear of letting colleagues down or appearing 'weak' (Chambers et al., 2017). This current research also found that such concerns can shape decisions around whether or not to breastfeed infants upon return to work (ASMS, 2018) and, as the next

section explores, influence the length of time taken for maternity leave, as well as the way in which the return to paid work is structured.

Nevertheless, as the literature substantiates, the push towards different ways of working in medicine is not just coming from women; many younger doctors are now seeking different ways of working because of a desire to have a greater balance between medicine as a career and their other lives, which may include their domestic commitments. In early presentations of the findings of this research, for example, I was approached by two male specialists who noted that they were feeling considerable push-back from their colleagues and DHB management at their requests to reduce their FTE so they might spend more time with their young families. These issues, as they stated, are not restricted to women.

As a consequence, it is vital to better understand and prise apart the gendered norms which currently govern how medical work ought to be structured, the accompanying expectations as to what constitutes 'normal' hours of work, and how this translates into an implicit recognition that certain modes of working are more closely aligned with commitment, dedication, and competence. Without adequate recognition of the power of these norms and the pressure that many feel to conform to them, or the guilt that they carry if they feel that their work practices deviate, efforts towards achieving well-being will be fundamentally circumscribed.

Case study: “Mother like you don’t work, and work like you aren’t a mother”

All but three of the women interviewed had children, and some were on maternity leave at the time of the interviews; one had recently returned to her paid job at the hospital. As with the findings of the previous section, the women were readily able to describe tensions around their decisions to combine their medical careers with parenthood, and it appeared that for many, their decisions concerning how to structure their maternity leave and their return to paid work had been challenging. Analysis of the material found reference to ongoing work while on unpaid leave, feelings of disparagement for taking maternity leave, fears of either explicit or implicit punishment for taking leave, and a feeling that speaking of children or performing the role of ‘mother’ could be damaging to career progress or their professional reputation.

In the first instance, there were considerable discussions throughout the interviews concerning the best time to have children. As noted previously, many felt pressure to either delay their pregnancy until they had completed training or structure their leave to have the least impact on their medical career. There was a diversity of approaches to how the women interviewed had scheduled their pregnancies, but one consistent theme was the fact that pregnancy was something that had to be scheduled with their career and managed carefully, not just in terms of how it might interrupt training, but also how it might shape future opportunities or experience.

As with discussions pertaining to working less than full-time, some described feeling that they might be disregarded by colleagues as ‘lazy’ or ‘slack’ for taking maternity leave. In the following interview excerpt, one woman noted how the lack of a ‘norm’ around length of time for maternity leave made it challenging to decide how much leave to take:

“Before I went on maternity leave, I felt like I had to pick up extra shifts. [Although] I would be covered ... I sort of felt guilty ... for taking optional time off. And because there’s no norm for maternity leave ... when I wanted to extend [my 6 months] by two months, I was quite torn – ‘Are they going to think I’m slack by wanting another two months too? Am I gonna be thought of as lazy because I’m taking more time off?’”

Others also spoke of informal rules governing the amount of time to take for parental leave, with many feeling they had to choose between taking at least six months off to enable locum cover or, at the most, a year off their paid work:

“... you have to choose either six months or a year, because that’s easiest for hiring purposes. ... that was ... the impression that I got that it wasn’t really okay to just pick and to say [I want] nine months. ... but I knew I didn’t want to come back full-time at six months, but I also didn’t think that we could afford financially for me to be off for a year.”

The ASMS Multi-Employer Collective Agreement (MECA) states that employees who have had at least one year of service at the time of commencing leave are entitled to parental leave of up to twelve months or six months if employees have less than one year’s service to their employer. Employees are further required to give at least one month’s notice of their intention to return to paid work. There are no further ‘rules’ regarding length of time that can be taken off. Significantly, and despite the provisions in the ASMS MECA, for the interviewee there was a sense that if she didn’t play by the informal rules, she risked being penalised upon her return to work:

“[A] colleague who had taken a year and then had ended up in a situation [where] ... she said she wanted to come back to work early ... she got told by her Director ... that ... she could only do ‘day stay’, which ... for 98% of people it’s penance, you know. You do it cos you have to do it. So to be told that that’s the only place you can work for the next four months was punishment. ... she got even joking comments ... things like people saying, ‘Well, you’ve got mummy brain now. Day stay’s all you can manage.’ Like, no shit – from men of course.”

As a consequence, she decided to structure her return to work so that she avoided part-time duties for fear that she might miss out on the more interesting or challenging work which she had been enjoying doing prior to her maternity leave.

Other women spoke of the challenges they experienced while on parental leave, some referenced experiencing significant postnatal depression and loss of confidence following the birth of children, including some who referenced simultaneous feelings of relief and guilt when they returned to paid work and found it much easier than being at home with their children. Others spoke of how they felt obliged to continue with non-clinical duties while on parental leave, whether they wanted to do it or not. These examples are detailed below in Table 2.



TABLE 2: EXAMPLES OF PARENTAL LEAVE EXPERIENCES

“What I didn’t realise, as I think many first-time mums wouldn’t, I didn’t realise how difficult it would be being at home with a newborn baby. You know, you think the baby sleeps 16 hours a day, 20 hours a day, I’ll have plenty of time. ... And I think, you know, women in medicine, high achieving, used to shift work, used to long hours ... masters of our destinies, we sort of think, oh I’ll be pretty good at this mothering thing. I didn’t realise how difficult it was going to be, and then it was a struggle is, is the honest answer.”

“I had quite bad postnatal depression and anxiety with [my baby] ... Even though she did sleep relatively well, just the whole adjustment from being like not super career-driven, but just being in total control of what was happening in your life and then not having control of anything, was just terrible and I really really struggled with that. ... I think medicine as a career kinda contributes to burnout, because that’s just your whole focus and you never – you know, it was a huge adjustment for me, and I know lots of other female doctors who have felt the same, you know, that have had kids. It’s really tricky.”

“I took a phone call when I was post-op in hospital, the operators put someone through to my cell phone and it just comes up as private number, so I don’t know who it is, so I answered it, and it was a doctor ... wanting to talk to me about referring one of my patients ... they said, ‘Are you in the hospital?’ and I said, well I am actually but [laughs] I’m sitting in a bed with a one-day-old baby beside me! And I said can I put you on to the on-call person, I’m actually on parental leave now. And they said, ‘Oh yes, yes sure’, and then they tried to slip in a little quick question first.”

“I actually continued doing all of my non-clinical work when I was on parental leave both times, partly because I wanted to, um, partly because it was just going to sit there waiting to be done if I didn’t anyway, it was just going to be a massive workload when I got back, um but the fact that, dropping to part-time would have meant the paid time to do all of that [sic], and I still would have needed and wanted to do it all, so I would have been doing it in my own time, unpaid, and I don’t have my own time anyway.”

“While I was away on maternity leave, I would be rung almost every second or third day, um, which ... actually really distracts from your maternity leave when you are tired and all you want to do is hang with your kids.”

“Obviously I’m not working at the moment but I’m – I am constantly writing, um, you know, teaching sessions in the evenings or I have, you know, VPN [virtual private network] access. I’m looking up my patients and, you know, thinking ahead and, um, I, I do a lot of work in the evenings but I can’t – there are certain times of the day where your family needs you.”

