

DISSERTATION

DOES GENDER MATTER?

A HERMENEUTIC PHENOMENOLOGICAL STUDY OF THE SHARED
EXPERIENCE OF WOMEN PHYSICIANS IN ACADEMIC PEDIATRICS

Submitted by

Michael V. Wukitsch

School of Education

In partial fulfillment of the requirements

For the Degree of Doctor of Philosophy

Colorado State University

Fort Collins, Colorado

Summer 2024

Doctoral Committee:

Advisor: Susan A. Lynham

Roe W. Bubar

Thomas Chermack

Sue Doe

Copyright by Michael Wukitsch 2024

All Rights Reserved

ABSTRACT

DOES GENDER MATTER?

A HERMENEUTIC PHENOMENOLOGICAL STUDY OF THE SHARED EXPERIENCE OF WOMEN PHYSICIANS IN ACADEMIC PEDIATRICS

Academic medicine, historically dominated by men, has perpetuated a hierarchical culture that marginalizes women (Boulis & Jacobs, 2008; Morantz-Sanchez, 1985; More et al., 2009; Pololi, 2010). Despite this, the presence of women physicians in academic settings has surged, challenging traditional norms. In pediatric academic medicine, women physicians encounter the need to navigate through this entrenched male-dominated culture. Understanding their experiences is crucial for hospital administrators and medical school leaders. This study investigates the experiences of women physicians in academic pediatrics at a nationally ranked institution.

This research sheds light on how women physicians navigate the challenges of a traditionally male-dominated work environment and how their professional lives intersect with personal aspects. This exploration of the layered complexities women physicians face in academic pediatrics provides insight into their lived experiences.

Employing hermeneutic phenomenology, this study delves into the lived experiences of women physicians, providing a platform to amplify their voices. Anchored in constructivism, the study's paradigmatic position is elucidated through five governing axioms: defining reality, the knower's relationship with the known, transferability, association linkages, and the role of values in inquiry (Lincoln & Guba, 2013, pp. 37-38).

Eight essential themes, distilled from participant interviews, capture the essence of their experiences. These themes, categorized into personal and institutional perspectives, are viewed through the lenses of agency and structure, mirroring the yin-yang duality. This approach acknowledges both harmony and potential overlap among themes, presenting the phenomenon as a synthesized whole.

Implications for theory, research, and practice are discussed. Further research avenues are proposed, along with insights for refining existing theory. Additionally, considerations for various stakeholders' practices are examined, encompassing recommendations for action. The study concludes with an epilogue, reconsidering the findings based on recent social events.

ACKNOWLEDGEMENTS

This dissertation has been a long journey that has taken a significant amount of time, energy, doubt, joy, and sweat equity. Like any journey, I never travelled it alone, and I want to express my sincere gratitude to those who have supported me and inspired me along the path.

My wife, LouAnn Wukitsch, showed unwavering love and support and rode along in my waves of work, perseverance, and self-doubt. You have always believed in me and supported my intellectual pursuits. I love you and am grateful for you.

My children, Peter, Leah, and Jonathan Wukitsch, gave up their father for many weekends and weeknights but demonstrated understanding and support throughout. I also appreciate other family members including my father and brother who never stopped asking, “Are you done with your *thesis* yet?” Their interest and support in my endeavors has been much appreciated and kept me grounded.

I am especially grateful for my advisor and mentor, Dr. Susan Lynham. She helped me see the world differently and develop my academic perspective, invested a tremendous amount of time with me, and was always helpful and supportive. She is an excellent educator and I strive for an ounce of her wisdom. As a recovering perfectionist, she taught me to “walk through the long grass,” and this life lesson has had a tremendous influence on me and my work. I am indebted to her.

Thank you to my dissertation committee of Dr. Roe Bubar, Dr. Sue Doe, and Dr. Tom Chermack for their time, knowledge, and support. They, along with early members Dr. Barbara Hooper and Dr. Yvonna Lincoln, have prepared me as a scholar-practitioner. This work was heavily influenced by Dr. Lincoln, whose contribution to qualitative research methodology and

the constructivist paradigm are immeasurable, and her early support and encouragement were critical in motivating me and setting the paradigmatic stance of this study.

My writing coach and editor, Dr. Laura Markos, was simply amazing to work with. This dissertation would not have been completed without her steadfast support. The depth of her knowledge, her skill at challenging me to improve my work, and her encouragement were invaluable. She made me a better and more disciplined writer and researcher. This work would not have been completed without her.

Special acknowledgement is due to the Colorado State Organizational Learning, Performance and Change (OLPC) faculty, Drs. Tom Chermack, James Folkestad, and Carole Makala, for sharing their knowledge and wisdom throughout the coursework leading up to the dissertation. They are high quality educators and experts who helped shape me on this journey as well. Bryce Buckley, the Business and Graduate Studies Operations Coordinator for the School of Education, has been a godsend.

The late Dr. Jerry Gilley was the head of the OLPC program when I started and integral to beginning my Ph.D. journey. I purchased his book with Steven Egglund, *Principles of Human Resource Development* (1989), and it had a significant influence on my perspective of HRD and my professional path. When I saw that he was the head of the program at CSU, I was hooked. I wish he were here to celebrate the completion of this study with me.

To my Colorado State University OLPC Brighton Cohort classmates—the conversations we had inside and outside of class were stimulating, the projects were fun and collaborative, but the camaraderie and shared learning created memories that I cherish. I specifically appreciated the support of Skip Grieser, who taught me that writing notes in the margins and all over a book were a legitimate way of engaging in comprehension and knowledge building. I will never read

books the same way again. Felix Weitzman challenged me intellectually and coached me to get out of my own way and stop overthinking everything. Bojan Ljubenko was continuously encouraging and gave me a history lesson on my family that I will never forget. Holly McLemore and I co-taught an online course at CSU early in our dissertation journeys and I am grateful for her friendship, encouragement, and collaboration. I also want to acknowledge and thank Tabitha Coates, Ryan MacTaggart, Coranda Ziegler, Stephanie Torrez, Amanda Pearson, David Dwyer, and Jimena Bretón, who shared their knowledge, critique, and life-learning lessons in our advising group sessions with Dr. Lynham.

Mark Hutt, from the CSU Brighton Cohort, and Ryan Simmons, co-authored my first published article in *Advances in Developing Human Resources* back in 2013. The experience of collaborating with them was a joy and one of the best experiences of my professional career. Their influence is reflected in this work and I hope I did them proud.

My study participants were all incredible people and I am grateful for the time that they spent with me sharing their stories. Serving as your voice was a great responsibility that I took seriously and I hope that you are reflected accurately in this work.

