THE REPRODUCTION OF PATRIARCHY AND THE POLITICS OF GENDER IN MEDICAL PRACTICE:

A CRITICAL DISCOURSE ANALYSIS ACROSS TRAINING, CAREER AND LIFE

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A Research Paper submitted to the Graduate Program in Health in partial fulfilment of the requirements for the degree of

Master of Arts

Graduate Program in Health
York University
Toronto, Ontario

September 2018

Abstract

Women physicians and women physician-researchers (WP/WPR), in Canada and in the United States, do not experience the same professional success, inclusion, and work-related health outcomes as their male colleagues despite current medical school acceptance parity. They work harder than the latter to meet clinical benchmarks, comply with professional imperatives, and live up to societal standards. These benchmarks, imperatives and standards are designed and reproduced by male physicians, when not reproduced by female physicians themselves.

The hardships that contribute to the distress and burnout experienced by women physicians and physician researchers – including yet not limited to multiple-role demands impinging on women's physical and emotional well-being – are acknowledged, yet not critiqued, by the medical community. Indeed, the dominant narrative within the profession frames these hardships as caused by gender-specific lifestyle and behavioural choices, using them as examples of how individual choices by women physicians and physician-researchers lead to career successes or failures, while neglecting to identify, much less challenge, the male-dominated construction of medical practice. Patriarchal structures, tendencies and biases embedded in the profession of medicine normalize and reinforce gendered institutional policies, professional practice, and societal values that favour male success in medicine and reproduce the distress and disadvantages experienced by women physicians and physician-researchers.

Using a discourse analysis approach that illuminates how the discourse of medicine tends to reproduce the social order by excluding its critical appraisal, this paper examines the medical and healthcare policy literature to reconstruct the boundaries of the debate around gendered inequities in medical practice. I discuss these inequities and their impact on the health and wellbeing of women in medicine, and propose policies with the potential to both address these inequities and contribute to the integration of women in medicine. In so doing, these policy courses may also have significant, positive implications for health care delivery, in Canada, the United States and elsewhere.

Key words: work-life balance; medical profession; gender; inequities; discourse analysis

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Introduction

Women physicians and women physician-researchers (WP/WPR) in Canada and the United States do not experience the same success, inclusion, and health as do their comparable male colleagues (Ash, Carr, Goldstein and Friedman, 2004; Reed and Buddeberg-Fischer, 2001; Woodrow, Gilmer-Hill and Rutka, 2006). At least in the Western world it is well documented that medicine has been a historically male-dominated profession that largely excluded women from medical practice, and it was not until the 1960s and 1970s that women began entering the profession in greater numbers (Jefferson, Bloor, and Maynard, 2015). As the number of WP/WPR grew, the breadth and depth of knowledge concerning women choosing a medical career increased, hand-in-hand with literature highlighting their problems -- of motherhood timing, lower pay for equal work, and the balance between a medical career and domestic life, i.e., work–life balance (see Clem, Promes, Glickman, Shah, Finkel, Pietrobon and Cairns, 2008; Miller, 2011). “Work-life balance” seemingly became a buzz phrase for professionals alike to use as a way of describing personal contentment and, largely, success, in multiple realms simultaneously. For WP/WPR, work-life balance became associated with domestic responsibilities in conflict with professional/academic pursuits and their ensuing resolutions of the two spheres (Harrison, 2008).

Other identified challenges as well as indicators of poor health for WP/WPR have included barriers to career advances (Ash, Carr, Goldstein and Friedman, 2004; Carnes, Morrissey and Geller, 2008), insufficient networking or mentorship opportunities (Phillips and Clarke, 2012), and higher rates of burnout and depression (Frank and Dingle, 1999; Raja and Stein, 2014). Scholars attribute these challenges and poor health indicators to gendered norms and structural differences within the institution that selectively disadvantage, stereotype, and stand in the way

of professional progress for WP/WPR (Boulis and Jacobs, 2008; Mayer, Files, Ko, and Blair, 2008; Valian, 1999).

Be that as it may, some progress has been achieved, as women are accepted into medical school at increasing rates (Micieli, Trope and Buys, 2016; Office of Research and Information Services, 2015). Taking a step further, evidence suggests that medical schools are taking more progressive stances on cultural and racial diversity in acceptance rates and education policies, such as reserved entry seats for Indigenous students (OMSAS, 2018). Nevertheless, significant challenges for WP/WPR persist during their education, training and career (Mobilos, Chan, and Brown, 2008). For instance, women tend to avoid medical specialties, such as surgery, that appear to pose greater challenges to work-life balance, and in these specialties, women are under-represented (Woodrow, Gilmer-Hill, and Rutka, 2006; Gautam, 2001; Marschall and Karimuddin, 2003). The literature documents well, and quantifies, these challenges (see, for example, Barnett and Gareis, 2002; Micieli, Trope and Buys, 2016; Shanafelt, Hasan, Hayes, Sinsky, Satele, Sloan, West and Dyrbye, 2016), thus indicating that they exist. They exist not only for WP/WPR, but seemingly also for governments, medical institutions and patients as they note fears of physician shortages in the future, using reasoning of the growing number of women in medicine who will ultimately withdraw completely from or participate part-time in the profession (Micieli et al., 2016).

Yet quantitative research, by its very nature, cannot interpret the meaning of these challenges for those experiencing them, nor can it reveal why a phenomenon, in this case differential professional and health outcomes for WP/WPR as compared to men, occur and persist. The medical literature observed in this paper and used in its analysis of “work-life balance”

especially does not reveal differences in opportunities, experiences or unique challenges to physicians/physician-researchers outside of the conventional and representative model of an affluent, Caucasian, heterosexual male or female. Women physicians and physician-researchers of colour, LGBTQ, disability and/or indigenous statuses do not garner the same attention and consideration as the Caucasian representations presented in the literature. They are not all but mostly omitted from the medical discourse except for the reference to few demographic surveys. This incorrectly suggests that these groups adhere to the same standards, are within the same elite status echelons and experience the same issues that govern aforementioned Caucasian, heterosexual women, despite their own distinct battles of racism, discrimination or isolation that often exacerbate attempts at balancing work and domestic matters. While stories of survival and success by WP/WPR of minority groups exist (Hassouneh, 2018), and they commendably do so as a means of addressing institutional racism and discrimination in medicine, there is a gap in the literature which does not discuss nor critique work-life balance for these minority groups. Therefore, without studies of these groups in relation to work-life balance, this paper cannot adequately interpret and critique the issue for *all* WP/WPR, but generalize to the populations used in the data.

A clue can be gleaned when examining how the literature discursively treats "work–life balance" issues when experienced by women and presumably Caucasian women. Generally, women appear to face "tough choices" between the demands of their profession and family (Potee, Gerber and Ockovics, 1999), while this is hardly the case for men. In fact, in the past the literature described men physicians who placed work before home life as commendable, or working above and beyond the call of duty, yet never as experiencing "work-life balance" conflicts (Dunn,

Arnetz, Christensen and Homer, 2017; Uhlenberg and Cooney, 1990). Even after more than twenty years since some articles on career and domestic responsibilities in the medical profession were published, similar, if not the same, inequities persist. While today the demands of medical practice are rarely presented in this explicitly gendered way, my investigation suggests that gendered norms continue to be legitimized within the medical literature itself, even as this literature acknowledges and critiques these norms that pose work-life balance issues and disadvantage women. This is because, at least to my knowledge, the literature does not probe how the problem of "work-life balance" is framed, or how the notion of "work-life balance" is discursively treated, such that the literature itself may reproduce rather than challenge patriarchal structures built into the practice of medicine.

The literature available indicates that the medical discourse mostly acknowledges and critiques gender inequities in work-life balance, such as suggesting structural reform to leadership positions in academic medicine (Conrad, Carr, Knight, Renfrew, Dunn and Pololi, 2010), and often recommends further study and inquiry. However, and regardless of the authors' gender, it appears to neglect challenges and inequities built into the benchmarks for success in medical practice, proposing instead solutions that require at best, WP/WPR be better supported in meeting these benchmarks, or at worst, make more "adaptive" behavioural and lifestyle decisions. The medical language is in itself limited to challenging a gendered social order in the practice of medicine and that to successfully address work-life balance and other inequities in medicine, patriarchal medical norms should be challenged, be rejected as explanations for work-life balance conflicts, and become the primary focus of analysis and intervention.

Statement of the Problem

The dominant narrative within the medical literature framed challenges that WP/WPR experience as the result of gender-specific lifestyle and behavioural decisions, seemingly inevitable when professional and domestic responsibilities are in conflict. Inequities within the literature warranted an investigation of the framing and discursive treatment of "work-life balance", and thus the goal of this paper: to examine the debate around "work-life balance" in medicine as it appears in the literature produced by the medical profession. I focused on how this debate is framed, aspects that were neglected or omitted from discussion in the literature (e.g. race, class and sexual orientation), and comparisons of how it was presented when it concerned women and men, respectively. I specifically generalize to Caucasian, hetero-normative men and women physicians because the literature did not discuss, critique or even contain examples of race, disability, class, or sexual orientation in balancing work and life.

My inquiry was guided by the following questions: What kind of language, produced by men and women physicians and physician-researchers, contributes to or challenges the 'natural' order of attaining professional and personal success? To what extent are there any resulting inequities that WP/WPR face that affect such professional and personal success? How do well-established norms and biases found within medical school and the profession itself influence decisions and attitudes made by WP/WPR? Is the formation and historical context of regulated medicine ignored by physicians, educators, researchers and policy-makers? If so, how does this affect the language surrounding research, practice and policies of the medical profession?

An analysis of "work-life balance" using literature that observes behaviour in medical school, the foundation of medical practice and research, and that extends into professional and personal endeavours, helps reveal how built-in gendered inequities in medicine concerning values,

practices, and benchmarks for success reproduce patriarchal structures. I hope to show that the impact of individual choices made by WP/WPR in medical discourse may lead to limited success for some, but also simultaneously result in failure for WP/WPR collectively. I argue that it is not individual choices, but these previously mentioned patriarchal structures of medicine instructing women to make perceived individual choices, that shape how men and women practice the profession, and thus are responsible for the negative effects experienced by WP/WPR. Finally I propose potential implications of these inequities and make recommendations for further study in order to improve the well-being of WP/WPR, and contribute to their professional integration in Canada, the United States, and elsewhere.

Gender in Medicine: A Brief History

The establishment of the institution of western medicine in Canada and the United States dates back further than confederation for both countries, with ideas and practices imported from European powers, and predictably few women entering the profession globally until past mid-twentieth century. The evolution of medicine in North America is rife with documented, exclusionary practices and regulations, particularly Canada's anti-Americanism for immigrating physicians in the eighteenth and nineteenth centuries and the outcome of the United States' Flexner Report that was predicated on following a biomedical model of medical education for North American students (Hamowy, 1984). Heavy paternalism, disguised as a means of protecting Canadians and Americans, initiated legal restrictions of practicing medicine in North America and established medical schools and governing medical bodies such as King's College (now the University of Toronto) and the College of Physicians and Surgeons of Upper Canada in 1839 (now the College of Physicians and Surgeons of Ontario), respectively (Hamowy, 1984). Despite

a divergent history for Canadian and American healthcare policies, physicians remained private providers whether publicly funded (Canada) or privately funded (United States) as they are now.