“There’s lots of aspects of working in medicine and being on your own with a child that is quite hard, but I still wouldn’t have it any other way. And I think my career decisions would have been really different if I didn’t have her. You know, I think I would’ve, um, probably sub-specialised and possibly gone overseas for a while and come back. But, um, again being a single mother with a child, meant that finishing my training in New Zealand if I could and getting a job all of a sudden became the most important thing. So that I now have more time with her than I would have had as a registrar.”

“I waited till I had finished studying and exams before we tried to get pregnant and then it ended up taking us two years to get pregnant so it delayed it even more, which was frustrating but in hindsight possibly a good thing because I’d finished my training and finished all the on-call.”

“When I went on maternity leave, one of them said to me, ‘Oh I wish I could just get fat and copy you.’ I was like, seriously, that’s what you think your wife did? Just get fat and take a year off? Like did you miss that whole, having a baby, raising a baby is quite tiring – like it’s not just taking a year off.”

“If you want to have children, you’ve got to have children while you’re training. It’s a line that they spin, but in reality you can’t, because you know if you give up your place, they will have to find someone to fill your place, and so then you’re held responsible for letting all your colleagues down, and then you’re always gonna be that woman who let your colleagues down. Or if you do give up your space to have a child, then there’s not the space for you to get back on it. So they can hold it – punish you for taking the time off so then they won’t let you back on, particularly in a very small specialty like mine. There’s no room.”

Accounting for gender

As summarised in the introduction to this Health Dialogue, women in medicine have historically faced a complex series of tensions variously barring or circumscribing their presence in medicine. While much has changed in terms of equality of access and participation, research continues to document the considerable inequities that persist in medicine along gender lines. In the context of the study, I was curious as to whether and how the women interviewed cited the impact of gender on their careers. In addition, I was interested to probe how the women felt their gender was received in their day-to-day interactions with patients and colleagues, and whether specific incidences suggested anything about how gender relations may influence their risk of burnout or other indicators of well-being. Underpinning this focus is the recognition that expectations around comportment, behaviour, and appearance frequently reflect gender stereotypes (also called gender schemas) pertaining to how women ought to behave (Valian, 1998). Understanding these gender-based expectations is important because research suggests that performing gendered roles can set up and perpetuate disadvantaged career trajectories while also negatively affecting well-being (Bartos and Ives, 2019).

Following on from the performative theorisation of gender which grounds this research, I trace the often contradictory ways in which the women interviewed described how their gender has affected their medical careers. I consider their initial reactions to the question of whether and how their gender had affected their overall careers before delving deeper into subsequent descriptions of gendered moments and encounters. Throughout, I seek to probe the framing of the significance of gender as much in terms of what is said as what is unsaid. Attending to seemingly mundane events where gender appears to matter enables a wider understanding of key power relations that shape and circumscribe the well-being of doctors in significant ways (Bartos and Ives, 2019). As with previous sections, comments are briefly described before being interpreted in greater detail with reference to the wider literature.

Individual challenges or a non-issue? Contradictory accounts of gender

All women were asked in the course of the interviews whether they felt their gender had ever posed any issues or challenges during their careers in medicine to date, including their choice of specialty and decisions made along their career trajectory. During the interviews, this often felt an awkward thing to ask, partly due to the more theoretical nature of the question but also due to the 'big' response the question potentially required. As a consequence, it was not entirely expected to have responses such as this:

“Um, no I don't think so? I haven't noticed any difference.”

“Well, ah, I find this really a challenging question because I've never actually faced any sort of overt sexism or chauvinism that I can really think of. Um ... so from my own personal experience, not really.”

Others responded to the question by referencing a 'feeling' that might suggest gender bias exists but is not something that they could provide explicit examples of:

“I can't give any concrete examples cos I'm not really sure that there are any, it's just sort of a feeling. Yeah.”

As conversations continued, many women continued to either acknowledge or cite specific examples where they felt that their gender might have mattered. As with the previous excerpt, gender-based issues were described with reference to perceptions of sexism, bias, or gender discrimination but more commonly as issues that affected others. In the following excerpt, for example, the interviewee expresses her reluctance to accept that her gender may be seen as an issue by others:

“Yeah, it's a really good question ... it's been said to me ... [that the previous clinical leader] had a big issue [with a young woman coming into the role ... It's something I don't like to accept. ... You sort of think, oh, I can't just pretend it's not real, [laughs] um, but I don't really like to accept it.” (emphasis added)

Similarly, others dismissed the notion that their gender may have been an issue for them personally but acknowledged that perhaps issues with 'gender difference' might remain a problem in other specialties:

"I don't know. Personally, for me, I don't think so ... I've never really felt that I've had to go out of my way to prove that I'm the best or better or as good as. ... I wonder whether in some of the other specialties there might be a little bit more of that ... I guess I'm thinking of some of the surgical specialties. Again, a bit of a generalisation. ... when I was a house officer, it was quite hierarchical and probably there was a little bit of gender difference. I don't know if that's changed over time. But ... it does feel like we've got more female trainees in general [laughs], than male, yeah."

In this excerpt, there are hints as to how gender matters in subtle forms; for example, the enduring presence of hierarchies was suggested as evidence that gender-based discrimination might persist but only in some "surgical specialties". Despite this, the interviewee suggested gender was likely to be a non-issue overall given the passage of time and the numerical growth in women in her field, which she inferred would render any issues with gender irrelevant.

For some respondents, specific circumstances where they felt their gender might have been an issue were downplayed and presented as more likely to reflect individual personalities or individual characteristics rather than representing a wider systematic issue with gender bias:

"[Since] I've come back from parental leave, all my patients have been seen by other doctors. [I've noticed] a few of them seem to have taken with a lot more respect what my male colleague had said to them, when I'd already said the same kind of thing. But I don't know if it was necessarily gender. It may have been gender, it may just have been their interaction or the way my colleague presents himself perhaps." (emphasis added)

For another interviewee, the significance of gender was acknowledged but only in light of specific personal circumstantial change, in this instance feeling that she had to 'prove' herself since having children. In the same excerpt, however, the interviewee acknowledges there might have been an issue with her gender previously, but this would only have been a problem had she been interested in orthopaedic surgery:

"I've only felt that personally since I've had children. I haven't felt that my gender – um, that I had to prove myself despite my gender before I had kids. Certainly there were runs I remember doing as a med student. Like, I'm particularly thinking of orthopaedics where I thought they didn't look at me as a future colleague because of my gender. But I didn't want to be an orthopaedic surgeon so I didn't care."

Collectively, these discourses frame gender as a non-issue, as something which might be 'real' but is more likely to be a 'generalised feeling'. In these accounts gender discrimination may exist, but it is something that happens to other women, and more often than not, to those who choose to work in male-dominated specialties such as surgery.

The tendency to downplay or dismiss outright the existence of gender-based discrimination has been substantiated in other research focusing on women in medicine (Webster et al., 2016). In their study into the disavowal of gender bias in surgery, Webster et al. (2016) noted that high-performing women are frequently unwilling to self-identify as victims of discrimination or inequity despite a willingness to recognise the existence of such discrimination or recognise instances when it may have affected others (Webster et al., 2016). In part, other research suggests this may reflect a need to understand success and achievement as a consequence of hard work, individual skill, and perseverance (Berg, 2002) although, as Valian (1998) notes, it is more common for women to frame their achievements as a consequence of good fortune or serendipity. The corollary of such a view, however, is that when failure, difficulty, or

setbacks are encountered, it is more likely to be framed as a consequence of an individual failing; negative encounters are due to not being strong enough, talented enough, or working hard enough. This individualised emphasis fails to acknowledge and account for wider social inequities that can shape and structure career progress achievement, and well-being.