I also want to thank my friend and former work colleague Jerrod Milton, as well as Pat Givens, for their early encouragement and support. Jerrod was the consummate continuous learner and highly respectful of academic pursuits. Pat loaned me a *Qualitative Data Analysis* book by Ian Dey (1993) and I can now finally return it. Finally, I am also thankful to Jenny Reese, MD, who gave of her time early on in the coursework and encouraged me to pursue the study topic. I hope this work has provided voice support to women physicians in academic pediatrics as we discussed so long ago.

DEDICATION

To Nancy J. Miller, my late mother. She was a proud feminist, eternal optimist, and incredibly resilient woman. Ahead of her time, she inspired my vocation in human resources management and organizational development. She wanted to change the world for the better, and to me she did. I am grateful for her influence in my life and hope I reflect the best of her.

TABLE OF CONTENTS

ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iv
DEDICATION.....	vii
LIST OF TABLES.....	v
LIST OF FIGURES.....	vi
CHAPTER 1: INTRODUCTION.....	1
Situating the Study in the Literature.....	4
Women Physicians in Academic Pediatrics.....	5
Critical Feminist Theory and the Gendered Organization.....	7
Critical Feminist Theory.....	7
The Gendered Organization.....	9
Organizational Culture and Academic Medicine.....	10
Overview of the Literature.....	11
Research Need and Questions.....	12
Study Purpose.....	13
Significance of the Study.....	14
Link to HRD.....	15
Theoretical Framework.....	16
Philosophical Paradigm: Locating the Study.....	18
Researcher’s Perspective.....	20
Ethical Considerations.....	21
Study Parameters, Delimitations, and Limitations.....	23
Operating Definitions.....	24
Structure of the Dissertation.....	25
CHAPTER 2: LITERATURE REVIEW.....	27
Situating the Study in the Literature.....	27
Exploring the Constructs.....	28
Women Physicians.....	29
Women Physicians in Academic Medicine.....	37
Feminism.....	40
Gendered Organization.....	42
Organizational Culture.....	43
Academic Medical Culture.....	44
Relationships Between the Constructs.....	46
Women Physicians in Academic Medicine and the Gendered Organization.....	46
Gendered Organization and Academic Medical Culture.....	47
Women Physicians and Academic Medical Culture.....	47
Women Physicians and Gendered Hierarchy.....	48
Summarizing the Literature Review.....	49
Competing Perspectives.....	50
Research Synthesis and Critical Analysis.....	52
CHAPTER 3: METHODOLOGY AND METHODS.....	58
Research Need and Questions.....	58

Inquiry Paradigm.....	59
Constructivism and Critical Theory	61
Constructivism	61
Critical Theory	63
Critical Feminist Theory	65
Rationale for This Study	66
Rationale From the HRD Perspective.....	66
Rationale From the Pilot Study Perspective	67
Research Approach	67
Site Selection.....	68
Participant Selection	68
Pilot Study.....	69
Methods of Data Collection, Participant Sampling, and Analysis.....	70
Data Collection	70
Participant Sampling	71
Data Analysis	72
Transcripts.....	73
Coding.....	73
Categories and Themes	73
Quality Criteria and Study Applicability	74
Fairness	75
Ontological Authenticity.....	76
Educative Authenticity.....	76
Catalytic Authenticity	76
Tactical Authenticity.....	77
Study Applicability	77
Summary of Methodology	78
CHAPTER 4: DATA OUTCOMES AND DISCUSSION.....	80
Data Outcomes.....	80
Yin-Yang Thinking.....	80
Introducing the Themes: Institutional and Personal	82
Discussion of Institutional Themes.....	85
The Glass Ceiling Still Stands	86
The Last Stand of the Good Old Boys.....	89
Dress as a Symbol of Power	90
Office Space.....	92
Dominance in Professional Groups	94
Choice of Physician Specialty and Subspecialty	95
Unequal Pay	100
Issues of Intersectionality and Barriers for Women of Color	102
The Baseball Game Double Standard.....	105
Mentors and Networking Activism.....	107
Mentors	108
Networking.....	110
Leadership Development Programs	111
Discussion of Personal Themes	113

Pulling Double Duty	114
Physician Identity and the Calling of Care	117
Imposter Phenomenon.....	127
The Significance of Partnerships	130
Summary	132
CHAPTER 5: IMPLICATIONS OF FINDINGS AND CONCLUSIONS.....	134
How the Study’s Findings Inform its Three Research Questions	134
How do women physicians in pediatrics describe their experience of gender in the context of academic medicine?	137
What are the participants’ experiences related to their inclusion in the patterns of formal and informal organization of the workforce?	138
Can women physicians in a localized setting confirm or disconfirm that gender has been successfully defused as an issue of status in academic medicine?.....	138
Reconciling the Findings With the Study’s Informing Bodies of Literature.....	139
Implications for Theory, Practice, and Future Research.....	140
Implications for Theory	140
Implications for Practice	142
Implications for Future Research	145
Review of the Study’s Quality Criteria of Authenticity	147
Fairness Criteria	147
Ontological Authenticity.....	148
Educative Authenticity.....	149
Catalytic Authenticity	149
Tactical Authenticity.....	150
Study Limitations.....	150
My Lived Experience as the Human Instrument of the Research	153
Serving Guba and Lincoln’s (1981) Seven Characteristics of the Human Instrument	153
Serving Guba and Lincoln’s (1981) Five Desirable Qualities of the Human Instrument	153
Other Learning as the Human Instrument of the Research.....	155
Drawing Conclusions	159
EPILOGUE.....	159
REFERENCES	164
APPENDIX A: INTERVIEW QUESTIONS	200

LIST OF TABLES

Table 1. Synthesis of Informing Literature	53
Table 2. Summary of the Constructivist Paradigm.....	62
Table 3. Summary of the Critical Theory Paradigm	64
Table 4. Summary of Quality Criteria	79
Table 5. Study Participants by General Pediatrics or Pediatric Subspecialty	98
Table 6. Guba & Lincoln’s (1981) Seven Characteristics of the Human Instrument as Applied in This Study	154
Table 7. Guba & Lincoln’s (1981) Desirable Qualities of the Human Instrument as Applied in This Study	155

LIST OF FIGURES

Figure 1. Three Bodies of Literature and Their Intersections Informing This Study.....	4
Figure 2. Yin-Yang Symbol	81
Figure 3. The Essential Themes in the Institutional and Personal Thematic Categories for Women Physicians in Academic Pediatrics.....	83
Figure 4. Hofstede et al.'s (2010) Balance of Values and Practices for Various Levels of Culture.....	118
Figure 5. Interpreted Components of Physical Identity	122

CHAPTER 1: INTRODUCTION

The number of graduates from U.S. medical schools identifying as women has increased significantly—from 26.8% in 1982-1983 to 48.4% in 2010-2011 (Leadley & Sloane, 2011)—and reached 51.8% in 2023 (Association of American Medical Colleges [AAMC], 2023d). Women physician graduates surpassed men at U.S. medical schools in 2020-2021 (AAMC, 2023d). Since 2019, the number of women enrolled in U.S. medical schools has surpassed men, and in 2023 represented 54.5% of total enrollment (AAMC, 2023g). Upon graduation from medical school, physicians apply for a medical residency for further specialty training. The residency period usually lasts from 3 to 5 years, depending on specialty (Mallon & Vernon, 2008). Women represented 48.2% of all residents in 2023 (AAMC, 2023b), up from 36.4% in 1999 (Leadley & Sloane, 2011). After residency, physicians typically take one of two paths. The AAMC (2023e), reported that the majority of physicians—over 80% as of 2021—went into nonacademic clinical practice. The remainder chose academic medicine, in which they work for a university as faculty in a combination of capacities: teaching medical students, conducting research, and providing clinical care to patients (Borges et al., 2010; Mallon & Vernon, 2008).