At various times in North America, the medical profession operated to exclude groups such as women and physicians of colour from licensed practice or education (Burnham, 2005; Hassouneh, 2018). Historical literature indicates overwhelming segregation of traditional medical men on the one hand and nurse or midwife women, neither of which were held in the same prestige, regard or financial status as physicians, on the other. This paints a picture of the typical caring woman and the curing man (Burnham, 2005). Bynum, Hardy, Jacyna, Lawrence and Tansey (2006) describe how medical men exploited the labour of women, which maintained their positions of disadvantage and inferiority, while these medical men simultaneously supplanted women into less prestigious positions that they (men) were once dominant in such as midwifery. However, as science became the basis of medical education and access to universities and medical schools was limited to mostly men, care from midwives was moved to care from physicians who were medical men at the time (Jones, 1996) and women were thus excluded from practicing. Nevertheless, medical *men* were portrayed as well-educated, wise and hardworking, tirelessly fighting to protect the lives of their patients from unlicensed "quacks" (Hamowy, 1984), but also evidently fighting to protect their authority and financial interests of a career in medicine.

Conversely, the thought of women even entering the profession of medicine was abhorrently rejected by their male counterparts (Bynum et al., 2006; Hamowy, 1984). Thus, entry to medical schools and medical licensing was restricted and exclusionary practices were apparent, such as the outright rejection of undesirable candidates from entrance to school (Jones, 1996). The few women who did pursue a medical degree were able to do so through loopholes in medical

school matriculation requirements in the nineteenth century (Bynum et al., 2006), and much later in order for medical schools to fill a low female student population quota in mid-twentieth century (Potee et al., 1999). These women, and mostly the women before them, were often deemed ambitious, exploitative of admission loopholes, and willing to travel great distances for a degree (i.e. Elizabeth Blackwell and Mary Putnam Jacobi in Bynum et al., 2006). For example, Elizabeth Blackwell, the first woman to graduate from an American medical school, travelled back and forth from Europe and the United States in pursuit of practicing medicine.

Generally, these women, and the women who were not accepted into medical school, were considered poor investments in offering and conferring medical degrees as they were perceived to be ready to abandon the profession at any moment to have a family, leaving gaps in care and overloading their colleagues with work (Potee et al., 1999). This institutional argument appears contradictory to licensing arguments men physicians were making at the time for the profession. Hamowy (1984) outlines how, simultaneously, Canadian physicians in particular pushed for a host of licensing and credentialing policies stating reasons of overcrowding in the profession, among others reasons, which made them unable to make a decent living that corresponded to the amount of time and education they put into their careers. Despite disparaging attitudes to women joining the medical profession, WP/WPR progressed at a slow pace and were confronted with inequalities that would not be questioned or critiqued until later in the twentieth century.

Similar – and often the same – inequalities and practice discrepancies that women experienced in the nineteenth and twentieth centuries persist today – but historically were even more explicit. Many women in the nineteenth century were excluded from both informal networks and formal medical associations that provided physicians with consultations and referrals, and

this was also a typical means to regulate the market in favour of credentialed, medical men (Jones, 1996). Even more visibly, women medical students were segregated to such an extent that they often started their own medical schools or hospitals to avoid issues of discrimination and exclusion (Bynum et al., 2006). These same issues of exclusion were also duly present for women and men of colour pursuing medicine.

In the United States, historical accounts claimed that, *in time*, "many schools … accepted minority students – students with what would be ordinarily considered inadequate background" (McLachlan and McKeown, 1971, pp. 25) gradually after the 1960s. Steps were being taken to increase the diversity in medical schools, though grudgingly, and many students, clinicians and faculty members of colour reported experiencing both overt and covert racism, continuing into this day (Hassouneh, 2018). Minority groups practicing medicine have historically been left at the bottom of hierarchies that govern power and resource distribution (Hassouneh, 2018) and have different experiences than their Caucasian colleagues. Blackstock (1996), for example, recounted intersectional experiences of being an African-American woman in the 1970s at Harvard Medical School where she felt her opinions and contributions were not taken as seriously as those of her Caucasian male and female counterparts were and emphasized the unique stressors and sense of being controlled that pervaded.

When women began entering medicine in greater numbers, questions surrounding the feminization of medicine and prospective changes to the profession emerged (Klass, 1996). At the time, women physicians were, in fact, overrepresented in the medical research community before 1990 compared to women practicing medicine (Boulis and Jacobs, 2008). This grew from barriers to other areas of medical work such as exclusion from informal clinical referral networks

(a common theme across decades and centuries), language barriers or racial bias, and lower-paid academic work versus higher-paid clinical practice (Boulis and Jacobs, 2008). More feminine areas at work were mirrored in traditional feminine roles in the home and are documented by WP/WPR as struggles around bearing the brunt of responsibility for childcare and domestic duties (Potee et al., 1999). As Klass (1996) indicates, women physicians were, and still are, concentrated in what are considered more feminine specializations such as paediatrics and family health. WP/WPR clustered at the bottom of the medical hierarchy in lower paid, less prestigious specialties, and now currently remain there, despite an overall increased distribution of women across all segments of medical work (Boulis and Jacobs, 2008).

Theoretical Considerations

This paper draws from a critical discourse analysis approach to investigate how discourse and practice interact with one another to reproduce, or challenge, structures of domination, social identities and professional practice (Fairclough, 1989; Fairclough, 2013). Contemporary critical discourse theory explores how structures of domination – often unknown to this paper's protagonists, WP/WPR – are constructed and shaped socially through the language used in the discourse of the medical community (i.e. as examples, the articles used in this paper), while the language itself simultaneously is shaped socially, practically and institutionally. Critical discourse analysis, as outlined by Fairclough (2013), analyses the constitutive power of constructing and replicating social identities, power relations, and knowledge. Originating from large-scale immigration and postwar sociological theory that was concerned with institutional inequalities in education for minority groups, discourse theory is described by Luke (1997) as a way of examining language as constructive phenomena that shapes the identities and practices of

subjects. Michel Foucault (1980) further elaborated on early critical discourse theory and suggested that language was not merely a means of describing and analysing society, but also a tool to construct, regulate and control the dissemination of knowledge within and among institutions and society.

While Fairclough (2013) extends discourse to mean any spoken, written, gestural or photographic communication, this paper focuses on written language as the primary source of evidence. Critical discourse analysis, in this paper, is used to guide and elaborate how individuals in the medical profession, steeped in gender inequalities and bias, use academic discourse to control decisions, behaviour, and practice of WP/WPR. Each article from my sample is considered a distinct discursive event and follows the three-part discourse framework outlined by Fairclough (2013): it is a written text, it is a piece of discourse practice, and it is an example of social practice. These three facets are complementary to each other in describing the connection between discourse and power/domination in medicine for WP/WPR.

My analysis is guided by Marxian tradition, especially from the work of Howard Waitzkin (1989) and Vicente Navarro (1980), which help reveal how medical language reproduces structural inequalities by naturalizing the social order, ignoring relevant context (such as the portrayal of medical men and the early segregation of women students in medical school), and excluding challenges to this order and process of naturalization. I shed light on the amplification of patriarchy reproduced through language that ultimately creates positions of disadvantage, excludes criticism of the social and institutional context, and often supports current social order in medicine.

I also draw from critical functionalism, specifically from the work of Herbert Gans, who applies a Mertonian, i.e., functionalist analysis, to identify processes that contribute to the

persistence of norms and practices (1972) – in this case patriarchal norms and practices in medicine – despite their "dysfunctionality" to disadvantaged groups – in this case WP/WPR – and despite apparent or "manifest," official attempts to address the harmful effects of these norms and practices. An example of this would be using a critical functionalist lens to observe how WP/WPR use behavioural "solutions" such as new coping techniques to overcome discrimination or stress in the workplace rather than addressing the harmful effects themselves within their historical context.

Finally, I discuss intersectionality, as described by Kimberle Crenshaw (1993), to assess the indivisibility of categories of race, class, and sexual orientation that has been built into the language of medicine. The intersection of categories of oppression signal that experiences will be different for various women, within and outside of the professional and academic ranks of medicine. For example, the experiences of white women physicians will certainly be different from those of their black colleagues or of indigenous medical students. This paper's investigation suggests that intersectional thinking on WP/WPR is rarely mentioned in the literature, if only in passing or as a statistic. This paper also combines intersectionality with a Marxian lens, bringing light to social inequities and class hierarchies that WP/WPR instinctively engage in, such as employing labour (.e. housekeepers, childcare workers) that is often filled by working class women of colour.

I further discuss Crenshaw (1993) in relation to WP/WPR, to describe how common portrayals of WP/WPR, by educators and their superiors, as primarily either mother/wife or physician, but rarely both, and their intersection with class, race, and sexual orientation contribute to inequities within their field and reinforce stereotyped behaviour and decisions from both men and women physicians. An intersectionality approach within the context of medical school will

help describe the assumption of the "mommy-track" (Strong, DeCastro, Sambuco, Stewart, Ubel, Griffith and Jagsi, 2013), or the eventual path of prioritization of being a mother over being a physician, that many WP/WPR and women in other professions are misaligned to be on from their professors and colleagues due to their gender.

Method

Using as "key informants" a sample of academic articles retrieved from Canadian and American academic databases, I investigated how discourse contributes to, or challenges, the reproduction of patriarchy in medicine and inequities between genders. Using "work-life balance" and "women physicians" as key words, I searched for articles indexed in Scopus, PubMed, Google Scholar and directly from leading North American medical journals, such as the Canadian Medical Association Journal (CMAJ), the New England Journal of Medicine (NEJM), and the Journal of the American Medical Association (JAMA) after the year 1990. I chose a timeline of 1990 to the present in order to summarise an approximate thirty-year span of WP/WPR work-life balance literature, and in order to allow enough time to pass after more women began entering the medical profession. I chose "work-life balance" as the primary focus of my analysis and key search word because it compellingly captured the challenges faced by WP/WPR as they juggle between traditionally assigned domestic roles and the responsibilities of a historically male-dominated profession.

I identified key themes pertaining to four chosen categories: 1) how the concept of work-life balance or functional equivalents is defined; 2) problems associated with work-life balance; 3) causes of work-life balance tensions; and 4) recommendations for addressing problems of work-life balance. I decided upon these categories based on my personal experience as a

prospective medical student, a master's degree candidate, and a hospital employee, and under the guidance of, and with recommendations from, my academic supervisor. While most of the articles were quantitative and communicated self-reported data, all had introductions, discussion and conclusion sections that shed light into the object of my investigation. I read the articles in their entirety, compiled and listed themes pertaining to each category according to their prevalence in the literature, and selected examples to illustrate, elaborate on, and clarify these themes.

To analyze my sample's findings, I used a critical discourse analysis lens within the themes to scan the literature for gender bias, inequities, and discrimination that authors both stated and omitted. I drew out language that denoted structures of power and domination, that made attempts to explain a conflict within work-life balance for WP/WPR (effectively or unsuccessfully), or that was devoid of discussing or mentioning race, class or sexual orientation when it could have been pertinent to the sample paper. I further observed how the authors framed and approached their topics in work-life balance, and their apparent levels of resistance, compliance and acceptance (van Dijk, 1993) of work or domestic conflicts and of the social order in medicine.

Data

The database and journal searches produced a large number of articles. I included original research, commentary, editorials and opinions written in English by women or men physicians or physician-researchers, produced in Canada or the United States. The rationale for including opinion pieces and editorials rather than only original research is that I am less interested in the accuracy of, or empirical support for, claims, than I was in the discourse produced by and for the medical community as an object of inquiry in itself. I included all articles in English that were fully accessible and addressed the topic of work-life balance or a functional equivalent (e.g.,

articles that discuss family responsibilities in relation to career responsibilities in medicine. See Guille, Frank, Zhao, Kalmbach, Nietert, Mata and Sen, 2017; Jolly, Griffith, DeCastro, Stewart, Ubel and Jagsi, 2014), regardless of the medical specialty or inclusion of other issues. I excluded articles in languages other than English or that were not accessible via the York University's library system, and a few that did not address in sufficient detail comparisons and interactions between a medical career and domestic life. This search, started in September of 2017 and completed in October of 2017, produced a sample of fifty articles (**Table 2**).