Furthermore, emphasising personality or individual circumstance also serves to tacitly shape a view of medicine as an even playing field where anyone can succeed if they try hard enough (Berg, 2002). As Webster et al. (2016, p563) emphasise, “These strategies have the discursive effect of making incidents of discrimination or inequity seem like isolated events that are contingent on individual factors and thereby dissociated from larger social and structural issues.” As suggested in the introduction, this view fails to recognise the persistence of significant gender-based bias as well as many other ‘isms’ of discrimination which operate to subtly disadvantage certain groups from success or advancement in medicine. Kaatz and Carnes (2014) describe this as the phenomenon of in-group and out-group bias which doesn’t necessarily require an intent to exclude, but rather the creation of an unequal context. Without understanding the bias that underpins certain structures and practices that serve to disadvantage women, what is left are stereotypical explanations as to why women collectively face horizontal and vertical segregation in medicine. As Ibarra et al. (2013, para 18) state:

“If [women] can’t reach the top, it is because they ‘don’t ask’, are ‘too nice’, or simply ‘opt out’. These messages tell women who have managed to succeed that they are exceptions and women who have experienced setbacks that it is their own fault for failing to be sufficiently aggressive or committed to the job.”

It is therefore unsurprising that the women interviewed appeared reluctant to recognise how their gender may have subtly shaped their career paths and choices. As others have noted,

focusing on the challenges facing women can inadvertently result in further ‘othering’ of women and the re-inscription of problematic stereotypes that women are not as able as men and require additional support or assistance to succeed (Valian, 1998). By contrast, research on interventions to tackle implicit gender bias suggests that becoming aware of gender stereotypes and gender-based discrimination is the first step in moving towards positive possibilities for change (Carnes et al., 2015). In what follows, women’s initial disavowal that their gender had shaped their presence in medicine is contrasted by describing their reflections on specific instances where their gender circumscribed their professional activities and shaped interactions with colleagues and patients in significant ways.

Making up for being female?

Expectations of how women should work and what traits or qualities women are expected to exhibit in medical contexts has been shown to rely on essentialist notions of gender-normative behaviour (Davies, 2003). There is considerable research to suggest the presence of strong societal expectations as to how women doctors ought to behave, in addition to the types of issues, patients, and fields of medicine they should be interested in. For example, in a UK study, women general practitioners were assumed to have a greater interest in health matters of women and children and were expected to be more empathetic, approachable, and communicative in their interactions with patients than their male counterparts (Kilminster et al., 2007). While empathy and good communication skills are vital in medicine, the issue here is that women are considered ‘obliged’ to perform these roles in their interactions with patients in ways their male counterparts did not because of the expectation that women are somehow innately better at such interactions.

Similarly, other research suggests that women in medicine are judged negatively by patients, colleagues, and even medical students if they fail

to demonstrate characteristics such as empathy, compassion, and modesty (Braun et al., 2017). A further study by Babaria et al. (2012) found medical students expressed concern and disappointment if their female supervisors were not caring and empathetic with patients and yet did not comment if their male supervisors failed to display the same behaviours. Another US study found that patients expressed disappointment if their female doctors were not as 'warm' as they expected them to be (Prince et al., 2006).

Recent research by Linzer and Harwood (2018) extends these observations to suggest that these gender stereotypes, with accompanying expectations as to how women doctors ought to behave in clinical interactions, present a significant additional emotional burden. Crucially, given the emphasis of this study, they find expectations relating to 'hidden rules of appropriate behaviour' can be both unsettling and stressful, and significantly predispose women to experiencing burnout.

This idea was referenced in an interview in a discussion about why women were collectively more at risk of burnout. Notably, the interviewee describes it as a consequence of the pressure to perform that women experience. As she explored:

"I think there's a lot of pressure to perform ... I think women are more unsure of themselves, so have to do a lot of extra work to prove themselves ...

CC: "Why do you think women feel less confident than their male counterparts?"

"It comes back to sexism a bit ... you know when in ward rounds where you'll walk in and you are the senior reg and there is a tall male med student with you and the patients gravitate towards the tall male. And so it's sort of techniques to make people aware that you are the leader ... and I think we need to overdo that, because we have to make up for being female." (emphasis added)

In referencing the pressure to adopt 'techniques', this respondent further evidences the hidden

labour women must undertake to demonstrate competency, suitability, and authority in their chosen field. Indeed, many of the women interviewed were readily able to cite instances where they felt their professional opinions were received differently, or even at times ignored, either by other medical colleagues, other staff, or patients because of their gender:

"Oh, wow, it's so hard. Actually, they just look past you, like you don't exist. They're just ignoring you – including house officers and, you know, it's not like your word means anything to anyone, but it, it has been quite hard. [laughs] It really has been. I think it, it's just, you know, being a young female doctor. They're like, 'Whatever – you just don't know what you're talking about.' I have had a few people, house officers and registrars deal with me that way and make you feel like an idiot."

As the above example suggests, feeling ignored or disregarded by more junior colleagues requires significant additional work which many women are bidden to perform in order to be heard or recognised as legitimate. Research by Houry et al. (2000) finds misidentification can lead to significant role strain, particularly if women doctors are having to work hard to assert themselves as the medical professional. Struggling to be heard is thus likely to have a subtle yet cumulative negative effect on well-being, as well as a detrimental effect on confidence.

Research suggests that women are significantly less likely to be correctly identified by patients as doctors than their male counterparts; this misidentification can also be made by other medical staff (LaBonty and Becker, 2001; Prince et al., 2006). Experiences of misidentification were raised consistently in the interviews. Most brushed off such instances as one of the quirks of being a female doctor, but others spoke of how it could hinder their efficiency in their work, as well as being a daily battle to contend with. It was clear throughout the interviews that these pressures to overtly present as the 'doctor' were gender-specific. As one interviewee explained:

“...when I’m in clinic, I’ll usually say, ‘I’m your doctor’, because otherwise [the patient will] think you’re a nurse. And there’s nothing – *absolutely* nothing wrong [laughs] with nurses or nursing, but it’s the fact that if I was a bloke ... sitting there asking you about your past medical history, your medications, talking to you about the kinds of things I’m going to do, you’d *never* assume that I was the nurse.” (emphasis in original)

As suggested in the introduction to this *Health Dialogue*, it is not insignificant that women continue to be misidentified as nurses, particularly given the characterisation of nursing as primarily concerned with care, comfort, and nurture – gender schemas constructing women as inherently more suited to nurturing and caring duties than men (LaPierre et al., 2016; Valian, 1998). Societal expectations concerning the gender specificity of ‘doctors’ are not innocent, and misidentification demonstrates the pervasive nature of gendered characteristics and gender role typing (Greenberg, 2017). Other descriptions of participants’ reflections of being misidentified as ‘nurse’ included the following:

“Patients treat you differently too as a female. – I love it when I’m on call. I just find it ... mind-blowingly amusing. I walk in the room. I’ll have junior doctors who have maybe just graduated medical school and the patient will talk to them like they’re the experts ... a lot of the younger guys get really uncomfortable ... and afterwards they’ll be like, ‘Oh, I’m so sorry. I’m so sorry. Like, I didn’t tell them I was in charge.’ I was like, ‘No, it’s all right, look, it’s just inherent bias that society still expects a white man to walk in ... and boss them around or be rude to them and then that’s the surgeon, you know.’”