As of 2023, there were 989,320 physicians in the US and its territories (AAMC, 2022c). Whereas physicians in academic medicine account for approximately 20% of all physicians (AAMC, 2023h), women comprise 44% of the medical school faculty in the US (AAMC, 2023i). Women joined academic medicine at higher rates than men during the 1980s, but have been slower to rise in academic rank than their male counterparts (B. Li et al., 2021; Nonnemaker, 2000; Richter et al., 2020). As of 2023, only 28% of full professors in academic medicine were women (AAMC, 2023i), and only 25% of department chairs were women (AAMC, 2023j).

Women enter the ranks of academic medicine for a number of reasons. Women physicians in academic medicine typically had an affinity for biology and sciences in high school and college, viewing academic medicine as a means to satisfy their intellectual curiosity and meet altruistic desires to help people (Pololi, 2010). Borges et al. (2012) found that women chose academic medicine careers based on fit (i.e., feeling congruence with their lives and careers, and satisfaction with their career choices), aspects of the academic medical center environment, the influence of people in their lives, exposure to academic medicine, and an interest in practicing clinical medicine. Edmunds et al. (2016) conducted a review of 52 studies between 1985 and 2015 regarding why women chose or rejected careers in academic medicine, pointing to significant limitations and inconsistency in study findings. However, Edmunds et al. found supporting evidence that women were attracted to teaching and suggested that enabling environments were a factor in attracting women into academic careers.

Pediatrics has been long considered a “women’s specialty” (Lopate, 1968, p. 120), (a) viewed as an area in which women feel comfortable, can excel (as they are more apt to be more accepted by department heads), and use their “special skills” (p. 120); (b) assumed to align with women’s roles as mothers; and (c) as a result, perceived as more nurturing (p. 120). Historically, women physicians have had greater representation in the medical specialty of pediatrics (Boulis & Jacobs, 2008; Pololi, 2010; Spector et al., 2019). This representation may be attributed to at least three factors: (a) pediatrics is a field in which women have felt comfortable and could excel based on their historical role as mothers (Lopate, 1968); (b) the increase in pediatric residency positions, created as a result of an increase in medical school capacity (Boulis & Jacobs, 2008); and (c) the perception in medical school that pediatrics allows for a balance of medicine and family (Boulis & Jacobs, 2008).

The influx of women physicians into pediatrics also coincided with the development of the women's health movement of the 1970s. The women's health movement emerged from the 1960s social activism of disenfranchised groups such as women, Blacks, Latin@, Native Americans, and LGBTQIA+, among others (Morgen, 2009). The narrative of the women's health movement benefited from a central work in women's health education, *Our Bodies, Ourselves*, published in 1973 (Boston Women's Health Book Collective, 1973). The book was derived from a bound set of course booklets written in 1970 by 19 Boston feminists at Emmanuel College, who were determined to educate women about their health and sexuality (Boston Women's Health Collective, 1970). In the 1973 book, a number of previously taboo topics such as abortion, orgasm, birth control options, and bisexuality were addressed, which helped women develop a consciousness of their unique health needs, independent of the traditional medical structure (Ginty, 2004; Wells, 2009). Childbirth and child health needs seemed to align to this new awareness, evidenced by chapters on childbearing and motherhood. Although pediatrics historically had a disproportionate number of women compared to other specialties, it seems that the evolution of women's health consciousness intensified the influx of women into medicine, and pediatrics in particular. For example, in 1970, 20.8% of pediatricians were women, whereas by in 2009, 55.2%—the majority of pediatricians—were women (Smart, 2012). The prevalence of women pediatricians continued to grow, to 63.3% in 2017 (Spector et al., 2019), and to 65.6% in 2022 (AAMC, 2024b). Specifically, academic pediatrics has also seen a significant shift, from women comprising 48.6% of pediatric academic faculty in 2007, to 54% in 2020 (Saboor et al., 2022). Although not exclusively responsible for the demographic changes in pediatrics, the women's health movement likely served as a strong catalyst in provoking and shaping the future of women in medicine and subsequently pediatrics as well (Morgen, 2009).

Based on the demographics alone, the medical specialty of pediatrics has provided women an entryway into the broader social and technical spheres of medicine. One might conclude that with so many women physicians in the pipeline, especially in pediatrics, women no longer need to be concerned with issues of gender equity. But is that how women pediatric physicians perceive their status? In light of the evolutionary role of women in medicine, it is worthwhile to understand how women in the traditionally most accepted areas of academic medicine, like pediatrics, see themselves today and within the context of the historically situated masculine culture of academic medicine (Beshiri, 1969; Boulis & Jacobs, 2008; Lopate, 1968; Lorber, 1984; Morantz-Sanchez, 1985; Nye, 2009; Pololi, 2010; Saboor et al., 2022; Spector et al., 2019; Starr, 1982). This study explores the perspectives of the women physicians, and more specifically women physicians in academic pediatrics, to understand whether there are cultural shifts that match with the demographic ones.

Situating the Study in the Literature

This study examines the lived experience of women physicians in a pediatric academic medical center and draws upon perspectives of gender from critical feminist theory as well as the concept of gendered organization in interpreting participants' experiences. The study also considers the lived experience of participant women physician in academic pediatrics within an organizational culture—specifically through the lens of one academic medical center. Men and the masculine perspective have long dominated academic medical center culture (Lorber, 1993; Nye, 2009; Pololi, 2010). Figure 1 illustrates the intersection of the three major literatures informing this study.

Critical review of the literature situating the study begins with the subject of women physicians in academic pediatrics within the broader context of medicine and the most recent

studies of this population. Provided next is a brief summary of feminism and the concept of gendered organization, followed by literature on organizational culture in academic medicine. The literature review illustrates how these areas intersect to inform this study of women physicians in academic pediatrics.