Findings

Out of the fifty articles selected, three journal articles were written solely by men authors, twenty-four articles were women-authored, and twenty-three were produced by a mix of both genders (see **Table 1** for a complete list of sample selection). All articles except for one (Campolieti, Hyatt and Kralj, 2007) were written by at least one author or researcher who had a medical degree, and many were written exclusively by medical doctors. Quantitative research articles typically began with a brief description of the work-life balance problem and why it was important for physicians, presented results of the studies that were conducted, and followed with discussion and conclusion sections. Qualitative or commentary-based articles generally did not have a traditional format, but could nevertheless be thematically classified within the four chosen work-life balance categories of *how the concept of work-life balance or functional equivalents is defined, problems associated with work-life balance, causes of work-life balance tensions*, and *recommendations for addressing problems of work-life balance*. These categorized themes in the literature were used to anchor ideas within the discourse that the authors were using concerning WP/WPR.

The common narrative produced within the selection of articles suggested that work-life balance was a catchall term given to the tension, challenges, and competing demands inherent in the profession of medicine. The authors described the interplay between career and family responsibilities and summarised them as being a choice at a personal and professional level that ultimately reflected their values and commitments as physicians and physician-researchers. However, with the interaction of work and life, associated problems arose such as burnout and poorer health, conflict within personal or professional life, and inconsistent career trajectories when WP/WPR embark on a course of maternity leave. These problems in work-life balance for WP/WPR appeared to be the primary cause of behavioural and individual choices that cause tension, especially among colleagues (i.e. going on maternity leave), gender differences (i.e. the relative ability to go on maternity leave), and professional stressors (decline in income while on maternity leave and missed opportunities). To counter the work-life balance problems that were plaguing WP/WPR, solutions were made such as better policy interventions to promote well-being, an increase in more positive mentorship and support, and behavioural suggestions like monitoring stress levels and developing better time management skills. A compiled list of the four main issues and their themes in the literature can be found in **Table 2**.

The authors – including WP/WPR themselves – subsequently made their arguments, gave their opinions, and presented their research results in very thematically similar and overlapping ways to their peers. For example, while implicit gender-specific negotiations of home and life were pervasive, many articles, while data heavy, excluded references to a gender context, but instead linked work-life balance issues to specific medical specialties or to the practice of medicine more generally when compared to other occupations (Keeton et al., 2007; Roberts et al., 2014; Shanafelt et al., 2012; Shanafelt et al., 2014; Shanafelt et al., 2015; Shanafelt et al., 2016;

Szender et al., 2016). In the following sections, I expand on the themes present in the literature and elaborate on their equity implications for WP/WPR.

Defining Work-Life Balance: The "Competing" Demands of Work and Life

Various definitions and descriptions of work-life balance were made by the authors in the literature in an attempt to make sense of how physicians organize their personal and professional lives and to share their own perspectives to their peers. One dominant theme in the definition of work-life balance was that a medical profession on the one hand, and life (i.e., domestic life) on the other, are two separate, contrasting, and often incompatible realms, and as such, require that *both* men and women balance competing demands. Definitions ranged from more realistic, optimistic views indicating that "[w]hile the daily practice of balance is certainly a valuable aspiration, *fulfillment* may be, for some physicians, a more encompassing and guiding state to strive for as [physicians] seek satisfaction" (Harrison, 2008, emphasis added) to melancholic pessimism that incorporates how employers have the sole intention of maximizing productivity such that the "concept of work-life balance acts as quicksand in … professional and personal lives resulting in slow drowning in frustration, depression, and exhaustion" (Schwingshackl, 2014). Overall, the attainment of work-life balance for WP/WPR seems bleak, understandably so when the corporatization of medicine dictates more productive, active professionals at the expense of their health and realisation of work-life balance.

Further, the literature pointed out that WP/WPR make personal choices that increase the likelihood of their experiencing work-life balance problems more than their men colleagues (Kuehn, 2012; Phillips, Hustedde, Bjorkman, Prasad, Sola, Wendling, Bjorkman and Paladine, 2016; Tarquinio, 2016). These personal choices span several social and professional arenas, from

large decisions like choosing a speciality to practice (Rohde, Moriatis-Wolf and Adams, 2016) to more focused decisions such as applying for certain academic grants (Tarquinio, 2016). This was apparent in the language used by the authors in my article selection, particularly when discussing prioritization and blending of work and home (Wang, 2015) and speciality choices of WP/WPR (Kuehn, 2012). An example follows:

> The flexibility offered in family practice is one of the reasons more women physicians than men physicians enter the discipline … and many women choose specialties based not only on their passion for that field, but because of the lifestyle it offers (Mobilos, Chan, and Brown, 2008).

This ostensibly factual statement implies that some specialties, say surgery, are not "flexible", because they do not offer the "lifestyle" that would enable a medical *woman* to achieve the desired work-life balance. Of note, specialty considerations are seemingly not worth mentioning when it comes to medical *men*. The literature also occasionally mentioned the need to pursue greater gender equity in the practice of medicine to address the disproportionate burden of work-life balance for women (Carnes, Morrissey and Geller, 2008), yet the overall balancing act between work and the domestic sphere was often described as a women's issue (see Gautam, 2001; Harrison, 2008; Mobilos, Chan and Brown, 2008; Parsons, Duke, Snow and Edwards, 2009).

Many authors appeared confident that women would be able to navigate work and life (Tarquinio, 2016; Wang, 2015), but perhaps not to the same extent as men physicians, due to additional "unique" stressors such as childrearing (Phillips et al., 2016; Sandler, Tackett, Longo

and Yoo, 2016), harassment in the workplace (Gautam, 2001), and marriage or partnership to a surgeon or another physician (Dyrbye, Shanafelt, Balch, Satele and Freischlag, 2010; Perlman, Ross and Lypson, 2015). Others appeared less confident, suggesting that WP/WPR could not "have it all" without modifying their lifestyles, such as their choice of a supportive and understanding partner (Isaac, Petrashek, Steiner, Manwell, Byars-Winston and Carnes, 2013; Perlman, Ross and Lypson, 2015). Finally, a small number of articles proposed that work-life balance for WP/WPR was not quite attainable, and that at best WP/WPR would be "able to combine career and family with *some* degree of success" (Sasser, 2004, emphasis added). Now, "with *some degree of* success" is not the same as "successfully", yet this one example illustrates the elusive nature of work-life balance – for women.

Overall, the literature portrayed the seemingly inevitable and intractable struggle of work-life balance both as inherent in the medical profession yet almost exclusively pertaining to women. Moreover, it fell on WP/WPR to decide how much to devote to a career or a life at home, and to prioritize between the two. Not a single article questioned whether, much less how, men physicians should balance the practice of medicine with the responsibility to raise a family.

Problems Related to Work-Life Balance: Prioritizing Family over a Medical Career

Based on the findings, the literature subtly assumed that women physicians will, and indeed do, spend more time in the domestic sphere than male physicians (Guille, et al., 2017; McAlister, Jin, Braga-Mele, DesMarchais and Buys, 2014). Not only do they spend more time in the domestic sphere, but "[w]omen, far more than men, consider the balancing of family, parental, and occupational roles when making career decisions" (Verlander, 2004) than their male colleagues. The authors of the sample articles elaborated that the real challenge resided in the

greater number of hours spent on domestic activities, e.g., childrearing, which undermined the chances of professional development for WP/WPR, whereas for medical men this was not the case – even the opposite. Most of the time, authors did not elaborate further. An example of this narrative follows:

> A majority of women are combining motherhood and career. Compared with their male counterparts, these women have greater domestic responsibilities and lower levels of career involvement. For female physicians, marriage and child-rearing clearly are associated with reduced hours worked and lowered earnings, while for men the effects of marriage and children are just the opposite (Uhlenberg and Cooney, 1990).

The authors, Uhlenberg and Cooney (1990), noted almost thirty years ago that WP/WPR were experiencing different work-life balance challenges than men physicians. This is reiterated twenty years later in a survey on parenting experiences of physicians in Newfoundland, Canada, which highlights the substantial number of more hours WP/WPR spend on childcare and domestic duties than their male counterparts, in addition to identifying the guilt women physician-mothers faced for their perceived performance in both professional and personal realms (Parsons et al., 2009). A particular set of problems arises when WP/WPR have another physician as a partner (Dyrbye et al., 2013; Raja and Stein, 2014) and their medical specialty (theirs, not their partner's) is surgery:

> Surgeons whose domestic partner [DP] is another physician appear to experience greater challenges balancing personal and professional life than surgeons whose DP is a working non-physician or whose DP stays at home (Dyrbye et al., 2010).

As the quote indicates, the work-life balance conflict was associated with WP/WPR having greater domestic responsibilities despite working full-time in a demanding medical setting. The evidence of greater domestic responsibilities and lower levels of career involvement by WP/WPR, perhaps less subtly, repeats itself: "In marriages between two physicians, wives are more likely to make accommodations in their career based on consideration of the effects on spouses and children whereas men were less likely to do so" (Robinson, 2003), and later in the following:

> [T]he most concerning barrier for female physicians was the potential need to extend their residency training if they became pregnant, causing them to be significantly less likely to have a child during residency training than male residents . . . [and] one respondent indicated that all her male co-residents had babies yet she, as a female, was discouraged from doing the same (Mattessich, Shea and Whitaker-Worth, 2017).

This sentiment is reaffirmed by Kuehn (2012) in a commentary that communicates the results of a nationwide survey of women surgeons in which most women surgeons defer having children until the completion of training, but interestingly women in specialities that have larger numbers of practicing WP/WPR have less controversial experiences and timing results for

childbearing. In a study on generational and gender shifts in internal medicine, both genders stressed the importance for having work-life balance, but 21% of women compared to 3% of men felt that their family responsibilities interfered with their work. More negative associations with differences in work-life balance, including increased number of total hours worked and decreased career achievement, derived from greater domestic responsibilities and childrearing than their spouses generally, can be quickly and effortlessly brushed off, however, by adding that men and women report experiencing the same levels of career satisfaction (Jinapriya, Cockerill and Trope, 2003; McAlister et al., 2014), defeating further inquiry into gender inequalities.

Unsurprisingly, higher rates of depression, stress, and burnout ensue from role strain and competing commitments for WP/WPR (Guille et al., 2017), but overall "[d]epression levels are reported to be markedly higher in physicians than in the general population" (Raja and Stein, 2014). Depression and other poor negative health indicators are frequent problems associated with work-life balance for WP/WPR. This is demonstrated further through survey results presented by McMurray et al. (2000) which suggest that WP/WPR also experience burnout due to lack of control over their work environment, but that men physicians do not mirror this finding. Authors noted the disproportionate amount of time spent by WP/WPR in domestic roles, regardless of the (in)flexibility of the medical institution, or of where WP/WPR are positioned in their career, and attributed this to gender bias:

> Promotions and tenure are biased in favour of men due to the male-oriented career framework in medicine … with no flexibility in timing of promotion or tenure for physicians with heightened family responsibilities (Verlander, 2004).

Only one article in my sample questioned the hierarchical and organizational structure of academic medicine that was favourable to men physicians and not to their women colleagues. In one study comparing men and women physician-teachers who had children, WP/WPR unsurprisingly indicated lower job satisfaction, less support from the institution, and slower career progress (Cujec, Oancia, Bohm and Johnson, 2000). Similar high rates of dissatisfaction persist as seen in Szender, Grzankowski, Eng, Odunsi and Frederick (2016). Another frequently cited problem was that WP/WPR were often overlooked for career advancement because they were seen as less ambitious or less able to balance work and family life because of the "mommy track" (Strong et al., 2013). Findings in one article suggested that such gender bias against WP/WPR affects their ability to fully participate in, and produce, medical research, and that this bias makes them less likely than their male colleagues of similar backgrounds, professional roles, and achievements to receive a full professorship (Carnes, Morrissey and Geller, 2008; Verlander, 2004). This bias also appears to explain the lower income and greater number of hours at work and at home spent by WP/WPR:

> Women physicians with children may not be able to return to their previous earnings trajectory even if they return to their previous work schedules (Sasser, 2004).