“I guess if you look young, people don’t take you so seriously. ... I get pissed off about it – and that’s not the patient’s fault, but they always call you ‘nurse’ and you go over and you know, it grates after a while of being called nurse ... There’s nothing wrong with

being a nurse, but it’s people just assuming you’re female, you’re a nurse, even though we’re wearing different scrubs that say Doctor on them.”

Another interviewee also described the burden of what they perceived as a gendered hierarchy between themselves and their male colleagues in terms of how they worked alongside (female) nursing staff:

(describing a new nurse in her ward) “In her head’s some sort of hierarchy. I see her with my male colleagues. If they were to say, can you please go jump off the bridge, swim back around and come back, she’d be like, ‘Okay, not a problem.’ I just think, come on, I’m not here to fight with you. We’re here as a team. And so that’s exhausting as well, the females that drag other females down. And there’s quite a few of them around, and in surgery too.”

A similar story was recounted by one of the women who worked in surgery; she felt that her female nursing colleagues were more likely to critique her abilities in theatre:

“[nurses] *definitely* say stuff to us that they wouldn’t say to guys. [They] question your judgement, like, ‘Oh, do you think you should call someone for help?’ or ‘Do you think that you’ve done enough now? You should finish because you’ve been taking a while.’ ... Whereas they *definitely* wouldn’t say it to the guys.” (emphasis in original)

Collectively, these small exclusionary practices can contribute to the need to work harder to prove oneself worthy or a recognised member of the professional category of ‘doctor’. The daily labour involved with proving legitimacy was clearly demonstrated in the reflections of the women interviewed where they described traversing invisible lines of appropriate comportment, appearance, and behaviour. As Kaatz and Carnes (2014) assert, recognising the role of gender stereotypes as they serve to operate in daily exchanges or social interactions is crucial to

understanding how gender stereotypes collectively work to disadvantage women as ‘outsiders’ in medicine. As they state: “Although inadvertent and generally unintended, the result is to systematically disadvantage women as they strive to gain equal footing in status, influence, control of resources, and institutional power” (p483). To bring this back to the context of burnout and well-being, it is not hard to see how regular small acts of misidentification or a sense of having to work harder to have professional opinions heard can have a cumulative detrimental effect on well-being. It is widely acknowledged that feeling supported by colleagues and working in a work environment where an individual feels accepted as a legitimate and valued member of the team is protective against work-related burnout (Walsh, 2013). For the women in my study who are also carrying the additional discursive burden of ‘women doctors’, their need to push back against stereotypical views and assumptions that they are not ‘serious doctors’ must be cumulatively exhausting.

Some respondents discussed instances where they felt they were expected to take on additional duties because of gender-based expectations. In the following excerpt, this respondent considers the wider significance of being asked to perform simple tasks such as fetching nappies while on ward rounds. While she didn’t begrudge doing so, she realised that her male colleagues were never asked to do the same, and that cumulatively, these small tasks could contribute to pressure and stress to complete her work:

“[It’s a] bit of a generalisation that women do tend to take on more, I think. And whether that’s emotionally but also even within the job, often putting up your hand to do the extra bit. And sometimes it’s even just the simple stuff. ... When you’re in the ward, someone asks you, you stop, and do it and there’s almost no expectation that your male colleagues would ever get asked. I realise that I do that a lot. ... if I’m in the ward reviewing a patient, often the families – I don’t know whether it is because I’m a

woman, will ask me, ‘Oh, I need a towel’ or ‘I need some nappies for, for my child’, and I’ll happily go off and get them, even though I may be in the middle of reviewing a patient. I’ve actually realised that I need to focus on what I’m doing for now, and just say, ‘Oh, who’s your nurse?’ ‘Can you ring the bell and ask your nurse?’ ... Whether it’s because a lot of us have families and often take on the bigger role of looking after the family as a whole, that you automatically just see those things that also need to be done.”

What emerges from this excerpt is a sense of the additional emotional labour that women are expected to shoulder in addition to the business-as-usual tasks required as doctor. Notably, for this respondent, there was still a reluctance to ascribe the expectations of her patients directly to her gender (“I don’t know whether it is because I’m a woman”), and yet simultaneously she felt that her willingness to assist with ‘simple stuff’ was because of broader normative gender differences reflecting women’s ability to ‘automatically’ see things that need doing.

In a similar vein, other respondents reflected that their gender was a factor in what types of patients they were encouraged to take on, or shaped assumptions concerning the types of work they would be best suited for:

“I don’t think [my gender has] stopped me from doing what I want to do, but there’s certainly a difference in how teams might treat you ... people will often perceive that because you’re a woman, that you’ll be better at managing a certain type of patient ... and it’s the kind of patient that can create burnout in clinicians really easily and the sort of stuff that should be ... shared equally amongst everybody in the team. So perhaps that – but otherwise no.”

As with the previous excerpt, this comment suggests the additional expectations that reflect gender-based stereotypes and assumptions. Significantly, for this interviewee, it was these



gender-based differences in 'how teams might treat you' that could lead to burnout because of the resultant inequity in workloads. This theme of women shouldering gender-based expectations of the type of work they are best suited for and the types of patients they ought to see is consistent with the literature; research suggests women are expected to have greater capacity to cope with patients with greater psychosocial needs or 'emotionally demanding' situations because of their assumed inherent capacity to be better suited to that type of work (Jefferson et al., 2015; Linzer and Harwood, 2018).

In addition to the emotional labour and inequity in workloads these women described, other respondents considered how gender-based expectations could have the unintended consequence of impeding their visibility in hospital settings. In the following excerpt, the respondent describes how assumptions as to the type of work women in her department ought to be interested in resulted in clear differences in the allocation of work, which in turn she felt circumscribed her ability to be seen:

"The females in the Department are on the palliative care and the paediatric committees and the males do the trauma ... and we do the fluffy stuff. Maybe we gravitate towards it, but you know, we're allocating who's got what portfolio and it's always like, the girls they'll do the palliative care and things like that. And because palliative care patients aren't as common as trauma patients, it's less valued ... So we probably spend more time on fluffy committees and things rather than the men who are out there. And if you're doing trauma, you obviously get seen by a lot of specialists in the hospital, so you stamp your authority as, 'I'm a consultant.' Whereas if you're doing paedics and palliative care and things like that, you don't get seen. And so [the other specialists in the hospital] they don't know who I am, because I don't see them through trauma committees and things like that."

CC: "So that lack of not being seen and perhaps not being recognised, what does that do?"

"... if I haven't met them, they're just – 'I don't know your experience. I don't even know that you're a consultant, how do I know you're not a registrar?' And I guess it's being younger as well. People don't know that you're a consultant until you introduce yourself ... I'm always trying to learn techniques to show that I'm the boss."