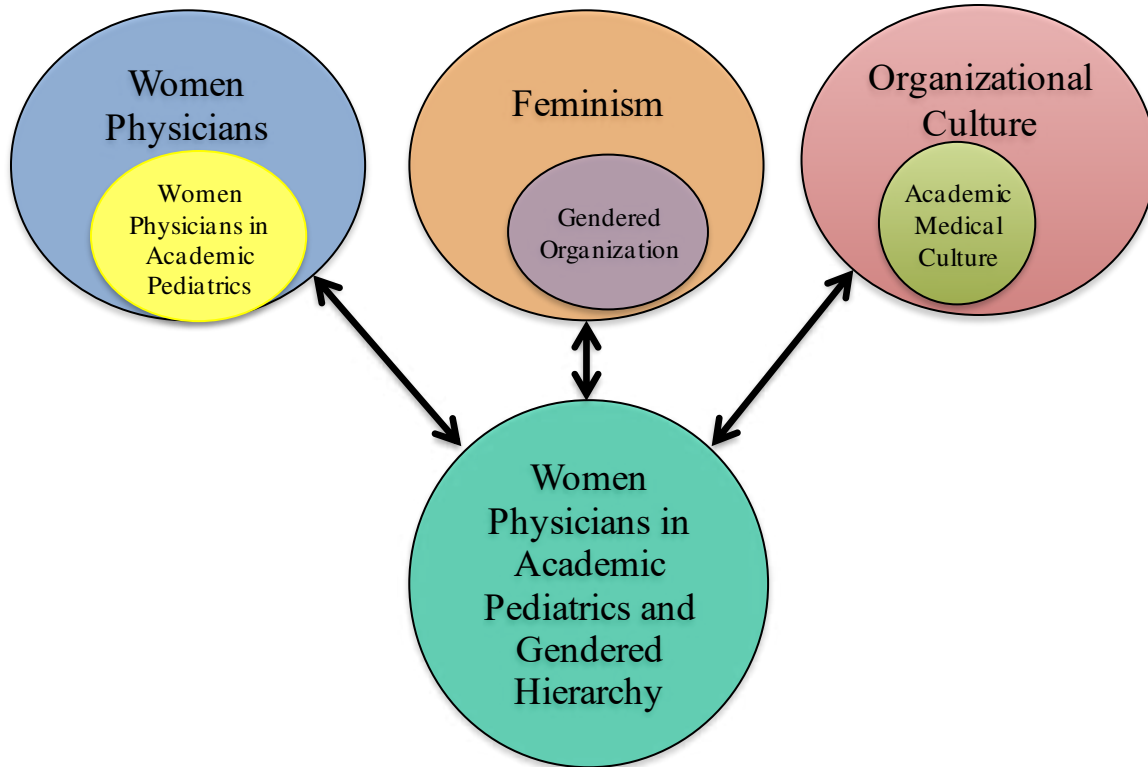


Figure 1. *Three Bodies of Literature and Their Intersections Informing This Study*

Women Physicians in Academic Pediatrics

As mentioned in the introduction, women physicians have played an increasingly important role in medicine. In 2021, women accounted for 37.1% of the active physician workforce in the United States, and that number should continue to grow, as over half—55.4%—of graduating physicians were women (AAMC, 2023f). The growth in the percentage of women

in the physician workforce suggests that women's prevalence is likely to increase, or at least continue in the majority, within academic pediatrics as well.

However, the sheer increase in the numbers of women physicians in academic pediatrics is only a recent phenomenon. Historically, women had been excluded from entering the medical ranks through the segregation of medical colleges and subsequent closure of women's medical colleges, as well as systematic limited quotas for medical school entrance sanctioned by the American Medical Association (Lopate, 1968; Nye, 2009; Starr, 1982; Walsh, 1977).

Research specifically focused on women physicians began with the first published study by Lopate (1968). Lopate pointed to the "token numbers" (p. 187) of women in medicine, described the experiences of women physicians and the reasons why the percentage of women were low (6-8% from data Lopate gathered in 1965). Lopate suggested a number of improvements to attract more women into medicine, including increased scholarship aid, flexible scheduling during training, and childcare tax deductions (p. 187). Although Lopate's research focused quantitatively on the low percentage of women in medical school admissions, Lopate also challenged "the [shifting] national climate of opinion concerning sexual roles" (p. 188) as a means to attract more women into medicine.

Since the 1980s, the medical establishment itself has produced much of the research on women physicians. Many studies have focused on characteristics of women physicians (e.g., Frank et al., 1998, 2001; Frank & Cone, 2000), particular areas of disparities or marginalization (Levine et al., 2011; Nonnemaker, 2000; Pololi & Jones, 2010); discrimination (Carr et al., 2000, 2003); or the general status of women physicians in academic medicine (Brown et al., 2003; Levinson et al., 1989; Nonnemaker, 2000; Pololi, 2010).

Glimpses into medicine through the lens of women physicians have also emerged in popular literature. Examples include Conley's (1998) description of her abrupt resignation from the Stanford faculty in *Walking Out on the Boys*, Cassell's (1998) anthropological study of women surgeons in *The Woman in the Surgeon's Body*, and Au's (2011) more whimsical personal experiences in *This Won't Hurt a Bit (and Other White Lies): My Education in Medicine and Motherhood*.

The particular study of women physicians is still a somewhat recent phenomenon, with a focus on quantitative description of women physicians within the broader context of medicine (e.g., Foster et al., 2000; Frank et al., 1998, 2001), or issues related to gender bias and advancement (e.g., Burgess et al., 2012; Carr et al., 2003; Nonnemaker, 2000; Risberg et al., 2009). However, many of these and other studies published in medical or related journals lack additional insight from outside medicine. As such, the evolving concepts of feminism, the gendered organization, and organizational culture provide additional avenues from which to increase understanding of the experiences of women physicians. This second body of knowledge in these concepts and their linkage to this study are discussed next.

Critical Feminist Theory and the Gendered Organization

The second body of literature central to informing this study is that of critical feminist theory, and its offshoot, the gendered organization. The experiences of women physicians in the literature and in this study are explored through these lenses.

Critical Feminist Theory

Critical feminist theory, often referred to as *feminism* or *feminist theory*, is a diverse and complex set of perspectives that originated as a social movement in the late 18th century to secure rights and political equality for women (Hekman, 2006). Feminist thinkers characterize

the world as patriarchal with a resulting masculine culture that oppresses women—contending that women must attain social power as a group to challenge their treatment (Lorber, 1984). One of the reasons inequities between men and women exist is because they are built and maintained by social institutions that create socially constructed assumptions of different sex roles (Acker, 1990, 1992; Alvesson & Billing, 2009; Britton, 2000; Mills, 1988). Modern feminist theory comprises a range of theories. Beginning in the late 1970s, the field of critical feminism began to look beyond more traditional elements of economic, political, and legal structures to explore deeper explanations of women’s oppressed status. Krollokke and Sorensen (2006) summarized critical feminist theory, or feminism, in terms of three waves. The first wave, they said, focused on the fight for women’s voting rights in the early 1900s. The second wave, from the 1960s through the early 1990s, directed attention toward women’s empowerment and differential rights. The third wave, from the 1990s to present,

seeks to overcome the theoretical question of equity or difference and the political question of evolution or revolution, while it challenges the notion of “universal womanhood” and embraces ambiguity, diversity, and multiplicity in transversal theory and politics. (Krollokke & Sorensen, 2006, p. 2)

Calás and Smircich (2006) traced the evolution of feminist schools of thought into liberal, radical, and psychoanalytic theoretical approaches, with each having different epistemological assumptions, but sharing the same ontological assumption regarding the location of women’s oppression. This ontological assumption posits a universally sexualized, transcultural, and transhistorical “woman” positioned against her other—“man.” Feminist analysis explores women’s role in society from a woman’s perspective, including how the two sexes can exist together or separately without oppression and subordination (Calás & Smircich, 2006; Hekman, 2006).