Yet another problem related to work-life balance identified in my sample was that even considering maternity leave or the fact that women spend a greater number of hours as primary caregiver of children, many WP/WPR still work the same number of long hours as their men colleagues (Jinapriya, Cockerill and Trope, 2003). This fact notwithstanding, as hiring

committees evaluate candidates, they tend to judge women as less able to juggle career and family life, and present candidates with scenarios and questions that they would not present to men candidates (Carnes, Morrissey and Geller, 2008). This is because, as one author put it bluntly, "women bear the brunt of child-rearing responsibilities" (Cujec et al., 2000).

This bias also applies to medical students or physicians-in-training. Because women are assumed to be less committed to a career once it conflicts with family, female medical students are often disparaged from pursuing, for instance, surgical specialties or career-focused specialists, and these attitudes contribute to their choices of medical specialization or to pursuing academic medicine (Beckett et al., 2015; Carnes, Morrissey and Geller, 2008; Tarquinio, 2016). One female medical student describes an experience she had during a general surgery observership:

> The surgeon (male) commented that women really should wait until after residency to have children as it is just too difficult … with the long hours and the fact that [WP/WPR] would most likely want to take time off to spend time with [their] kids … NO MENTION of why men should avoid having kids until after surgery (Phillips and Clarke, 2012).

The literature also indicated that WP/WPR tend to feel that they must work harder than males to demonstrate their ability and commitment to the profession when their values are called into question, and they are automatically relegated to "mother" rather than physician by their colleagues and superiors (Phillips and Clarke, 2012).

Causes of Work-Life Balance Tensions: Inherent Gender Roles and Behaviours

In most articles from this paper's sample, causes of work-life tensions leading to worse health, poor career outcomes, or non-desired choices of "flexible" specialties included biases against WP/WPR, socialized differences and normative gender roles, and a greater amount of time involved in domestic chores and childcare, despite equivalent clinical hours worked (Jolly et al., 2014). As an example of poor health in relation to gender roles, Shenoi (2016), a physician in fellowship training describes her parenting experience as emotionally challenging, physically exhausting and at risk for burnout while her husband was in a different city finishing his PhD, but later decides that the medical environment and not gender characteristics is to blame for burnout. Isaac et al. (2013) echo these genderless sentiments by interviewing the spouses of women physicians and finding that men married to WP/WPR agree that their wives negotiating time in the medical sphere is the biggest issue in attaining work-life balance and a happy marriage. The authors, Isaac et al. (2013), take it a step further and encourage WP/WPR and their husbands to work around accept social roles that violate domestic norms such as husbands as full-time homemakers.

An interesting, recurrent theme was the acknowledged inequalities in success rates, yet these inequalities were more often attributed to the way women and men interact with each other in the workplace and the way WP/WPR tended to invest in relationships and engage in collaborative behaviour rather than hierarchical and competitive behaviour as demonstrated by their male counterparts (Mayer, Files, Ko and Blair, 2008). As Rohde, Moriatis, and Adams (2016) note, WP/WPR also reported higher likelihood of not being able to reach both personal and career goals as one of the main reasons for not entering more male-dominant specialities like orthopaedic surgery. This typical gendered behaviour and resultant choices sometimes dictated the specialty WP/WPR practiced (Beckett et al., 2015). Gender differences in work-life balance

were, other times, overlooked by high tuition fees of medical school and gaps in pay among specialties typically chosen by either men or women, as elaborated upon by Aronson (2017), than were attributed to existing patriarchal structures and standards (see **Table 2** for key themes that illustrate the categories of inquiry as defined by this study).

Discrimination was a frequent cause of tension, drawing WP/WPR away from otherwise desirable specialties, such as surgery. One particular study of medical students described explicit disdain by medical educators and practicing physicians for women surgeons-to-be because of an assumption of inferior skills and issues of forthcoming motherhood as outlined in the following:

> Women as patients were not subject to discrimination; however, female doctors were, on occasion, maligned … [while] men were portrayed as capable of working in any speciality, women were described as unfit surgeons, both because they were assumed to lack manual skills and because they would never put surgery before parenting (Phillips and Clarke, 2012).

A frequent, often implicit, cause of work-life balance tension was the (wrong) timing for parenthood. Thus a recurring theme in the literature was that it would be easier if WP/WPR chose specific times during their training and career to become parents (Potee, Gerber and Ickovics, 1999). Even still, almost twenty years after this publication of issues in motherhood, these same trends persist today (Mattessich, Shea and Whitaker-Worth, 2017). These recommendations to time pregnancy in a more appropriate way were usually presented as an observation, couched in neutral and matter-of-fact language, for instance, the ostensibly straightforward statement that "[t]he optimal timing for parenthood appears to be after the completion of medical training"

(Cujec et al., 2000). Neither this or any article in our sample ever wondered whether optimizing the timing for parenthood was an issue for medical men, but was often a hot topic or survey question for subjects in studies about motherhood and pregnancy during medical education, training and career (Phillips, Nimeh, Braga and Lerner, 2014; Potee, Gerber and Ickovics, 1999; Sandler, Tackett, Longo and Yoo, 2016; Shrier and Shrier, 2005). Furthermore, when reports on parenthood for both genders are presented in the literature, non-childbearing parents – in this case, medical men – are examined in a subtly different way. Rather than questioning parenthood timing or ability to handle the responsibility of work-life balance with added pressures, generational and societal changes appear to be the predictors for desiring more time and involvement with family (Sandler, Tackett, Longo and Yoo, 2016) and are thus commended for pursuing more enjoyment outside of medicine for men physicians.

In a study on generational and gender shifts in internal medicine, both genders stressed the importance for having work-life balance, but 21% of women compared to 3% of men felt that their family responsibilities interfered with their work, further adding that when the study examined only parent physicians, none of the seventeen physician-fathers reported having family-to-work conflict while six of the nine physician-mothers reported this struggle (Jovic, Wallace and Lamaire, 2006). The authors did not make serious recommendations for further study or discussion of gender differences.

Recommendations to Address WLB Tensions: "Let Us Teach Them How to Cope"

As to how to deal with work-life balance, a running theme in the paper's sample was the observation that the ability to "thinking carefully before acting" leads to lesser stress and burnout, and thus the recommendation, for WP/WPR, albeit not their men colleagues, to think carefully

before responding to a discriminating, male-dominated work environment, by "monitor[ing] their stress level and address[ing] it productively." (Gautam, 2001). While I agree with this sound advice for individual cases, the proposed solution to work-life balance tension does not address the source of discrimination. Instead, it offers seemingly reasonable advice on how to react to it politely and without essentially challenging the norms. To reduce any stress that WP/WPR may incur, the following is stated:

> "[W]omen who require more flexible work arrangements in terms of their schedule because of non-professional obligations [i.e. domestic, household, childrearing obligations] will select specialities that provide them this flexibility. For example, physicians in general practice have a great deal of flexibility in terms of their hours of work and the days they work … [and] surgeons have less flexibility in terms of their hours and days of work and also have to provide on-call services" (Campolieti, Hyatt and Kralj, 2007).

This outwardly straightforward and pragmatic language explains that some WP/WPR need more flexibility for childcare and home responsibilities and will thus choose more "flexible" specialities such as family practice. This article does not inquire if or assume that men physicians require the same amount of flexibility. These are not necessarily considered recommendations, but are statements that suggest a process and reason for making certain decisions – in this case, choice in specialty for WP/WPR.

Training to develop coping skills, as well as "educating" women, were also suggested as ways to deal with the challenges of work-life balance (Gautam, 2001; Robinson, 2003), as well

as the advice to prioritize – e.g., making intimate relationships a priority – accessing appropriate child-care, and hiring outside help for the home in order to help shoulder domestic responsibility (Armstrong, Alvero, Dunlow, Nace, Baker and Stewart, 2009; Mattessich, Shea and Whitaker-Worth, 2017; Robinson, 2003; Verlander, 2004). These recommendations were undoubtedly sound (i.e., one enabling child care or the hiring of outside help), yet were all but absent with reference to men physicians, and in themselves did not present a challenge to gendered norms, but instead assumed that women would be primary caregivers. Moreover, they implicitly assumed a class affiliation that would enable WP/WPR to outsource domestic labour to largely poor women – generally working poor women of colour – a strategy that may support the health and well-being of *some* women, but not necessarily of women more broadly.

Interestingly, some authors praised WP/WPR who challenge traditional domestic roles and who "appear to be getting better at relinquishing household and childcare tasks to spouses and others" (Robinson, 2003) or WP/WPR who are supporting their non-medical partner's careers, which acts as a protective barrier for mediating stress in a marriage (Isaac et al., 2013). With that being said, Isaac et al. (2013) noted language of resentment by spouses of women physicians when asked about being the primary caregiver and having a perceived lack of choice, but these issues are mitigated through making other joint-decisions such as hiring outside help or carving out time, but are generally supportive of constructing new work-family paradigms.

As mentioned earlier, some articles did not draw attention to specific gender differences in work-life balance, but rather expanded on the corporatization of balance in medicine, emphasized the need for making individual choices, and suggested combining work and life in order to be more harmoniously balanced.

> The cold truth is that all corporations are specifically designed to maximize their financial profit, not the happiness or well-being of their employees … [physicians] can under no circumstances leave it to [their] employers to determine the quality of [their] own lives … the task of creating our own happiness has to remain in our own hands (Schwingshackl, 2014).

The stressors that physicians experience in trying to create work-life balance can also be managed by individual and organizational systems approaches that address emotional well-being and control over the environment (Dunn, Arnetz, Christensen and Homer, 2007) rather than mindless acceptance of new gadgets aimed at stress-reduction, but in reality are meant to make a physician more productive (Schwingshackl, 2014). Aiming to find peace in trying to balance work and life while seeking inner happiness is advised for WP/WPR (Figueroa, 2016; Shenoi, 2016). Other articles vaguely added on that structures and institutions unfavourable to women ought to be challenged, yet stopped short of recommending major changes, calling instead for modest policy changes such as greater support for breastfeeding practices in medical establishments for WP/WPR (Parsons et al., 2009; Sarma et al., 2017).

> [W]orkplaces should strive to create supportive environments for breastfeeding women, and enough flexibility to sustain this practice (Sarma et al., 2017).

I wholeheartedly support breastfeeding if that is what a woman chooses to do, and encourage the support of this practice in the workplace, not only for WP/WPR but for all women in the workforce. However, this call is far from calling for the transformation of the hierarchical,

male-dominated structures and norms pervading the medical profession. A notable instance of the pervasiveness and invisibility of these norms was the case of authors suggesting that behavioural adjustments would help WP/WPR to be more like their men colleagues, and lead to greater success achieving work-life balance. For instance, a few of them discussed how women could develop better time management skills, find supportive spouses, and seek suitable mentors to work-life problems (Armstrong et al., 2009; Dyrbye et al., 2013; Keeton et al., 2007; Phillips et al., 2016; Strong et al., 2013).

These behavioural adjustments were persuasive as they were framed as collaborative and were paired with suggestions that WP/WPR could build networks of support for women peers and foster mentorships (Gautam, 2001; Mayer et al., 2008; McMurray et al., 2000; Robinson, 2003; Shenoi, 2016; Tarquinio, 2016). Nevertheless, they neglected to indicate why better time management, supportive spouses, or suitable mentors were not required to succeed as a medical man. Moreover, these suggestions, while reasonable, are not easy to follow. As indicated by the literature, there are already too few WP/WPR role models and mentors, certainly fewer than men, and the ones who succeed do so by standards of a male-dominated profession (Mattessich et al., 2017).