This vignette demonstrates how subtle gender stereotype-based expectations concerning the types of work that women 'ought' to gravitate towards can disadvantage women. It also demonstrates how gender-based assumptions can create and maintain expectations of gendered behaviours, thus creating a self-fulfilling prophecy. The fact her male colleagues are more visible because of the work they are allocated further serves to reinforce gendered perceptions that men are better suited to this type of work and, as a consequence, enables them to be more readily recognised as 'the consultant'. It is possible to understand how these small exclusionary practices can accumulate to circumscribe opportunities for women to advance in their chosen specialty. In contrast to her male colleagues who are 'out there' and readily recognised as 'the consultant', being stuck on 'fluffy committees' limits her visibility, requiring greater and conscious effort. Accordingly, this doctor felt she needed to 'learn techniques' to display authority and ensure that she would be recognised as a consultant. Other research substantiates the manner in which gender stereotypes frequently lead to confusion about female consultants' identity by patients of both genders as well in collegial interactions, particularly if staff are unfamiliar with the consultant in question (Jefferson et al., 2015).

These examples evidence the complex series of expectations women navigate in clinical settings. Not only do gender-based stereotypes serve to internalise perceptions that women are better suited to certain types of encounters, they

also result in additional work. This work spans emotional and physical labour, and ranges from situational expectations that women will respond to requests from patients, such as fetching nappies, but also includes behavioural assumptions that women are inherently better suited to dealing with particular types of patients, as well as fields of work deemed more 'feminine'. The cumulative consequence of these small acts is to circumscribe visibility, as well as create additional work-related burdens, which, as both the women interviewed and the wider literature suggests, can lead to work overload and increase their risk of burnout (Ellinas et al., 2019; Linzer and Harwood, 2018).

This additional work matters, not in the least because the same attributes are not deemed to be an essential feature for male doctors (Kilminster et al., 2007) but also because it suggests that gender norms, particularly as they relate to women, can subtly shape perceptions of women's legitimacy in medical contexts. In the next section, I discuss how these gendered norms can also shape expectations as to how women ought to behave as well as translate into assumptions concerning appropriate comportment, dress, and appearance.

The gendered labour of comportment

"You're supposed to dress a certain way and act a certain way, and you're supposed to be, as a female, unapproachable and grumpy and bitchy."

As research into identity formation in medical students has demonstrated, learning the professional identity of 'woman doctor' is an ongoing process shaped by encounters with colleagues and patients, as well as immersion in medical culture (LaPierre et al., 2016). Research suggests that medical students rapidly learn what is valued in medicine, and particularly the emphasis placed on traits which are stereotypically coded masculine, such as decisiveness, assertiveness, and directness. For women, this can result in the subtle feeling that they need to "erase their gender in order to play the role of physician" (Babaria et al., 2012, p1018).

Research into the cumulative consequences of implicit gender bias demonstrates that assumptions concerning the types of behaviours and appropriate roles according to stereotypical gender norms has significant consequences for women's career trajectories (Ellinas et al., 2019; Phillips et al., 2016; Shillcutt and Silver, 2019). As Greenberg (2017) states, women in medicine are frequently penalised for not acting in accord with gender norms either by failing to exhibit traits deemed feminine or for exhibiting traits deemed masculine, such as self-assertiveness or directness. Women thus face a double bind as they are expected to have mastered characteristics coded masculine such as decision-making and assertiveness to prove competence in their clinical role; yet in their other social role as 'woman' they are also expected to display characteristics more commonly ascribed to their feminine gender such as warmth, nurturance, and supportiveness (Braun et al., 2017; Phillips et al., 2016).

These tensions were referenced in the course of interviews, often in ways which hinted at the taxing nature of this hidden labour, including strategies to change demeanour or actively manage clinical encounters. Significantly, it was implied and often explicitly remarked that this burden was not shared by their male colleagues. As one interviewee considered:

"I think it's really hard to be assertive but not aggressive. Whereas for a guy, you can say, 'Right, I'd like all my instruments set out like this and I'd like this,' and [the nurses] will do it. Whereas if you're a woman, they're like, 'Oh, she's so uppity, she kind of ...' I think it's really hard to get that balance right, definitely, as a female. That's probably one of the hardest things." (emphasis added)

Similarly, another woman noted how she agonised over how to comport herself around her registrar colleagues in a way that accounted for her new status in the medical hierarchy as 'specialist' but didn't come across as being too arrogant, or as she frames it, 'too big for her boots'.

“So I find now, just starting as a consultant, there’s a lot of the junior registrars who we were all registrars together and it’s kind of hard to be not too chummy with them, but still – you don’t wanna be, suddenly turn into someone that thinks they’re too big for their boots– you know, like it’s really hard, and I think it’s easy for guys, probably. Or they don’t feel that pressure. They don’t feel as bad. They don’t worry about upsetting people. They don’t go home and think, oh gosh, did I say this to so and so? Did they seem upset? Or whatever.”

As Babaria et al.’s (2012) study into the socialisation of medical students demonstrates, this additional work remains hidden because women are socialised to ignore it; they become ‘too used’ to gendered encounters to the point they become resigned to the inevitability of what Babaria et al. define as ‘gendered experiences’. And yet the burden of this additional labour is clear in the frustration articulated by the women in this study pertaining to the exhausting nature of treading the fine line of expected behaviours. This tension and sense of constant negotiation was described in the following ways:

“I think that’s born out of the expectation about how women conduct themselves ... if you’re forceful and proactive then you’re a bit of a bitch. And if you sit back and are docile and feminine, then you get walked all over and you don’t win either way.”

As the women in this study suggest, their gender is received differently and valued or devalued according to how their gender identity is perceived in different clinical encounters. For example, in the following excerpt, one woman reflected on how making an effort to be friendly and polite resulted in her being perceived as a ‘soft touch’, with the consequence that she was over-burdened by extra work when on shift as a junior registrar:

“[as a junior registrar] I was in the Emergency Department and I was getting snowed under, completely snowed under. And I heard one

of the Emergency Department registrars go, ‘Oh, [xxx’s] on. She’s really nice, so just ring her about everything.’ And it’s that perverse, like – because I was pleasant, I took the time to listen, but because I took the time and listened and tried to educate, I was then getting *completely* nailed ... If you’re nice, you totally get taken advantage of, yeah.” (emphasis in original)

As she continued, one of the perverse consequences of this effort to comport herself in a different manner is that it can discourage pleasant interactions for fear of people taking advantage. As she describes in the following excerpt, she could always tell when her friend was on call because she adopted a ‘tone like ice’ when receiving phone calls:

I’ve got a paediatric friend who’s just the salt of the earth, such a nice person. When she’s on call, you can tell just by picking up your phone and listening to her, because the tone just cuts through ice. I just start laughing, because I’m like, ‘You’re on call.’ She’s like, ‘Yes.’ [laughter] And it shouldn’t be like that. You shouldn’t be able to pick up the phone and turn into this whole other person.”

As this example demonstrates, this woman’s colleague felt that she had to comport herself in a way that differed significantly from her usual ‘nice’ character, presumably in order to avoid being taken advantage of as the interviewee felt she had been when she was attempting to be pleasant and helpful. This example demonstrates the perverse situation: women are actively seeking to counteract the gendered expectations as to how women ‘ought’ to behave, which can result in a frosty persona with a ‘tone like ice’. As Phillips et al. (2016, p1112) succinctly sum up: “Exhibiting behaviours such as self-promotion of self-confidence can negatively impact a woman’s ‘likeability’ yet doing so is an essential move to counteract prevailing gender stereotypes.” The downstream effect of this is again, the additional work that women have to shoulder, but also the hidden nature of such work.