In addition, Black feminists such as Lorde (1984) challenged the traditional feminist approach as one-dimensional—representing the perspective of White, heterosexual, Anglo-Saxon women—to recognize the unique perspectives of Black women as well as lesbians. The challenge by Black feminists evolved the theoretical notions of feminism and opened the door for discussions on intersectionality as a construct to examine the relationships among multiple dimensions of gender, ethnicity, class, and color (Johnson-Bailey, 1999; McCall, 2005).

These different critical feminist theory perspectives provide a theoretical foundation from which to understand why women physicians provide a unique perspective within the broader academic pediatric arena. The voices of these physicians may offer specific ideas to reduce oppression or subordination, resulting in greater organizational contribution, and perhaps improved patient care practices. In light of this discussion of critical feminist theory, the focus now shifts to the implications of critical feminism and the gendered organization.

The Gendered Organization

The discussion of gender is rooted in critical feminist theory. The term *gender* refers to the socially and culturally imposed divisions of the sexes (Rubin, 1975). Acker (1992) further defined the term gender as “the patterned, socially produced distinctions between female and male, feminine and masculine” (p. 250).

Although women continue to make proportional gains within academic medicine, academic medical structure and the culture that supports it are still heavily gendered toward the masculine (Edmunds et al., 2016; Spector et al., 2019; Tsouroufli et al., 2011). This contention is based on the theory that gender is socially constructed and maintained as a fundamental meaning-making societal structure (Alvesson & Billing, 2002, 2009; Cislighi & Heise, 2019; Hekman, 2006; Heise et al., 2019; Lorber, 1994).

A *gendered organization* is one in which gender serves as a basic principle present in “the processes, practices, images and ideologies, and distributions of power in the various sectors of social life” (Acker, 1992, p. 567). Medicine developed a strong masculine-based gender identity due to historical limitations placed on women in medical school admissions and a strong cultural prejudice aimed at the suppression of women (Boulis & Jacobs, 2008; Chin, 2002; Group & Roberts, 2001; Morantz-Sanchez, 1985; More et al., 2009). Feminism’s rise in the 19th and early 20th centuries, and its revival in the 1960s, were crucial in advancing the role of women in medicine. However, those women who did become physicians tended toward specialties that were seen as less threatening to the male-dominated medical culture (Boulis & Jacobs, 2008). Pediatrics is one of the areas of medicine most impacted by the increasing prevalence of women into its ranks. Pediatric residency applications for women increased from 61.6% in 1999 to 73.1 in 2022 (AAMC, 2023b); in academic pediatrics departments, women comprised 61% of the faculty in 2022, up from 49% in 2011 (AAMC, 2023c; Leadley & Sloane, 2011). Due to the demographic shift in the prevalence of women in medicine and specifically pediatrics, these gender-based professional identities and related gendered organizational cultures must change to ensure full inclusion and an environment of optimal advancement of women physicians (Edmunds et al., 2016; Spector et al., 2019).

Organizational Culture and Academic Medicine

Academic medicine in the US evolved from the formalization of medical training in the 19th century. Although women had played a historical role in caring for the sick, the process of medical professionalization through the rise of medical colleges and societies purposefully excluded women (Starr, 1982; Walsh, 1977). The gendered, exclusionary nature of medical

professionalization to which women have been subjected is crucial to understanding the current culture of academic medicine.

Organizational culture is a complex concept. Alvesson (2013), drawing on previous perspectives of organizational culture, highlighted five key assumptions about cultural phenomena as

- having a relationship to history and tradition;
- having depth, being difficult to grasp, and requiring interpretation;
- being collective and shared by members of groups;
- being “ideational in character, having to do with meanings, understandings, beliefs, knowledge and other intangibles” (p. 3); and
- being “holistic, intersubjective and emotional rather than strictly rational and analytical” (p. 3).

Alvesson’s description of organizational culture provides a useful lens from which to view academic medicine and the role of women specifically. In the experiences of women physicians in academic pediatrics, particularly in a localized setting, organizational culture influences those experiences. Synthesizing organizational culture with the gendered organization describes the environment which women in academic pediatrics must navigate.

Overview of the Literature

Literature which integrates (a) the development and specific concerns of women physicians as a force in medicine, (b) the notion of gendered organizations, and (c) the culture of academic medicine, is explored in and informs this study to uncover or reveal deeper meaning from the study participants’ experiences. Women physicians’ experiences can be interpreted

better through an understanding of the social and organizational contexts in which they work and live.

The literature review which follows this chapter situates and summarizes these three bodies of literature informing this study, and the relationships among the three constructs of (a) women physicians in academic pediatrics (in a historical context), (b) the gendered organization, and (c) the organizational culture of academic medical centers. This review specifically links these relationships through the foundational research in each area, concepts derived from the research of these areas, the current stance in these areas, and the construct relationships that tie the areas together.

Given this study's context for this study, its rationale is explained next. The remainder of this chapter focuses on the research need and subsequent research questions, as well the study's purpose and significance. Also explicated is the study's linkage to the discipline of human resource development (HRD). The study's theoretical framework and paradigmatic positioning situate this research. Then the researcher's perspective, ethical considerations, study parameters, delimitations, limitations, and definitions are discussed, before closing with the structure of the dissertation.

Research Need and Questions

Academic medicine has evolved from a distinctly male-dominated professional identity resulting in a hierarchical culture that has historically subordinated women (Boulis & Jacobs, 2008; Morantz-Sanchez, 1985; More et al., 2009; Pololi, 2010). Conversely, the percentages of women physicians in academic medicine have increased dramatically over time, potentially challenging academic medicine's traditional culture and hierarchy. Women physicians comprising this expanding presence in academic medicine must finesse or navigate the

traditional male-dominated academic culture, and manage the response of other women in traditionally gender-oppressed roles, such as nursing (Group & Roberts, 2001). What constitutes finessing or navigating of environment for women physicians is not yet well understood. Such understanding will help inform hospital administrators and medical school leaders regarding the unique challenges facing women physicians in academic pediatrics. Recent studies have indicated that women physicians have a higher burnout rate than their male peers (Chesak et al., 2020; Rotenstein et al., 2021; Rotenstein et al., 2020; Templeton et al., 2019; Yeluru et al., 2022). These reports further imply a unique gender dynamic in medicine that needs to be addressed.