Discussion

In this paper, I looked at the language within the discourse that physicians and researchers were using in academic journals to describe the experiences and studies of work-life balance in medicine. These results are typically presented in a straightforward way, outlining both the positive and negative aspects of physician behaviours in and attitudes of work-life balance, while reminding their audience (women physicians/physician-researchers and their colleagues) that

their circumstances could be much worse. Often the literature stressed a need for more research to be conducted on particular aspects of work-life balance, but overall there seemed to be a sufficient amount of evidence to show that WP/WPR are adversely affected by trying to balance work and life matters. Instead, more critical appraisal and discussion of the structural inequalities in practicing medicine should be explored rather than procuring new statistics that reveal the same results as before. The language also emphasized the need to combine both professional and personal domains for future success, but did not outline the choices and sacrifices WP/WPR would have to make in comparison to their male colleagues in order to reach the same standards of success in medicine. As I will discuss, this discursive approach to having the elusive "work-life balance" in medicine, though it may work for the advantaged few, does not work for or help the case of the general population of WP/WPR or the subsets of minority groups.

The literature in this paper's sample of articles has predominantly moved away from using more blatant masculine language that normalizes men as physicians and as dominant powers and has moved into more gender-neutral terms. While work-life balance discourse acknowledges that WP/WPR have poorer health outcomes and a greater likelihood of experiencing work-home conflicts, the language that physicians of both genders present in describing work-life balance and WP/WPR does not challenge the issues of inequity and patriarchy present in the profession, but instead reproduces the social order of medicine, created by men and for men, through articulating antiquated solutions that were once the dominant ideology and practice. Often times, any critique of the reproduction of inequities in the medical profession is non-existent and the literature takes on an egalitarian tone that women and men physicians experience similar work-life balance issues.

While this may be true to a certain extent, and WP/WPR experience *some* of the same issues as their male counterparts, there is nevertheless a bigger trade-off for WP/WPR between work and life. Though this is not always explicitly stated in the language, it is implied in the delivery and definitely is rarely questioned, causing inequalities in professional and personal lives to persist. Therein lies one of the biggest problems for women in medicine: The language used by both genders in the literature does not question why or how such inequalities from a bigger trade-off by WP/WPR exist or endure, but naturalizes normative gender structures in medicine through the recurrence of behavioural suggestions rather than criticism of institutional reform or power dynamics. The following sections expand on intersectional experiences in medicine through the education, training, and career of women physicians and physician-researchers.

Race, Class and Sexual Orientation

An overwhelming majority of the literature discusses work-life balance on a single-axis while intersectional experiences of race, class and sexual orientation in medicine are noticeably absent. This may be the case due to minority groups historically being excluded from medical education and practice and then continuing into current literature. It is well documented that women physicians and women physician-researchers have attempted and are still attempting to break down gender stereotypes in the medical profession, but subsets of minority groups within the category of WP/WPR nevertheless are confronted with on-going biases and labels. Dominant groups, thus, control the knowledge and language that is being disseminated.

The nature of the medical discourse posits that work-life balance issues impact physicians in largely the same way without regard of varying group experiences within the institution. A lower or middle-class born, woman of colour physician/physician-researcher, by presumption,

experiences the same challenges and stresses that embattle her upper-middle-class born, white woman physician counterpart. This idea is demonstrated to be false and intersectional experiences of gender, race and sexual orientation do, in fact, exist for all WP/WPR. Blackstock (1996), for example, describes her own experiences of racism and discrimination while in medical school and during her career, and yet the literature in this paper's sample of work-life balance does not explore qualitative or quantitative data outside of traditional medical professional models. Experiences learning, training, and practicing in a medical environment are, of course, unique and personal to individuals and groups, but collectively cannot be simply reduced to *all* women physicians. Not only are non-white, non-heterosexual WP/WPR subtly instructed to prescribe to normative male-created and male-dominated biases within the medical language that investigates work-life balance, but also must conform to standards reproduced and upheld by their WP/WPR colleagues. In the institutional hierarchy of inequalities in practicing medicine, Caucasian, hetero-normative men physicians are on the top and WP/WPR in sub-minority groups are on the bottom.

The absence of language in medical discourse that addresses work-life balance for women of colour, indigenous or LGBTQ statuses indicates oppression in the medical profession by means of silencing their voices. This happens directly – for example, academic journals not publishing literature on work-life balance for minority groups – or indirectly – by not highlighting experiences of minority groups in analyses or discussions of work-life balance and further generalizing findings to all WP/WPR. The dominant groups in medicine produce literature that generalizes one set of the medical professional population's experiences to the entire community, and demonstrates little consideration for the lived experiences of women in minority groups or the institutional barriers that prevent them from succeeding in the same ways as their male

counterparts or Caucasian WP/WPR colleagues. Work-life balance discourse, thus, serves as topical guidelines and discussions on how to succeed in medicine by dominant group standards using dominant group methods.

The power and control of minority groups by the institutional dominant pervade medical boundaries, however. As with many professions in North America, Caucasian, affluent and class-privileged individuals are overrepresented in the medical field. Often the literature, assuming financial success among WP/WPR, suggested overcoming work-life balance challenges by seeking childcare and retaining household staff, regularly leading to outsourcing labour to a workforce that is primarily women and people of colour with limited financial resources. Engaging in employment of these groups of labourers, especially without conscious thought or consideration for the larger repercussions or consequences, contributes to and reproduces an already existing patriarchal medical institution of deep inequalities. This illustrates the blind acceptance of racialized, gendered and classed hierarchies that physicians operate within, outside of the medical institution itself.

Education

As discussed by Philips and Clarke (2012), the hidden curriculum of medical school is prevalent, with biases and institutional norms becoming engrained in students early on. These norms socialize potential WP/WPR to choose less rigorous, lower-paid specialities, such as family medicine and psychiatry, and thus supports a social order within the medical institution that sees men physicians in the roles of high-earning surgical specialties whereas WP/WPR are driven into lower-earning “feminine” fields. As greater numbers of women pursue these areas of medicine, the same specialities become less prestigious and desirable, and both power and income

discrepancies increase. From this socialization into creating more distinct feminine specialities and disciplines, WP/WPR experience power inequalities from greater difficulty attaining educational/research grants, lower degrees of prestige, and less influence in medicine (Reed and Buddeberg-Fischer, 2001).

The overt discrimination and power dynamics in medical school prevents the future success of WP/WPR and influences them away from practicing in surgical or highly-specialized fields. This attitude held by senior academics and clinicians to gently persuade women out of certain specialities and exclude women from informal networks and collaborative activities, acknowledged in the findings of this paper, is important revealing language in medical discourse. However, merely presenting examples of exclusion and discrimination do not go far enough to critique the functionalism of excluding WP/WPR from certain areas of work, which reproduces patterns of dominance and helps maintain patriarchy in its already existing form.

Seeking mentors and role models during medical school is used as a solution in the literature to assist students in making decisions in choice of specialty, but several issues could potentially arise with trying to obtain a mentor, of which these issues are rarely mentioned. Because there are few WP/WPR in some specialities, it may be difficult to find a suitable mentor that can share her work-life balance experiences in the field that the medical student is interested in pursuing. It may be even more difficult to find a specific mentor with the same group characteristics (i.e. women of colour) that a prospective WP/WPR is trying to find. While the literature does stress the importance of having a mentor, a critique is lacking of the structural and institutional reasons for why there are so few suitable WP/WPR mentors.

Women physicians and physician-researchers who are available as mentors may also not be able to respond to perceptions of being on the "mommy track" or to give appropriate guidance to oppose the idea if they do not have children themselves, or if they seemingly give poor advice that reproduces traditional gender roles. In the sample of articles in this paper, women medical students often question whether they will be able to juggle having children during medical school or training. Without probing the socialized gender roles that the "mommy track" assumes in medical institutions, medical students will forever be chasing the elusive balancing act between WP/WPR on one hand and being a mother and wife on the other. In the work-life balance literature, women were spoken about as either mother or physician, but often not at the intersection of both. As both of these roles are equally important to many WP/WPR, it is important to discuss not only how to best operate in both spheres, as the literature expresses, but also how to appraise and alter existing inequitable structures that harm chances of succeeding in medicine.

Training

Work-life balance problems in training are often attributed to timing of parenthood, even more so during this aspect of medicine than during medical school or later in the careers of WP/WPR, due to the usual timelines of pregnancy and residency/fellowship coinciding. Women physicians and women physician-researchers, particularly those in their family-building and training years, work long, demanding hours, and as such may not have the time nor the opportunity to think about the structural inequities they, WP/WPR, are subjected to and reproduce within and outside of the medical field. While this does not excuse ignorance or time availability as justification for idle behaviour, it does speak to the construction and design of medicine as an institution of deeply-rooted inequities. It also suggests that behavioural adjustments can be made

to help a WP/WPR succeed in personal and professional life simultaneously. At least not in the literature on work-life balance is there critical appraisal of the inequalities and social norms that persist. It was enough of a struggle for WP/WPR to be able to enter medicine, and now they are required to unwittingly follow the policies and order set forth by middle and upper class, usually affluent, Caucasian men physicians, businessmen and policymakers, when not reproduced by WP/WPR themselves.

This is particularly apparent when women are more readily able to access maternity leave, though perhaps less willing than the general population because of their perceived awareness of creating stress on their colleagues during training – but their partners, especially when their partner is another physician or surgeon, are more hesitant to take paternity leave because of the reversal of traditional roles that would result. This is even more pronounced in male-centric surgical specialities when presented in the literature as it creates images that WP/WPR will not, at best, be as supported as women in more female-centric specialities, and at worst, be unsuccessful and resented by colleagues. Although maternity and *some* paternity leave policies are available in theory, in practice they are ineffective and unrealistic when women physicians are not only pressured to return to work earlier than they desire, but also more likely at risk to be discounted for career advancement because of the necessary personal time that they have taken. Much of the research in the literature claimed that WP/WPR perceived that breaks in training (i.e. maternity leave) as detrimental to their career trajectory. The language that normalizes the discussion of parenthood timing and maternity leave for WP/WPR, rather than general paternity leave in medicine for all physicians or a critical analysis of the health disparities and inequities among minority groups maintains gender roles and the social order of the medical profession.

Women physicians and women physician-researchers, particularly in surgical specialties, face gender and maternity issues vis-à-vis career pursuits. The common rhetoric remains that women are the primary caregivers and bear the responsibility of child-rearing and domestic duties, even as highly successful professionals. The literature analyzed declares, rather inconclusively, that women medical professionals who do not participate in motherhood often experience greater career success and take on higher management and leadership roles at work, but have lower career satisfaction. This language suggests that women will be happier and more satisfied with children than without, but will have to relinquish one area to succeed in: she can either be happy as a mother and be less successful, or be unhappy because she is not a mother but will have a successful career. The literature does not consider or even attempt to normalize paternity leave for fathers or question if they have to make the same sacrifices as women.

The literature expressed a lack of positive role models and formal mentorships for women during residency and fellowships, and this was regularly attributed to senior women physicians being unhelpful or in medical roles that were not suitable for the mentorship that was being requested (Robinson, 2003; Ferris, Mackinnon, Mizgala, and McNeill, 1996; Woodrow, Gilmer-Hill, and Rutka, 2006; Gautam, 2001; Parsons et al., 2009). A lack of mentorship and role model opportunities may signal stagnant, passive behaviour or, at worst, trouble for maturing WP/WPR when there is little guidance for them on how to best "balance" work and life, but this consequently still plays into patriarchal norms that are presented and reproduced. Role models and mentors in and of themselves cannot challenge or change the patriarchal normative structure of medicine, however, and in fact may paradoxically help reproduce them if they "mentor" women to succeed by meeting patriarchal standards.