Other women interviewed noted how if they were naturally quiet, the additional pressure to speak up and assert themselves as ‘the doctor’ presented an additional burden to overcome in clinical contexts. For example, one interviewee described her sense of interactions with other medical staff in a theatre environment:

“When you’re quite mild-mannered and softly spoken, you’d walk into theatre and you just know that people assume you’re a nurse, which is fine, you know, it would be great to be a nurse but it’s just a given ... you speak up to state what your role is, and then there’s this ... slight push back that being assertive is actually not particularly great. There’s push back to that too, isn’t there?”

As she continued, these interpersonal interactions had not only resulted in her questioning whether she needed to change her behaviour, but also, at the most extreme, led her to question her competence and whether she belonged in her specialty:

“When you start getting this subtle kind of push-back, it – you start questioning, do I need to change myself? And, fortunately a surgeon who’d come out from the US she was just herself, and she continued to be herself. And I thought, well, actually, I’m okay. I don’t have to put on a suit, and I don’t have to start getting really angry and bitchy and demanding – you know all these kind of stereotypes. I thought, no, that’s, that’s just wrong and that won’t be good for my patients.”

Throughout the interviews, I found it notable to observe the ease with which the women could describe the challenges for women in surgery as well as the specific characteristics of these doctors. In the following section I explore the characterisations of women in surgery as articulated by the interviewees and attempt to draw the significance of these constructions for the place of women in medicine as well as hinting at how these constructions have the capacity to shape or constrain the well-being of women in medicine in significant ways.

Women in surgery

Surgery perhaps more so than other medical fields continues to be numerically male-dominated as well as a field in which Pringle (1998) observes is a “field whose traditions and values are firmly masculine ... an area in which all but the exceptional few are presumed incapable of surviving” (p69). Women entering surgery have faced more explicit challenges than women in medical fields deemed more ‘suitable’ for women. For example, the high rates of women leaving surgery has been ascribed to a lack of role models, gruelling workloads, challenges combining unpredictable surgical workloads with domestic commitments, and issues with sexual harassment and discrimination (Liang et al., 2019). Recent publicity surrounding a surgical trainee in Sydney, Australia, where she felt ‘beyond burnout’ as a consequence of being forced to work extreme hours and was castigated as an ‘emotional female’, serves as a case in point (Aubusson, 2019).

In the following example, one of the surgeons interviewed described comments received in the context of her teaching and supervisory work:

“I remember a junior saying to me, ‘Can you please start acting like a consultant?’ I’m like, ‘What do you mean? ... You mean running it like a boy? I don’t come in and bark your orders and then leave. No, of course I’m not. I’m here to educate you in a different way.’”

As she continued, her attempts to perform her surgical role differently from the masculine stereotype of ‘awesome surgeon’ also resulted in the sense of not being a full part of her team:

“For me as a surgeon, if you’re not in there every day, if you’re not alpha-maleing it up and telling everyone what an awesome surgeon you are, your work is disregarded, you don’t feel appreciated, and that’s why it’s so – it’s such a disconnect and it’s just an unpleasant place to be.”

Emerging from other interviews were often contradictory reflections on the complex struggles

women in surgery face, from requiring to show they are 'tough' enough for the work, as well as frustrations expressed by the few women interviewed who worked in surgery regarding the types of traits and behaviours they felt bidden to enact in order to demonstrate their suitability for the role. In the following interview excerpt, the traits and character of a female surgeon were described by a non-surgical doctor as driven by a need to show toughness and competence in a field which demanded strength:

"The caricature of a female surgeon is blunt, bombastic, self-assured ... able to sing their own praises, often at the expense of seeing the value in people around them ... I think when you're constantly being challenged and questioned like surgical training does, I think you need to be self-assured and confident in your own abilities to make it, and that's not necessarily a bad thing ... I think [this is because] women in surgery are fighting the societal stereotype that they are too soft for the decision to take a piece of metal and cut into someone else. ... Taking a big knife and hacking away parts of your body ... I think that probably at its very base, that seems too ... nasty for a woman to do. And so you have particularly strong masculine women to be able to do that ... a man could steel himself to do that if he really thought he was doing the right thing, but a woman's too soft to do that sort of thing so in order to do that you have to prove that you are hard ... You have to take on characteristically masculine attributes in order to do such a nasty thing to someone."

In a recent *Lancet* paper exploring the high rates of women leaving surgical training, Liang et al. (2019) suggest that as men don't carry the same need to prove their suitability for medicine, they have a greater capacity to rebuff or absorb negative interactions than their female counterparts. They liken small but cumulative negative encounters as blocks which coalesce to form a tenuous tower. Their tower metaphor is useful to conceptualise how seemingly minor factors such as enduring a negative interaction with a colleague on top of an already teetering tower of issues can coalesce to

tip individuals over the edge, resulting in burnout or, in the context of their research, a decision to leave training. As Liang et al. state: "A factor that causes additional stress to a male trainee is more likely to be the final block that causes a woman to leave" (p547).

For the surgeons involved in this research, the pressures to 'act like a surgeon' were described as draining and frustrating. In the following interview excerpt, a surgeon describes the moment when she lost her temper and was 'being aggressive and swearing', despite her efforts to be polite and respectful with her nursing colleagues:

"For three years I've been getting equipment in a particular operating theatre that was not on my preference card. ... I'm halfway through this case and they give me a pair of scissors that are [not appropriate for the work I'm doing] and I'm holding up the scissors saying, 'Where's the charge nurse?' They're like, 'Oh, she's not here.' I said, 'Go get the charge nurse.' They get the charge nurse, and I said to her, 'Would you give your fucking male colleagues these pieces of equipment? Like seriously, it's not on my preference card, and every week you give me the same piece of shitty equipment and every week I tell you, "This isn't what I want." Do you do this to my male colleagues? Do you not roll out their cards?' ... It took me being aggressive, swearing at them, to get what I needed. Up until then I'd been like, [adopts breezy, cheery tone] 'Hey guys, this isn't what I use. Is this on my card? Can we get me what's on my card?' But it wasn't until I turned around and just went 'Fuck! ... What the fuck is wrong with you? This isn't on my card!' that they finally went, oh, we better give her what she wants. I mean, why? Why would you do that? Like, they never do this to my male colleagues ... I rang my younger male colleagues, who'd started around the same time as me: never had the same problem. No. They get what they want. Female – nah."



Recent research by Hutchinson (2019) on fellows and trainees of the Royal Australasian College of Surgeons (RACS) suggested the commonplace nature of events such as those described above. Hutchinson suggests understanding these events as ‘micro-inequities’ or small acts of subtle gender

bias which, over time, accumulate to significantly and detrimentally affect the status and well-being of women in medicine, particularly those working in male-dominated specialties such as surgery. As Hutchinson notes, the need to push back against unhelpful attitudes of nursing colleagues

or gender stereotypes concerning expectations of skill and knowledge (and lack thereof) is something that women in medicine bear disproportionately. Moreover, they are socialised to tolerate such interactions as a necessary part of ‘becoming a surgeon’ (cf Babaria et al., 2012).

Research has documented the persistence of significant gender bias in the context of interactions between female doctors, nurses, and other medical staff. Studies have found that nurses offer less help, are less respectful, and demonstrate less confidence in the abilities of female doctors (Gjerberg and Kjølørød, 2001; Wear and Keck-McNulty, 2004). Similarly, research finds that nurses have expectations that female doctors will tidy up after themselves without expecting the same of male doctors (Jefferson et al., 2015). Other studies find that nurses of both sexes consistently rate women doctors more negatively than their male counterparts in evaluations (Galvin et al., 2015).