Accordingly, this research study explores an understanding of the experience of women physicians in academic pediatrics at a nationally ranked pediatric institution. This study is guided by these three research questions:

- How do women physicians in pediatrics describe their experience of gender in the context of academic medicine?
- What are the study participants' experiences related to their inclusion in the patterns of formal and informal organization of the workplace?
- Can women physicians in a localized setting confirm or disconfirm that gender has been successfully defused as an issue of status in academic medicine?

Study Purpose

This study informs understanding of how women physicians in an academically affiliated pediatric institution (a) finesse or navigate the challenges of their work environment, which is traditionally male-dominated; and (b) understand the additional personal-life components that are influenced by their professional work environments and academic pediatric culture. One goal of

the study is for the reader to develop an understanding of the layered complexity that this study's women physicians in academic pediatrics face in their work lives, and achieve a vicarious social and emotional experience through them. As such, my desire is that the reader understand the atmosphere women physicians in academic pediatrics face, so as to support changes in hospital or health system policy. The outcome of these changes will benefit women physicians in academic pediatrics; make the care teams within the hospital setting more effective, open, and accepting; and ultimately improve both clinical outcomes and the patient experience. As the researcher, my hope is that this research will inform and help to facilitate policy and practice changes to engage women physicians and their professional colleagues in the co-creation of this new environment.

In addition, an understanding of the experiences of women physicians in the academic pediatric setting can build upon and add to existing theoretical frameworks already developed in the literature. Critical feminist theory is challenging traditionally gendered organizational hierarchies and accepted cultural norms. HRD scholars have looked to critical feminism in arguing for workplace and human resource reform (Fenwick, 2004), and in advocating practice that "honors and models concepts such as democracy, justice, equity, freedom, self-determination and empowerment" (Callahan, 2007, p. 81). Bierema (2002) supported the use of feminist research in recognizing gender as a category of analysis, and in advocating for social action and change. Study of women physicians in an academic setting such as this study provides an opportunity to inform and support these aims.

Significance of the Study

This study provides significance in three ways. First, although there has been extensive research related to women physicians, there is little research related specifically to the

experiences of women faculty in the academic hospital setting. This study offers voice to the women physicians in this academic pediatric setting, to share their unique experiences in a nationally regarded medical school and affiliated pediatric institution. Second, this study fills a void in the extant literature: research which is positioned primarily from the postpositivist paradigm and, more specifically, qualitative studies within that paradigm. None of the extant studies found at the time of this study's literature review explored the experience of women physicians in academic pediatrics using a hermeneutic phenomenological approach. Instead, the discussion of gender in the medical field has focused on three predominant perspectives: (a) career selection and satisfaction; (b) the discrimination perspective, which identifies characteristics and behaviors within the specific industry, organizations, and groups contributing to the disparities between men and women physicians; and (c) the social change brought about by the increased prevalence of women physicians, and subsequent perceived loss of status by men physicians (Boulis & Jacobs, 2008). For example, Files et al. (2017) reported that women were "less likely to be addressed by professional title than were men introduced by men" (p. 415). Third, the subject of women physicians has gained increasing attention throughout the world, as evidenced by studies outside the US and in several non-English-speaking countries (De Koninck et al., 1997; Harrison, 1998; Nomura & Gohchi, 2012; Ramakrishnan et al., 2014; Wildschut & Gouws, 2013), suggesting that further understanding of the unique dynamics of the environment is valuable.

Link to HRD

A large portion of the extant literature on women physicians comes from within medicine itself, with little contribution from the HRD perspective. HRD focuses on development and unleashing of human expertise at the individual, team, work process, organizational, national,

and/or international level. Swanson and Holton (2009) defined HRD as “a process for developing and unleashing expertise for the purpose of improving individual, team, work process, and organizational system performance” (p. 4). McLean and McLean (2001) defined HRD more broadly, as

any process or activity that, either initially or over the long term, has the potential to develop adults’ work-based knowledge, expertise, productivity and satisfaction, whether for personal or group/team gain, or for the benefit of an organization, community, nation or, ultimately, the whole of humanity. (p. 322)

Understanding and subsequent theorizing of how women physicians navigate their environments—particularly in a context of a specific hospital—provide HRD practitioners with an opportunity to influence and improve those environments through interventions.

This study examines the dynamics within an academic workplace setting, which is reliant on collegial and collaborative relationships (Pololi, 2010). Understanding and improving workplace relationships to increase organizational effectiveness is critical to the work of HRD. This study provides a unique perspective into the academic medical sector, an area that has been studied primarily from within the medical community, and not through the lens of HRD.

Theoretical Framework

Grounded theory, first developed by Glaser and Strauss (1967), is a set of systematic methods consisting of flexible analytic guidelines for collecting and analyzing qualitative data to construct theories grounded in the data themselves (Charmaz, 2006), and therefore constitutes inductively driven theory-building. These guidelines emphasize field study of participants, collecting and analyzing data simultaneously, adopting comparative methods, and checking and elaborating on tentative categories. A grounded theory study begins as an inductive approach while using rigor to categorize and develop themes from the data (Charmaz, 2006).

Initially, I conducted a pilot study with five participants utilizing constructivist grounded theory methodology, and subsequent methods developed by Charmaz (2006) which connect well to the constructivist paradigm. The pilot study was intended to determine if there was enough uniqueness to support a more complete dissertation study, and for me as the researcher to explore qualitative methodologies related to the research topic. I discovered challenges during the pilot study related to data analysis and richness of data interpretation using Charmaz' constructivist grounded theory method. Although the line-by-line method Charmaz suggested for novice researchers was helpful to me in learning how to code data, the method also proved restrictive in creating units from multiple sentences or parts of sentences.

The pilot study yielded a number of themes, from which four were selected for write-up: (a) navigating through gendered hierarchy, (b) gendering subspecialty choices (e.g., surgery), (c) managing the polarities of work-life balance, and (d) creating a supportive and relational environment. Additional themes emerged from the data, but setting restrictions on the pilot study forced consideration of a smaller, more obvious set.

Based on the interest of the pilot study participants and the need to limit the theme analysis, there seemed to be value in further discovery. My dissertation committee agreed and challenged me to take my analysis into deeper and more abstract interpretation via a new study. To construct deeper and more abstract interpretations of the interview data, I resituated my new dissertation study in the realm of hermeneutic phenomenology.