Career

Women physicians and physician-researchers have made great strides in practicing medicine since their entrance into the profession, according to the research in the sample of articles. Behavioural suggestions like better prioritization and stress reduction, on the surface, appear to be well-meant, but are far from realizing equitable conditions for minority groups. These articles determine, for example, that both men and women physicians have equal amounts of satisfaction with having a career in medicine despite women physicians spending more time in the domestic sphere, but do not address a multitude of factors and issues like how, importantly, career satisfaction does not capture the inequities in gender norms that are shaped and reproduced by both men physicians and WP/WPR in medicine. Often the qualitative studies conducted in the literature, written by both genders, exclude criticism of the institutional structures in medicine, and the historical context that issues were created from, that could be the current cause of gender disparities in number of working hours, health outcomes or work-life balance success.

Women physicians and women physician-researchers appear in the literature to make individual choices (Gautam, 2001), but their individual choices are often regulated by gender and institutional norms. The use of flexible scheduling and daycare, suggestions made by authors, demonstrate this. The brunt of responsibility still falls on WP/WPR to plan daycare and schedule properly and are not real, individual choices because they are not directed at all physicians, but at women in medicine. Choices such as reducing number of hours at work to be at home more often during early years of parenthood could also result in slower career progress, missed opportunities or a lack of work-life balance. This suggests that the social identities of WP/WPR are constructed and reproduced through the language of behavioural solutions to work-life balance tensions. This

ultimately affects a greater likelihood of WP/WPR experiencing work-life balance issues more than their male colleagues while the literature portrays this type of conflict for WP/WPR as characteristic of the profession, and yet does not mention or allude to why this conflict is not as prevalent with male colleagues. On the contrary, WP/WPR reported leaving academic medicine more frequently than males because of work-family conflicts (Beckett, Nettiksimmons, Howell and Villablanca, 2015). WP/WPR of colour, LGBTQ and indigenous status will have other unique conflicts to negotiate in addition to the tensions they experience in balancing work and life.

While it is encouraging that some women challenge traditional roles and managed to relegate traditional women tasks to others, this framing blames the victim, as those women who *fail* to challenge these roles and *fail* to delegate domestic tasks are implicitly blamed for experiencing work-life tensions, while the structural victimizers get a pass. While tackling *individual* challenges in a male-dominated medical world are to be encouraged and may benefit *particular* women, they will not change the structural basis of gender inequities in medical practice. WP/WPR may not be able to "have it all" until underlying structures of domination in medicine are eliminated.

Implications for Practice, Policy and Equity

This paper's findings indicate that WP/WPR work harder to meet clinical benchmarks and societal standards designed for them by men physicians and often unintentionally reproduce and legitimize these benchmarks themselves. The medical literature largely acknowledges and even critiques the hardships experienced by WP/WPR – including the multiple-role demands affecting their physical and emotional well-being, the creation of "work-life balance" tensions and

medicine's inflexible environment. Nevertheless, it directly or indirectly downloads the responsibility on women for these hardships, often framing the effects of gendered norms as caused by gender-specific lifestyle and behavioural decisions, using instances of these decisions to illustrate how the choices of WP/WPR lead to career successes or failures. In so doing it neglects to challenge the male-dominated construction of medical practice or of the lived, distinctive experiences of minority WP/WPR groups.

Burnout, depression, tensions with work-life balance, and overall dissatisfaction with life and career are often presented as outcomes of individual choices and circumstances, followed by behavioural suggestions and individual solutions to combat said challenges. In the meantime, the normative, patriarchal structures built into the practice of medicine remain invisible and WP/WPR continue to engage in policies and practices created by non-medical and medical men. The social order, produced by men physicians and maintained by WP/WPR, is legitimized when the latter tacitly consent to male-constructed norms of behaviour.

Persuasive notions of empowerment and personal choice facilitate gender inequity by further separating work and domestic responsibilities (Gascoigne, Parry, and Buchanan, 2015), a separation that mostly benefits men physicians. The emphasis is placed on the individual rather than the on medical institutions, the profession of medicine, or the state, thus exacerbating the very real conflict between the demands of a medical career and the domestic sphere. Recommendations for amelioration appear to ultimately contribute to the reproduction of patriarchy in medicine. This is because, while well intended, the recommendations do not challenge the patriarchal paradigm in the medical profession, a paradigm that in itself is at odds with achieving "work-life" balance, for women *and* men. Calls to address the problem are frequent, yet do not appear to challenge how medical institutions operate, nor do they demand a

reconsideration of the social values that are the real sources of conflict. When the language used is devoid of a critical appraisal of social institutions, the language becomes a contributor to the reproduction of the status quo, and patriarchal domination in its many forms persists.

Notably, WP/WPR themselves perform the ideological work of patriarchy. The language used in academic medical literature by women authors fails to advance the status of women in medicine and often puts the onus of responsibility for dealing with "appropriate" lifestyle choices on WP/WPR themselves. This language largely excludes a deeper critique of the social and institutional context of the profession of medicine, a profession in which the standards of successful performance are themselves gendered. This way, language *cannot but contribute* to the disadvantaged status of WP/WPR. The silence observed from WP/WPR themselves surrounding the deeper reasons for inequities in clinical specialties also contributes to the normalization of male-dominated practices, policies, and behaviours. One such instance calls for institutional support for *maternal* policies yet not *paternal* policies (Mattessich, Shea, and Whitaker-Worth, 2017), a support that further enforces the gender stereotype that not only it is largely women who effectively are responsible for child-rearing and homemaking, but that this is how it *should* be, while the main role of their male counterparts is, and should be, that of breadwinner. Against this background, calls for better, i.e. "adaptive", behavioural and lifestyle choices for WP/WPR overshadow deeper discussions of persisting patriarchal norms, policies and practices.

Building upon my findings, I propose that the relative privilege that comes with practicing medicine, and likely the class and ethnic background of those women most likely to enter the medical profession, discourages WP/WPR from critiquing the system, leads them to adjust to societal expectations, and encourages behavioural explanations for their successes and failures in the medical sphere -- a subtle form of self-blame. It is not only a form of self-blame, but also a

means of holding on to the often unstable privilege that accompanies becoming a highly-paid WP/WPR. Maintaining the status quo and unintentionally supporting a patriarchal system makes it more difficult for future women physicians to succeed. Even when women succeed, their success plays into a male-dominated model of "successful physician", as it implicitly mandates that success for WP/WPR requires that they reach the career echelons and benchmarks reached by men. Whether success entails a high-ranking surgical position at a hospital for a single WP/WPR, or the ability to balance a professorship, clinical work and a family, women have learned to manoeuvre through a male-created and male-dominated system, and the lesson learned understandably weakens any motivation they may have to *critique* the system.

Challenges to these standards exist, yet are scarce. While not in the context of work-life balance (that is not part of our sample), some authors recognize the inequities experienced by WP/WPR, yet do not recommend ways to cope or to help them meet *existing* benchmarks, but rather *critique* these benchmarks – the structure of medical leadership, organization chairs, and hierarchy in medical academia -- and recommend *specific* policy changes – to the current, indeterminate length of chair positions, to the organizational structure towards a more collegial orientation, and to less hierarchical, more collaborative and transparent decision-making (Conrad, Carr, Knight, Renfrew, Dunn and Pololi, 2010).

Limitations

I concede that my study, as a qualitative study focused on a critical discourse analysis of the medical literature, has limitations. For instance, my scoping review of databases and leading journals at times produced articles that were not accessible via York University's library and could have contributed to the paper in unique ways. Articles that were not included may have offered

information that challenged key findings and components of my argument or likely could have helped solidify my arguments further. Also, my focus was primarily literature produced by medical professionals themselves within the boundaries of peer-reviewed journals – findings might have been different had I looked into other methods of producing language such as blogs, podcasts, and other forms of medical discourse, also produced by medical professionals, yet with space to harbour more radical and nuanced debates. Additionally, I did not speak to WP/WPR themselves to explore in depth their views on normative patriarchal medical structures, the social order of medicine, or work-life balance conflicts. Importantly, within potential interviews of WP/WPR, I did not seek to explore LGBTQ, indigenous, non-Caucasian or class relations, what their work-life issues would be, and how they would be handled. I note earlier in this paper, however, that the literature rarely makes mention of such cases. In addition, from a global perspective, the literature I investigated represented a narrow segment of WP/WPR. Work-life balance issues in the practice of medicine may reveal significant differences and challenges in other parts of the world, under different political, cultural and economic contexts.

Conclusion

I believe that my findings reveal important features of the gendered nature of the medical profession and medical practice, and importantly, *how this nature and practice may be reinforced by women themselves*, even as these features impinge on their own health and well-being. I also believe that the paper's findings can offer fruitful venues for further investigation of structural barriers to women's health and wellbeing in other settings, contexts, and professions. In the UK for instance, female students in engineering and technology were found to uphold contradictory views about women in these professions, often believing that they were less suited to succeed in

these professions, yet simultaneously believing that respondents themselves were equally well-prepared as men are to meet male-suitable benchmarks of success (Powell, Dainty and Bagilhole, 2012).

Challenging historically patriarchal practices and attitudes is necessary to ensure professional, health, and social equity among genders in medicine. The sheer increase of the number of WP/WPR in and of itself is unlikely to produce the needed paradigm shift and breakdown of patriarchal standards in medicine, especially if women themselves are socialized to perform the ideological work of reproducing these standards. A movement led by women from within the medical community and genuinely supported by their men colleagues is necessary, but is unlikely to emerge if both are engaged in the reproduction of gendered inequities, even at the micro-level of language – never mind policy and practice.

Challenging gendered normative structures will allow WP/WPR success in the same timeframe as their male colleagues, under equitable circumstances, and with realistic expectations. Establishing progressive programs that critique and erode social norms and tradition (Woodrow, Gilmer-Hill, and Rutka, 2006) are positive steps, but greater attention and action are needed. The idea that the impact of individual choices by WP/WPR may lead to success or failure should be rejected. It is not individual choices, but rather the patriarchal structures of medicine, that shape how men and women practice the profession, and that are responsible for the negative effects experienced by WP/WPR. Even the success of *some* women could paradoxically work against the success of *all* women, if success compels women to follow in the footsteps of men and comply with gendered standards. The continuation of this pattern of disadvantage will harm women physicians and women physician-researchers, as well as their families and patients.

References

2016-2020 PARO-CAHO Agreement. (2016). Retrieved October 1, 2017, from http://www.myparo.ca/your-contract/#pregnancy-and-parental-leave

Ash, A., Carr, P., Goldstein, R., and Friedman, R. (2004). Compensation and advancement of women in academic medicine: Is there equity? *Annals of Internal Medicine*, 141:3, 205-212.

Barnett, R. and Gareis, K. (2002). Full-time and reduced-hours work schedules and marital quality: A study of female physicians with young children. Work and Occupations, 29:3, 364-379.

Blackstock, D. (1996). A black woman in medicine. In D. Wear (Ed.), *Women in Medical Education: An Anthology of Experiences*. Albany: State University of New York Press.

Bleakley, A. (2013). Gender matters in medical education. *Medical Education*, 47, 59-70.

Boulis, A. and Jacobs, J. (2008). *The changing face of medicine: Women doctors and the evolution of health care in America*. New York: Cornell University Press.

Burnham, J. (2005). *What is Medical History*? Cambridge: Polity Press.

Bynum, W., Hardy, A., Jacyna, S., Lawrence, C. and Tansey, E. 2006. *The Western Medical Tradition: 1800 to 2000*. New York: Cambridge University Press.