Another individual spoke of her epiphany moment when she realised there might be issues with how her gender was received as a woman training and working in a male-dominated surgical field. In her experience, gender discrimination manifested in subtle exclusionary practices, including socialising and after-work activities in which she wasn’t included. She stated:

“I ended up becoming an accidental feminist. Like I really did not think about the gender issue, [but] – I remember my first day in training and one of the profs says, ‘Where’s your tie?’ You know? And he could kind of probably just foresee what the next five years of my training would probably be like and, my goodness, you know, it’s not the 1960s, but actually, in training centres there’s boys’ clubs and they all go jogging together and running together, or kind of having a bit of a joke in the handover in your room. But when you’re there it kind of goes a bit silent, a bit cold – the people are pleasant, no one’s ever been nasty, but it, it’s just ...” (emphasis in original)

The wider significance of what Wallace (2014) terms such “small but significant exclusionary practices” (p3) as informal social networking and male-only sports clubs are explored in Pringle’s (1998) research into women in surgery, where it was observed there is a strong sense of being part of a ‘club’, which she notes is “fostered as much on the sports field and in the locker room as in the operating theatre” (p91). For the surgeon interviewed above, not only did she not fit with the expected gender norm of a surgical trainee, but her sense of inclusion was limited, reduced to feeling like a bit of an outsider. This embodied sense of exclusion was hard to articulate (“it’s just ...”) and, as with the other comments pertaining to gender bias, was ‘a feeling’ that she didn’t fit and wasn’t entirely welcome. For this woman, her sense of belonging in surgery was further compromised when she received an abusive phone call from another colleague shortly before exams:

“It was interesting now I look back at subtle but also overt bullying ... Like I will never forget a colleague [who] phoned me at 11 at night about a week before exams. He was just so angry, and I can’t recall provoking this anger. But he just phoned up and he said, ‘Look, you think you’re so great. I could’ve been a surgeon but I chose not to be, okay, so just deal with it.’ And it was just out of the blue and I was just flabbergasted and really upset about it. I thought, right okay, what, what am I doing wrong to evoke all this? Am I a nasty person and this and that? I needed a *relative* point to understand whether I’m doing an okay job or not. And for me it came back to patients. I thought, right, if I’ve got X-number of patient complaints then I’m out. And the complaints didn’t come ... And that’s probably what kind of kept me going, to be honest.” (emphasis in original)

The shock of being at the receiving end of such aggressive behaviour was something this woman simply had to shoulder. For her, understanding whether she belonged in medicine, whether she was doing a good job, depended on how she felt her presence was received by her patients.

One of the consequences of these subtle pressures and acculturation in surgical training was summed up by another interviewee as follows:

“Unfortunately, everything you hear about surgeons is true. Like, the whole bullying culture, the inability to accept females. It’s different training. It’s like, the way we’re trained is the apprenticeship model, but it doesn’t work. It doesn’t apply to every individual that comes through, but if you don’t fit that model they spend your, your entire training just trying to smash, you know, the square peg into the round hole. And I look at some of my trainees, and not just females but predominantly females, and you just see them, everyone trying to mould them in to fit that hole and they keep on smashing them and it’s no wonder they come out the end ... You see a lot of surgeons, female surgeons, and they are bitter. And they are tired. And they are the quintessential bitch, because they’ve had to be that way to get there. And, you know, most of them didn’t start out like that. They were *moulded* by the system to be like that, you know.” (emphasis in original)

This section has sought to explain the subtle and often contradictory ways in which the women interviewed articulated the role of gender in shaping their experiences and careers in medicine. Despite initial disavowals concerning the significance of their gender, their reflections and descriptions reveal simultaneous pressures to appear ‘unmarked by gender’ (Webster et al. 2016) while demonstrating how expectations regarding comportment and interests are implicitly gendered. In highlighting these tensions, it is not my intent to somehow ‘school’ the women interviewed as incorrect; rather, the purpose of highlighting these contradictions is to emphasise the manner in which medicine as a professional field remains infused with gender bias, albeit in subtle and covert ways.

Throughout these descriptions, I have sought to highlight the subtle and often contradictory expectations that women in medicine variously have to push back against or shoulder. By highlighting

how women’s gender matters in medicine, it is not my intent to somehow reinforce or re-inscribe a sense that there are essentialised or innate differences between men and women. By contrast, by returning to the performative understanding of gender which underpins my analysis, the purpose here is to examine how the women involved in this study have variously identified and resisted gender-based discrimination in their medical careers.

As Valian’s (1998) research into gender schemas demonstrates, for women to enter male-dominated professions such as medicine, or to choose specialties such as surgery with its masculine characterisation and emphasis on agentic traits, women can be disadvantaged or implicitly judged as less suitable for that type of work because their gender does not fit (see also Hinze, 1999). For the women in my study, and particularly for the surgeons interviewed, this sense of incongruence was revealed in their accounts of struggles concerning attempts to work or teach differently, as well as the burdens posed by negative and unhelpful interactions with other medical staff. Other narratives described have sought to demonstrate how pervasive gender stereotypes encourage, albeit in a latent manner, women to variously draw upon certain elements of their gender schemas to find their place in the masculinised field of medicine.

As I have sought to demonstrate, this hidden labour has key implications for well-being; these micro-inequities are cumulative (Hutchinson, 2019) and manifest as an uneven playing field where additional issues such as heavy workloads or acts of unpleasantness from colleagues or patients can pose the final straw (Liang et al., 2019). In order to change the culture of medicine, there needs to be greater attention to the subtle and often hidden acts of gender bias that shape women’s presence in medicine. As LaPierre et al. (2016) suggest, it is not insignificant that many women variously disavow or downplay the existence of gendered barriers or differences in medicine; this is a key part of ‘fitting’ into the culture of medicine. Nevertheless, without a clearer focus on how gender pervades medicine, it is unlikely that genuine improvements will occur.

Conclusions

“I think [the risk of burnout] amplifies at this point in my career because I have tried so hard ... to show my dedication by committing to all these extra curricular things, but the more you do that, the more stress you place yourself under, but if you don’t do that, you’re seen to be less than the man who’s doing the same ... It’s not only the time you take out for the parental leave, but I have to take some time back for myself now or I will become burnt out. And so, again, my male colleagues are accelerating up that sort of slope, of being the ones who decide things within my department and things like that.”

This *Health Dialogue* set out to answer the question of why women in their thirties appear to be at greater risk of burnout than their male counterparts, and indeed, at greater risk of burnout of any age group working in the New Zealand senior medical workforce. The qualitative analysis suggests that burnout propensity for this age group of women is related to struggles concerning work–life balance, latent temporal expectations concerning the primacy of medical work, and underpinning all of these themes, subtle and overt manifestations of gender bias.

While this research has a clear focus on burnout, this analysis situates burnout as a symptom of wider issues and concerns faced by this critical workforce which have the capacity to influence well-being. Alongside research into the consequences of increasing clinical creep, growing patient demand, and acuity, this research presents a focus on other manifestations of inequity which shape and structure the culture of medicine.