Hermeneutic phenomenology, described in detail in Chapter 3, is an active process of co-creation between the researcher and participant wherein meaning is produced through readings of texts, reflexivity, and interpretation (Laverty, 2003). Phenomenology, as an approach to research, describes the lived experience of human beings "as they appear, show, present, or give

themselves to us” (Van Manen, 2014, p. 26). Through its focus on *lived experience*, Van Manen (1990) added that hermeneutics describes how one interprets the descriptions or *texts* of this lived experience. Denzin and Lincoln (2011) defined hermeneutics as an approach to the analysis of texts that stresses how prior understandings and prejudices shape the interpretative process. Hermeneutic phenomenology, then, is a process of co-constructing meaning using thick, rich description of lived experience as it presents itself in concert with interpretation, reflexivity (developing greater consciousness of meaning), and the resulting deeper interpretation. The methodology of hermeneutic phenomenology “aims at uncovering and seeing through the presumptions and suppositions that shape our understanding of the world and understanding of life” (Van Manen, 2014, p. 55). Hermeneutic phenomenology also makes us “mindful to be critically and philosophically aware of how our lives (and our cognitive emotional, embodied, and tacit understandings) are socially, culturally, politically, and existentially fashioned” (Van Manen, 2014, p. 13).

By using hermeneutic phenomenology as an approach to study women physicians in the pediatric academic setting, this study’s purpose is to understand their lived experience in the context of their environment and provide human instrumentality from which to hear the voices of the study participants.

Philosophical Paradigm: Locating the Study

Naturalist inquiry, referred to in this study as constructivism, is anchored in five governing axioms or “basic beliefs” (Lincoln & Guba, 1985, p. 33) that provide the building blocks for a conceptual or theoretical structure or system. The axioms of constructivism explain the nature of reality (ontology), the relationship of the knower to the known (epistemology), the

possibility of transferability, the possibility of association linkages, and the role of values in inquiry (Lincoln & Guba, 1985, pp. 37-38).

Ontology in the constructivist paradigm is relativist—that is, that reality is based on multiple mental constructions that exist socially and are experientially based, local, and specific, dependent for their form and content on the persons who hold them (Guba, 1990, p. 27).

The epistemology is subjective—where the “relationship between knower and known is highly person- and context-specific” (Lincoln & Guba, 2013, p. 40), and findings are based on the process of interactions between the two. In other words, knowledge is based on the dynamics of identifying and interpreting new ideas. The aim of constructivist research, is “to understand and interpret through meaning of phenomena (obtained from the joint constructions/reconstruction of meaning of lived experience) [with] such understanding providing improved practice” (Lincoln et al., 2011, p. 106). Shared knowledge is created through “cumulative reconstructions of individual constructs or constructions (individual knowledge) coalescing around consensus” (Lincoln & Guba, 2013, p. 55).

As a constructivist study, several additional key concepts serve to inform the conceptual approach and development of this study. One key concept is that the researcher serves as the instrument to co-construct knowledge by understanding and interpreting the meaning of the participants’ lived experiences (Lincoln & Guba, 1985). A second key concept relates to the methodological process in the use of dialectical hermeneutics. Concepts developed from the lived experiences of the participants are defined hermeneutically, that is, as an unveiling through interpretation, and “compared and contrasted dialectically with the aim of generating one (or a few) constructions on which there is substantial consensus” (Guba, 1990, p. 27). Analysis in a constructivist study is inductive, in that theoretical categories emerge from the interaction

between the researcher and the data, rather than deductively from predetermined hypotheses or concepts.

Another critical concept in the constructivist paradigm is goodness or quality criteria. Trustworthiness of the theoretical concepts is based on the authenticity of the process and the interpretation of the data. The process of goodness is reached through agreement and understanding between the researcher, participants, and other actors in the process of dialogue, shared conversation, and construction (Lincoln et al., 2011).

Researcher's Perspective

This study is situated from a North American, White, male, and privileged-outsider perspective. Outsiders are nonmembers of a specified group (Merton, 1972) and I am in the outsider position as I am not a physician, nor a woman, nor from other underprivileged groups. I also have hierarchical position power, as I am a human resources executive in the health care industry. My desire is to improve various work dynamics to make health care delivery more effective, open, and accepting; and to improve outcomes. From my observations over the past several years, the scientific perspective (particularly in the academic setting) has downplayed (a) the role of experience in managing workplace dynamics; and (b) the potential that these dynamics have to influence workplace environs, clinical outcomes, and the patient experience.

I discovered this study's topic pertaining to women physicians by accident—as I interviewed a physician for a class exercise and found her story interesting and compelling. I thought that as a male, nonphysician, I could bring a unique interpretation to the experiences of women physicians, which would allow me the opportunity to practice and improve skills related to dialogue, suspension of judgment, and hermeneutic phenomenology. My position as a senior

level administrator, specifically in human resources, gives me a unique vantage point for to understand broader organizational dynamics and provides a venue for participants to be heard.

Ethical Considerations

As a researcher, my primary responsibility is to conduct ethical research “grounded in the moral principles of respect for persons, beneficence and justice” (Marshall & Rossman, 2011, p. 47). These principles demand that the researcher not use study participants as a means to an end, that their privacy and anonymity are preserved, and that they freely consent to their right to engage in or decline participation without prejudice. The beneficence principle of *primum non nocere* (first, do no harm) requires that the researcher reasonably ensure that participants are not harmed in the study. The principle of distributive justice considers who does and does not benefit from the study—respecting the historical injustices of oppressed groups. Creswell (2009) described ethical issues that arise from the research process and suggested safeguards, also used in this study, to protect and respect the rights of the participants:

- Participants received research objectives in writing and orally, including an explanation of how data would be used, to ensure clear understanding of the study (Creswell, 2009, p. 89).
- Written permission was required of participants before I proceeded with the study as it was communicated (Creswell, 2009, p. 89).
- An application was filed prior to the beginning of the study with the Colorado State University Institutional Review Board (IRB) for protection of human participants. In addition, I consulted the Research Integrity & Compliance Review Office as necessary to ensure proper filing and management of ethical concerns (Creswell, 2009, p. 177).

- Participants received detailed descriptions of data collection devices (such as tape recorders for interviews) and activities.
- Each participant received a verbatim transcription and report of their own respective data. Member-checking is an important technique for establishing credibility (Lincoln & Guba, 1985).
- I considered participants' rights, interests, and wishes first when reporting the data (Creswell, 2009, pp. 90-91). Participants were clear regarding their rights and expressed no concerns prior to, during, or following the completion of the study.
- Letters (e.g., Participant A) were used in lieu of pseudonyms to provide anonymity, and participants were given the opportunity to withdraw from the study at any point if they so chose, without prejudice (Creswell, 2009, p. 90).

This study's focus is at the intersection of women physicians, the critical feminist perspective, and academic medical culture. I am neither a woman nor a physician. As a White male in a position of executive authority, specifically human resources at a health system, I have an additional responsibility to be concerned about power, oppression, and privilege, and to engage with "the complexities of power and how it operates in the social order" (Cannella & Lincoln, 2011, p. 84). With due respect for the area of study and in the spirit of feminist communitarianism ethics, multiple voices were represented, moral discernment enhanced, and social transformation promoted (Cannella & Lincoln, 2011). I committed to confront the research questions, and subsequent data collection and interpretation, through reflexivity: "critical reflection on how the researcher, the participants, setting and research procedures interact and influence each other" (Glesne, 2011, p. 151). I practiced reflexivity through journaling and

dialogue with my advisor as well as my doctoral cohort. These items are addressed in Chapter 5 as to my role and responsibilities as the human instrument of the research.