Choo, E., Kass, D., Westergaard, M., Watts, S., Berwald, N., Regan, L., Promes, S., Clem, K., Schneider, S., Kuhn, G., Abbuhl, S., and Nobay, F. (2016). The development of best practice recommendations to support the hiring, recruitment, and advancement of women physicians in emergency medicine. *Academic Emergency Medicine*, 23:11, 1203-1209.

Clem, K., Promes, S., Glickman, S., Shah, A., Finkel, M., Pietrobon, R., and Cairns, C. (2008). Factors enhancing career satisfaction among female emergency physicians. *Annals of Emergency Medicine*, 51:6, 723-728.e8.

Cole, L. (2017, July 27). Definition of cultural hegemony: How the ruling class maintains power using ideas and norms. Retrieved October 20, 2017, from https://www.thoughtco.com/cultural-hegemony-3026121

Conrad, P., Carr, P., Knight, S., Renfrew, M., Dunn, M., and Pololi, L. (2010). Hierarchy as a barrier to advancement for women in academic medicine. *Journal of Women's Health*, 19:4, 799-805.

Crenshaw, K. (1993). Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Stanford Law Review*, 43, 1241-1299.

Dyrbye, L., Shanafelt, T., Balch, C., Satele, D., and Freischlag, J. (2010). Physicians married or partnered to physicians: A comparative study in the American college of surgeons. *Journal of the American College of Surgeons*, 211:5, 663-671.

Fairclough, N. (1989). *Language and Power*. London: Longman.

Fairclough, N. (2013). *Critical Discourse Analysis: The Critical Study of Language*. London: Routledge.

Ferris, L., Mackinnon, S., Mizgala, C., and McNeill, I. (1996). Do Canadian female surgeons feel discriminated against as women? *Canadian Medical Association Journal*, 154:1, 21-27.

Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings, 1972-1977.* New York: Pantheon Books.

Frank, E. and Dingle, A. (1999). Self-reported depression and suicide attempts among U.S. women physicians. *The American Journal of Psychiatry*, 156:2, 1887-1894.

Freidson, E. (1985). The reorganization of the medical profession. *Medical Care Review*, 42:1, 11-36.

Gans, H. J. (1972). "The Positive Functions of Poverty." The American Journal of Sociology 78(2): 275-289.

Gascoigne, C., Parry, E., and Buchanan, D. (2015). Extreme work, gendered work? How extreme jobs and the discourse of 'personal choice' perpetuate gender inequality. *Organization*, 22(4), 457-475.

Gautam, M. (2001). Women in medicine: Stresses and solutions. *Western Journal of Medicine*, 174, 37-41.

Hamowy, R. (1984). *Canadian Medicine: A Study in Restricted Entry*. Vancouver: Fraser Institute.

Hassouneh, D. (2018). *Faculty of Color in the Health Professions: Stories of Survival and Success*. Hanover, New Hampshire: Darmouth College Press,

Heru, A. (2005). Pink-collar medicine: Women and the future of medicine. *Gender Issues,* 22:1, 20-34.

Jefferson, L., Bloor, K., and Maynard, A. (2015). Women in medicine: Historical perspectives and recent trends. *British Medical Bulletin*, 114, 5-15.

Jones, D. (1996). Father knows best …? In D. Wear (Ed.), *Women in Medical Education: An Anthology of Experiences*. Albany: State University of New York Press.

Klass, P. (1996). The feminization of medicine. In D. Wear (Ed.), *Women in Medical Education: An Anthology of Experiences*. Albany: State University of New York Press.

Luke, A. (1997). Theory and practice in critical discourse analysis. In L. Saha (Ed.), *International Encyclopaedia of the Sociology of Education*, 50-56, Oxford: Pergamon.

Marschall, J. and Karimuddin, A. (2003). Decline in popularity of general surgery as a career choice in North America: Review of postgraduate residency training selection in Canada, 1996-2001. *World Journal of Surgery*, 27, 249-252.

McAlister, C., Jin, Y., Braga-Mele, R., DesMarchais, B., and Buys, Y. (2014). Comparison of lifestyle and practice patterns between male and female Canadian ophthalmologists. *Canadian Journal of Ophthalmology*, 49:3, 287-290.

McLachlan, G. and McKeown, T. (Eeds.). (1971). *Medical History and Medical Care: A symposium of perspectives*. Oxford University Press: London.

Merchant, S., Hameed, S., and Melck, A. (2013). Pregnancy among residents enrolled in general surgery: A nationwide survey of attitudes and experiences. *The American Journal of Surgery*, 206:4, 605-610.

Meyerson, D. and Fletcher, J. (2000). A modest manifesto for shattering the glass ceiling. *Harvard Business Review*, 778:1, 127-136.

Micieli, J., Trope, G., and Buys, Y. (2016). Gender gap and declining surgical activity among new graduates: Cataract surgery in Ontario. *Canadian Journal of Ophthalmology*, 51:3, 154-169.

Miller, A. (2011). The effects of motherhood timing on career path. *Journal of Population Economics*, 24:3, 1071-1100.

Mobilos, S., Chan, M., and Brown, J. (2008). Women in medicine: The challenge of finding balance. *Canadian Family Physician*, 54, 1285-1286.e5.

Navarro, V. (1980). Work, ideology, and science: The case of medicine." *International Journal of Health Services*, 10(4): 523-550.

Office of Research and Information Services (2015). Canadian Medical Education Statistics 2015, The Association of Faculties of Medicine of Canada: Ottawa (ON), Vol. 37, pp. 9-32.

Ontario Medical School Application System. (2018). Ontario Universities' Application Centre. Retrieved July 10, 2018, from https://www.ouac.on.ca/omsas/

Parsons, W., Duke, P., Snow, P., and Edwards, A. (2009). Physicians as parents: Parenting experiences of physicians in Newfoundland and Labrador. *Canadian Family Physician*, 55, 808-809.e4.

Phillips, S. and Clarke, M. (2012). More than an education: The hidden curriculum, professional attitudes and career choice. *Medical Education*, 45, 887-893.

Potee, R., Gerber, A. and Ockovics, J. (1999). Medicine and motherhood: Shifting trends among female physicians from 1922 to 1999. *Academic Medicine*, 74:8, 911-919.

Powell, A., Dainty, A., and Bagilhole, B. (2012). Gender stereotypes among women engineering and technology students in the UK: Lessons from career choice narratives. *European Journal of Engineering Education*, 37:6, 514-556.

Reed, V. and Buddeberg-Fischer, B. (2001). Career obstacles for women in medicine: An overview. *Medical Education*, 35, 139-147.

Reskin, B. and Roos, P. (1990). *Job queues, gender queues: Explaining women's inroads into male occupations*. Philadelphia: Temple University Press.

Robinson, G. (2003). Stresses on women physicians: Consequences and coping techniques. *Depression and Anxiety*, 17, 180-189.

Shanafelt, T., Hasan, O., Hayes, S., Sinsky, C., Satele, D., Sloan, J., West, C. and Dyrbye, L. (2016). Parental satisfaction of U.S. physicians: Associated factors and comparison with the general U.S. working population. *BMC Medical Education*, 16:228, 1-10.

Sonnad, S., Colletti, L. (2002). Issues in the recruitment and success of women in academic surgery. *Surgery*, 132, 415-419.

Stentz, N., Griffith, K., Perkins, E., DeCastro Jones, R. and Jagsi, R. (2016). Fertility and childbearing among American female physicians. *Journal of Women's Health*, 25:10, 1059-1065.

Valian, V. (1999). *Why so slow? The advancement of women*. Cambridge, Massachusetts: MIT Press.

van Dijk, T. (1993). Pricinples of critical discourse analysis. *Discourse and Society*, 4:2, 249-283.

Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behavior*, 30:2, 220-239.

Waitzkin, H. and Britt, T. (1989). Changing the structure of medical discourse: Implications of cross-national comparisons. *Journal of Health and Social Behavior*, 30:4, 436-449.

Wear, D. (Ed.). (1996). *Women in Medical Education: An Anthology of Experiences*. Albany: State University of New York Press.

Woodrow, S., Gilmer-Hill, H., and Rutka, J. (2006). The neurosurgical workforce in North America: A critical review of gender issues. *Neurosurgery*, 59, 749-758.

Zola, I. (1972). Medicine as an institution of social control. *The Sociological Review*, 20:4, 487-504.

Table 1 – Selection of articles analyzed, by time period and gender of authors

Period	Gender of Authors in Selection of Articles					
	Women authors	**#**	**Male authors**	**#**	**Both**	**#**
1990-1996		**0**		**0**	Uhlenberg, P. and Cooney, T. (1990). Male and female physicians: Family and career comparisons. *Social Science and Medicine*, 30:3, 373-378.	**1**
1997-2003	Gautam, M. (2001). Women in medicine: Stresses and solutions. *Western Journal of Medicine*, 174, 37-41	**2**		**0**	Cujec, B., Oancia, T., Bohm, C. and Johnson, D. (2000). Career and parenting satisfaction among medical students, residents and physician teachers at a Canadian medical school. *Canadian Medical Association Journal*, 162:5, 637-340.	**4**
	Robinson, G. (2003). Stresses on women physicians: Consequences and coping techniques. *Depression and Anxiety*, 17, 180-189.				Jinapriya, D., Cockerill, R., and Trope, G. (2003). Career satisfaction and surgical practice patterns among female ophthalmologists. *Canadian Journal of Ophthalmology*, 38:5, 373-378.	
					McMurray, J., Linzer, M., Konrad, T., Douglas, J., Shugerman, R. and Nelson, K. (2000). The work lives of women physicians: Results from the physician work life study. *Journal of General Internal Medicine*, 15, 372-380.	
					Potee, R., Gerber, A. and Ockovics, J. (1999). Medicine and motherhood: Shifting trends among female physicians from 1922 to 1999. *Academic Medicine*, 74:8, 911-919.	
2004-2010	Carnes, M., Morrissey, C. and Geller, S. (2008). Women's health and women's leadership in academic medicine: Hitting the same glass ceiling? *Journal of Women's Health*, 17:9, 1453-1462.	**9**	Dunn, P., Arnetz, B., Christensen, J. and Homer, L. (2007). Meeting the imperative to improve physician well-being: Assessment of an innovative program. *Journal of General Internal Medicine*, 22:11, 1544-1552.	**2**	Armstrong, A., Alvero, R., Dunlow, S., Nace, M., Baker, V. and Stewart, E. (2009). Balancing the professional and personal. *Fertility and Sterility*, 91:1, 18-21.	**3**
	Harrison, R. (2008). Evolving trends in balancing work and family for future academic		Campolieti, M., Hyatt, D. and Kralj, B. (2007). Determinants of stress in medical practice:		Dyrbye, L., Shanafelt, T., Balch, C., Satele, D. and Freischlag, J. (2010). Physicians	