For the women in this study, their identity as doctors embodies the passion, pleasure, and commitment that has resulted in their successful careers in medicine. They have worked hard to achieve their status as medical specialists, and it is a role which they derive great pride, pleasure, and satisfaction from performing. These women

have sacrificed significant portions of their lives in pursuit of clinical excellence, and their work is both meaningful and a source of passion and joy. For women in medicine more broadly, however, the burnout statistics suggest a ‘dark side’ of this devotion and passion for medical work, which requires sensitive and nuanced attention.

Discussing work–life balance with research participants frequently gave rise to broader conversations regarding tensions between medicine as a career and the gendering of women’s other ‘lives’ and commitments in ways that have not yet been widely explicated in the medical burnout literature. All of the women interviewed discussed varying degrees of difficulties resulting from attempts to combine their medical career with personal choices, such as whether to have children, and how to balance their paid work against domestic responsibilities, whether or not they had children. Their narratives framed medical work as all consuming, relatively inflexible, and something which they had to manoeuvre their personal lives and goals around with varying degrees of success.

Attaining a semblance of work–life balance will remain a struggle for all doctors, but particularly those who seek to play an active role in their domestic affairs, so long as medicine is constructed as a profession which demands temporal primacy. For women, the ‘work-centric’ culture of medicine (LaPierre et al., 2016) will remain particularly burdensome until pervasive societal gender schemas are challenged that continue to portray women as best placed to hold physical and emotional responsibility for the domestic sphere. Until these gender schemas are unpacked and deconstructed, women will continue to bear a disproportionate emotional load for juggling their professional and personal commitments with significant consequences for their well-being. Simultaneously, however, for those who do choose to restructure their working arrangements to

enable them to better balance paid and unpaid working commitments, they must not feel their decision to do so is implying they are not taking their medical careers seriously. There remains further work to be done to prevent the subtle denigration of alternative working arrangements so that those who work differently from the full-time norm do not feel like ‘second-class’ doctors, and similarly, that these opportunities are presented in a way that doesn’t imply women are continuing to conform to gender stereotypes of women who put their families before their medical careers (LaPierre et al., 2016). Until the wider cultural meanings that link professionalism, dedication, and competence are decoupled from temporal assumptions, any attempts to protect against burnout will be unsuccessful so long as working less than full-time continues to be judged against a full-time ideal.

The focus on gender bias in circumscribing well-being which permeates this analysis may make for challenging reading. This focus on the various manifestations and consequences of gender bias is not intended to be accusatory; rather, it is put forth as an opportunity and challenge for the need to improve medical culture for the benefit of all.

There are now more women than men coming out of medical school, and this re-balancing of the gendered composition of the medical workforce should be celebrated. Women are no longer the ‘other’. Despite this, women doctors remain subject to vertical and horizontal segregation, paid less on average than their male counterparts, and clustered into certain specialties that are viewed as ‘family friendly’, but perhaps not insignificantly, as lower in prestige. Without understanding the power of gender bias in medicine, efforts to explain why women bear a disproportionate risk of burnout can unwittingly serve to reinforce entrenched stereotypes concerning women’s legitimacy in medicine, while also serving to reinforce uneven power relations which suggest women struggle because they aren’t strong or tough enough to cope (Bartos and Ives, 2019). On a positive note, research suggests that specific interventions which attend to gender bias in

workplace culture are likely to pay dividends in terms of redressing gender-based discrimination (Carnes et al., 2015).

In this regard, the commentaries from the likes of Sibert (2011) and others who question whether women are good for medicine are fundamentally misguided. We know that there are significant doctor shortages in DHBs, with specialist shortages nationally estimated to be around 22%, and this situation is expected to deteriorate. It is predicted there will be a mismatch between future specialist numbers and patient demand (ASMS, 2019b). This problem, however, does not inhere in the decisions for women to enter medicine and strive for different ways of working. Here, the arguments of journalist Lisa Belkin (2011) are particularly helpful. In response to Sibert, she states that:

“The problem is not that workers ... are demanding too much, but rather that professions are archaically structured. ... The answer is neither to shut up, nor to buck up. The answer is to recalibrate the hours and expectations of professions so that they can be done by the ‘new worker’ – not a man with a wife at home (which is the assumption of the old structures) but rather a mother or father with a working partner and responsibilities at home.” (para 13)

It is worth considering how efforts to address these shortages would benefit from tackling the cultural markers of certain specialties like surgery – not in the least, expectations concerning workloads and working hours. Both men and women coming out of medical school are seeking different ways of working and finding meaningful ways to participate in medicine. Many are seeking greater flexibility in training patterns and work hours. For these demands for greater flexibility in training and practice to be realised, however, structural and attitudinal change is required. Enabling legitimate opportunities for those entering medicine to work differently must be accompanied by better planning for medical staffing and rethinking training programmes and work schedules. It will require significant leadership, vision, and a commitment

to improve the working lives of all. Without this, it is likely that those who seek to practise medicine part-time will be subtly discriminated against as seeking working patterns that suggest a lack of commitment and dedication to their medical careers. As this research demonstrates, the internalisation of these feelings of 'slacking' or guilt can have serious consequences. Furthermore, opportunities for working differently must be structured in such a way that those who seek to care for themselves and others do not feel as if their careers will be compromised. If we wish to improve the parlous state of burnout and improve the well-being of our medical workforce overall, we must attend to some aspects pertaining to the culture of medicine which remain a barrier.

As I have sought to demonstrate in this analysis, if we are serious about changing burnout statistics, we need to question assumptions about time and medical commitment and the implied subjugation of non-work time, including family time and time for self-care. It is imperative that we challenge the implied notion that having a medical workforce made up of increasing numbers of women will mean a workforce stigmatised by latent assumptions that women are more risky, less committed, and less competent than their male counterparts. As Beekman (cited in Belkin, 2011) asserts:

"Many young men are asking their practices if they too can have a 4 day work week, have some dedicated time with their families, and be home for dinner some nights. Why does this have to mean that [they] are not committed to their patients? Why can't it be interpreted that this is a generation of physicians who value balance and in fact, ... may make ... better doctors as a consequence?"

As the quote cited at the start of this conclusion suggests, it is vital to consider how the culture of medicine creates an uneven playing field for well-being. For women who strive for success in medicine, who may at times feel the need to 'make up for being female', it is imperative to attend to the role of subtle gender-based inequities. Failure to do so will result in a reliance on simplistic

'common sense' explanations as to why women are at greater risk of burnout, which may inadvertently reinforce problematic stereotypes as to why they are failing. Ibarra et al. (2013) state:

"If [women] can't reach the top it is because they 'don't ask', are 'too nice', or simply 'opt out'. These messages tell women who have managed to succeed that they are exceptions and women who have experienced setbacks that it is their own fault for failing to be sufficiently aggressive or committed to the job."

This research has sought to demonstrate the importance of understanding burnout and other indicators of well-being as indicators of wider systemic issues including workforce pressures but also issues with the culture of medicine. It is imperative that we acknowledge the significance of these issues if we are serious about changing the culture of medicine to meet 21st century expectations of doctors and the patients whom they serve. We hope that the issues raised in this research will be thought-provoking and encourage debate; these conversations will be the first step towards developing policies that will enable transformational change in the culture of medicine. Simultaneously, however, it is vital that this change is supported and accompanied by changes in employment practices and working conditions, both of which will require adequate resourcing to ensure the retention and recruitment of the senior medical workforce and high quality patient-centred care upon which the public health system depends.



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