	physicians: A role for personal stories. *Medical Teacher*, 30, 316-318.		Evidence from Ontario physicians. *Industrial Relations*, 62:2, 226-254.		married or partnered to physicians: A comparative study in the American college of surgeons. *Journal of the American College of Surgeons*, 211, 663-671.	
	Jovic, E., Wallace, J. and Lemaire, J. (2006). The generation and gender shifts in medicine: An exploratory survey of internal medicine physicians. *BMC Health Services Research*, 6:55, 1-10.				Keeton, K., Fenner, D., Johnson, T. and Hayward, R. (2007). Predictors of physician career satisfaction, work-life balance, and burnout. *Obstetrics and Gynecology*, 109:4, 949-955.	
	Mayer, A., Files, J., Ko, M. and Blair, J. (2008). Academic advancement of women in medicine: Do socialized gender differences have a role in mentoring? *Mayo Clinic Proceedings*, 83:2, 204-207.					
	Mobilos, S., Chan, M., and Brown, J. (2008). Women in medicine: The challenge of finding balance. *Canadian Family Physician*, 54, 1285-1286.e5.					
	Parsons, W., Duke, P., Snow, P., and Edwards, A. (2009). Physicians as parents: Parenting experiences of physicians in Newfoundland and Labrador. *Canadian Family Physician*, 55, 808-809.e4.					
	Sasser, A. (2004). Gender differences in physician pay: Tradeoffs between career and family. *The Journal of Human Resources*, XL, 477-504.					
	Shrier, D. and Shrier L. (2005). An exploratory study of mother-daughter physicians: An intergenerational comparison of professional and personal experiences. *Journal of Women's Health*, 14:10, 946-957.					
	Verlander, G. (2004). Female physicians: Balancing career and family. *Academic Psychiatry*, 28:4, 331-336.					
2011-2017	Aronson, L. (2017). A tale of two doctors – Structural inequalities and the culture of medicine. *New England Journal of Medicine: Medicine and Society*, 376:24, 2390-2393.	**13**	Schwingshackl, A. (2014). The fallacy of chasing after work-life balance. *Frontiers in Pediatrics*, 2:26, 1-3.	**1**	Dyrbye, L., Varkey, P., Boone, S., Satele, D., Sloan, J. and Shanafelt, T. (2013). Physician satisfaction and burnout at	**15**

					different career stages. *Mayo Clinic Proceedings*, 88:12, 1358-1367.	
	Beckett, L., Nettiksimmons, J., Howell, L. and Villablanca, A. (2015). Do family responsibilities and a clinical versus research faculty position affect satisfaction with career and work-life balance for medical school faculty? *Journal of Women's Health*, 24:6, 480-489.				Dyrbye, L., Sotile, W., Boone, S., West, C., Tan, L., Satele, D., Sloan, J., Oreskovich, M. and Shanafelt, T. (2013). A survey of U.S. physicians and their partners regarding the impact of work-home conflict. *Journal of General Internal Medicine*, 29:1, 155-161.	
	Figueroa, M. (2016). Work-life balance does not mean an equal balance. *Frontiers in Pediatrics*, 4:18, 1-2.				Guille, C., Frank, E., Zhao, Z., Kalmbach, D., Nietert, P., Mata, D. and Sen, S. (2017). Work-family conflict and the sex difference in depression among training physicians. *Journal of the American Medical Association: Internal Medicine*, E1-E7.	
	Isaac, C., Petrashek, K., Steiner, M., Manwell, L., Byars-Winston, A. and Carnes, M. (2013). Male spouses of women physicians: Communication, compromise, and carving out time. *Qualitative Report*, 18, 1-12.				Jolly, S., Griffith, K., DeCastro, R., Stewart, A., Ubel, A. and Jagsi, R. (2014). Gender differences in time spent on parenting and domestic responsibilities by high-achieving young physician-researchers. *Annals of Internal Medicine*, 160:5, 344-353.	
	Kuehn, B. (2012). More women choose careers in surgery: Bias, work-life issues remain challenges. *Journal of the American Medical Association*, 307:18, 1899-1901.				Phillips, E., Nimeh, T., Braga, J. and Lerner, L. (2014). Does a surgical career affect a woman's childbearing and fertility? A report on pregnancy and fertility trends among female surgeons. *Journal of the American College of Surgeons*, 219:5, 944-950.	
	Mattessich, S., Shea, K. and Whitaker-Worth, D. (2017). Parenting and female dermatologists' perceptions of work-life balance. *International Journal of Women's Dermatology*, 3, 127-130.				Phillips, J., Hustedde, C., Bjorkman, S., Prasad, R., Sola, O., Wendling, A., Bjorkman, K. and Paladine, H. (2016). Rural women family physicians: Strategies for successful work-life balance. *Annals of Family Medicine*, 14:3, 244-251.	
	McAlister, C., Jin, Y., Braga-Mele, R., DesMarchais, B., and Buys, Y. (2014). Comparison of lifestyle and practice patterns between male and female Canadian ophthalmologists. *Canadian Journal of Ophthalmology*, 49:3, 287-290.				Phillips, S. and Clarke, M. (2012). More than an education: The hidden curriculum, professional attitudes and career choice. *Medical Education*, 45, 887-893.	

	Perlman, R., Ross, P. and Lypson, M. (2015). Having it all: Medicine and a family. *Mayo Clinic Proceedings*, 90:6, 713-715.				Raja, S. and Stein, S. (2014). Work-life balance: History, costs, and budgeting for balance. *Clinics in Colon and Rectal Surgery*, 27:2, 71-74.	
	Rohde, R., Moriatis-Wolf, J. and Adams, J. (2016). Where are the women in orthopaedic surgery? *Clinical Orthopaedics and Related Research*, 474:9, 1950-1956.				Roberts, D., Shanafelt, T., Dyrbye, L. and West, C. (2014). A national comparison of burnout and work-life balance among internal medicine hospitalists and outpatient general internists. *Journal of Hospital Medicine*, 9:3, 176-181.	
	Sarma, A., Nkonde-Price, C., Gulati, M., Duvernoy, C., Lewis, S. and Wood, M. (2017). Cardiovascular medicine and society: The pregnant cardiologist. *Journal of the American College of Cardiology*, 69:1, 92-101.				Sandler, B., Tackett, J., Longo, W. and Yoo, P. (2016). Pregnancy and parenthood among surgery residents: Results of the first nationwide survery of general surgery residency program directors. *Journal of the American College of Surgeons*, 222:6, 1091-1098.	
	Shenoi, A. (2016). Unbalanced but satisfied? *Frontiers in Pediatrics*, 3:120, 1-3.				Shanafelt, T., Boone, S., Tan, L., Dyrbye, L., Sotile, W., Satele, D., West, C., Sloan, J. and Oreskovich, M. (2012). Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Archives of Internal Medicine*, 172:18, 1377-1385.	
	Tarquinio, K. (2016). Work-life balance? It is not about balance, but priorities. *Frontiers in Pediatrics*, 4:6, 1-3.				Shanafelt, T., Raymond, M., Kosty, M., Satele, D., Horn, L., Pippen, J., Chu, Q., Chew, H., Clark, W., Hanley, A., Sloan, J. and Gradishar,W. (2014). Satisfaction with work-life balance and the career and retirement plans of US oncologists. *Journal of Clinical Oncology*, 32:11, 1127-1136.	
	Wang, T. (2015). Work-life balance: Hopeless endeavour or rather, a true privilege? *Frontiers in Pedatrics*, 3:99, 1-3.				Shanafelt, T., Hasan, O., Dyrbye, L., Sinsky, C., Satele, D., Sloan, J. West, C. (2015). Changes in burnout and satisfaction with work-life balance in physicians and general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, 90:12, 1600-1613.	
					Strong, E., DeCastro, R., Sambuco, D., Stewart, A., Ubel, P., Griffith, K. and Jagsi,	

					R. (2013). Work-life balance in academic medicine: Narratives of physician-researchers and their mentors. *Journal of General Internal Medicine*, 28:12, 1596-1603.	
					Szender, J., Grzankowski, K., Eng, K., Odunsi, K. and Frederick, P. (2016). Evaluation of satisfaction with work-life balance among U.S. gynecologic oncology fellows: A cross-sectional study. *Gynecologic Oncology Reports*, 16, 17-20.	

Table 2 – Identified categories and themes on work-life balance in the medical literature

Issue	Common Themes	Quotations
Defining work-life balance for physicians	• The trade-off/interplay between career and family responsibilities • Tension between family and career generated by competing demands • A way to increase productivity and well-being • Professional and personal choices made by physicians • Achieving fulfillment from work and family • The search for greater gender equality in life and career • WLB is not a set of balancing scales, but a pyramid of values or blend of priorities • "Having it all"	"How highly career-driven contemporary male and female physician-researchers allocate time to professional and domestic responsibilities (Jolly et al., 2014). "The concept of work-life balance acts as quicksand in our professional and personal lives resulting in slow drowning in frustration, depression, and exhaustion." (Schwingshackl, 2014). "While the daily practice of balance is certainly a valuable aspiration, fulfillment may be, for some physicians, a more encompassing and guiding state to strive for as we seek satisfaction in our personal and professional lives" (Harrison, 2008).
Problems associated with work-life balance for physicians	• Poor mental and physical health including burnout and stress symptoms • Women physicians and researchers leave medicine/ general reduction in clinical/surgical/academic hours and direct increase in domestic responsibilities for female physicians because of WLB priorities (including general loss of income compared to male	"Depression levels are reported to be markedly higher in physicians than in the general population" (Raja & Stein, 2014). "While the trend toward part-time clinical practice may not harm patient outcomes, it is occurring in the midst of a growing physician shortage in North America" (Jovic et al., 2006).

	colleagues) • Conflict within personal life or marriage • Career trajectory before, during and after maternity/paternity leave • Women physicians forego demanding specialties because of lack of WLB • Concept of WLB does not actually exist and often worsens rather than improves because of unrealistic expectations • Glass ceiling and gender inequities/assumptions	"A common theme for women was perhaps a sense of guilt about their performances as both mothers and family doctors at all stages of their careers" (Parsons et al., 2009). "Female physician teachers with children had lower job satisfaction, less institutional support and slower career progress than male physician teachers with children" (Cujec et al., 2000). "Women, far more than men, consider the balancing of family, parental, and occupational roles when making career decisions" (Verlander, 2004).
Causes of work-life balance problems among physicians	• Result of behavioural and individual choices that cause tension such as taking on more domestic/childrearing responsibilities and maternity leave • "Role strain" on women physicians and being mothers/spouses • Lack of role models and mentors for female physicians • Professional stressors such as time-constraints, lack of resources, decline in compensation, erosion of professional autonomy and decision-making	"In marriages between two physicians, wives are more likely to make accommodations in their career based on consideration of the effects on spouses and children whereas men were less likely to do so" (Robinson, 2003). "It may be that there are challenges inherent to the practice of clinical academic medicine that are fundamentally at odds with balancing family care responsibilities" (Beckett et al., 2015). "Barriers to work-life balance appear to be deeply rooted within professional culture…gendered societal

	capabilities • Socialized gender differences • Result of a demanding speciality choice or prioritizing career over life • Lack of perceived or actual control of work or domestic environment • Discrimination • Lack of good support system	expectations of women's roles, within and outside the workplace, continue to have a substantial impact" (Strong, 2013). "Female physicians perceived significantly less control than male physicians regarding a variety of daily work activities…In addition, control of workplace issues was related to risk of burnout for women, but not men" (McMurray, 2000).
Solutions to work-life balance problem for physicians	• Behavioural suggestions like better time management, monitoring stress, networking, prioritization, having a supportive spouse, finding inner-peace • Policy/educational programming interventions to promote well-being and success within medical organizations • Need more positive mentorship and support • More research is needed/no solution • More on-site day-care, flexible scheduling, job sharing, and replacement staff for maternity leave • Integrate work and what we consider to be life	"Nurturing and protecting our personal and professional relationships are keys to avoiding burnout" (Shenoi, 2016). "The opportunity for variable and flexible work scheduling, as well as the support of spouses, life partners, or other family members, were cited as key facilitating factors" (Phillips et al., 2016). "Strategies to improve the work experience of middle career physicians are needed to maintain productivity, minimize turnover, and improve patient care" (Dyrbye et al., 2013). "Women physicians should press for institutional changes that could reduce stress on and discrimination against women" (Robinson, 2003).

	• Specialty choice in medicine should be conducive to physician's anticipated future lifestyle • Embrace medical culture of spending more time at work because that is what a physician's life entails • Need new work-family paradigms • Address structural and systemic inequalities that specifically affect women physicians	"We must have realistic expectations of what one can accomplish … we need to foster the right kind of mentoring … we need to develop collaborative links between women to support and learn from each other through coaching and networking" (Figueroa, 2016). "Every medical school and residency program should have a written policy regarding parental leave" (Potee et al.,1999).