Study Parameters, Delimitations, and Limitations

Most research designs contain delimitations, or boundaries, by which the researcher contains and controls the study (Mauch & Birch, 1993; C. M. Roberts, 2010). The constructivist paradigm and the perspective of human knowledge as a social construct bound this study. This study focuses exclusively on the experience of women physicians practicing or having completed their residency exclusively at an independent, Midwestern academically affiliated pediatric institution, distinct from and unrelated to the site of the pilot study, and in a different region of the US. I had no previous relationship with this institution, nor any conflict of interest. This hospital was selected as it was an independent, nationally-recognized, academically affiliated pediatric institution, located in reasonable proximity to the researcher, enabling access to potential participants. I requested and was granted permission to conduct the study there by that pediatric institution and its IRB.

Participants were selected through initial and theoretical sampling, a process which seeks data to develop and refine theoretical categories (Charmaz, 2006). The number of participants was determined based on saturation—the point at which further data through participants or other means no longer helps develop theoretical understanding or reveals new characteristics of the categories. The sampling process was in the hands of the researcher.

Limitations, or factors that affect the study but are outside the control of the researcher, are primarily a result of the selected methodology, conceptual framework, and design (Marshall & Rossman, 2011; Mauch & Birch, 1993). The study's boundaries or delimitations create a

study's ensuing limitations. Lynham (2002) contended that theories require continual development and refinement because they are "never complete" (p. 233).

As a qualitative study within the constructivist paradigm, this study is not intended to be generalizable. It is based exclusively on the context of the participants and their experience within this specific academic environment as well as the honesty of the participants interviewed. It is the prerogative of the reader to determine appropriate transferability.

Operating Definitions

Health care is a complex environment and a number of key terms are used throughout this study. Following are key terms and their meanings as used herein:

Academic medicine refers to

the combination of medical schools, teaching hospitals, and their faculty members and staff. It is an enterprise of multilayered, multitasking institutions that share common missions: to provide general professional education and specialized graduate training to future physicians, biomedical scientists and other health care professionals; to conduct biomedical, behavioral, clinical, and health services research; and to champion the application of new knowledge in the alleviation of suffering, rehabilitation of injury, and prevention of disease and premature death. (Mallon & Vernon, 2008, p. 1)

Pediatricians are medical practitioners who "diagnose and treat infections, injuries, and many types of organic disease and dysfunction. They work to reduce infant and child mortality, foster healthy lifestyles, and ease the day-to-day difficulties of those with chronic conditions" (Stephens, 2011, p. 6).

Pediatrics refers to the medical practice that focuses on the "physical, emotional, and social health of infants, children, adolescents, and young adults from birth to 21 years" (Stephens, 2011, p. 6).

Pediatric subspecialists are

pediatric residents who choose to focus on a particular aspect of child health, either exclusively or as a part of their general pediatric practice, [and] complete a subspecialty fellowship after residency. Pediatric subspecialists are more likely to work in academic

settings, where their responsibilities include teaching and research along with direct patient care. (Stephens, 2011, p. 7)

Residency refers to postmedical school training generally lasting from 3 to 5 years required as part of full medical licensure and board certification (Mallon & Vernon, 2008, pp. 21-22).

Subspecialty in pediatrics refers to medical practice that focuses on a “particular aspect of child health, either exclusively or as a part of their general pediatric practice” (Stephens, 2011, p. 7). Pediatric subspecialties include academic generalist, adolescent medicine, allergy and immunology, cardiology, child abuse, child/adolescent psychiatry, critical care, dermatology, developmental and behavioral, emergency medicine, endocrinology, gastroenterology, hematology-oncology, infectious diseases, neonatology, nephrology, neurology, pulmonary medicine, rheumatology, and pediatric surgery (Mink et al, 2012; also see St. George’s University School of Medicine, 2021, on medical specialties and subspecialties in general).

Structure of the Dissertation

This dissertation comprises five chapters, references, and appendices. This Chapter 1: Introduction provides an overview of the study. Chapter 2: Literature Review provides a review, summation, and synthesis of literature related to the informing theoretical frameworks of this study, including women physicians, medical culture, and critical feminist theory. Chapter 3: Methodology details the underlying research paradigm as well as the research strategies employed. The research methods, including participant and site selection, data collection and analysis approach, and the study’s quality criteria of trustworthiness and authenticity are also described. Analysis of the data and discussion of the findings are presented in Chapter 4: Data Outcomes and Discussion. This dissertation concludes with Chapter 5: Implication of Findings and Conclusions, which provides study implications for theory and for future research,

recommendations for further study, conclusions, and an Epilogue—which positions this study in the context of more recent social events.

CHAPTER 2: LITERATURE REVIEW

This chapter connects this study to “the larger, ongoing dialogue in the literature, filling in gaps and extending prior studies” (Creswell, 2009, p. 25) and helps position the study relative to the synthesis of the literature that informed the study’s design, as introduced in the preceding chapter. Specifically, this chapter focuses on situating the study in the literature, and explores the constructs involved in the study.

Situating the Study in the Literature

This study focuses on the intersection of three constructs salient in exploring the lived experience of women physicians in academic pediatrics. Guided by the research questions delineated in Chapter 1, the informing constructs are (a) women physicians in academic pediatrics, (b) feminism and the gendered organization, and (c) the organizational culture of academic medical centers. These constructs interrelate in that (a) women physicians in academic pediatrics perform their roles within academic medical organizations; and (b) both the role of physician and the academic organizational culture have gendered historicity, or historical actuality. It is difficult to decouple the gendered realities that women physicians experience and the gendered organizations in which they work. Academic medical cultures are rich in histories in which women were often marginalized and denied the opportunity for entrance into the medical community (Boulis & Jacobs, 2008; Morantz-Sanchez, 1985). This section provides a critical review of the bodies of literature on these constructs and how they inform this study.

In Figure 1 (presented in Chapter 1), literature on the first construct, women physicians, explores the subject of women physicians as they have been portrayed in the literature and how that portrayal is uniquely positioned due to historical actuality and gender.

The literature on the second construct, feminism, examines critical feminist theory, feminism, and the gendered organization. Literature on these related concepts supports the sociohistorical positioning of women as oppressed by male-dominated structures, and explains the concept of the gendered organization and the challenges women face in these structures. Exploring the concept of the gendered organization also provides a lens through which to understand and better interpret the study participants' experiences.

In addition, *intersectionality*—the idea that gender is not a stand-alone construct and is shaped by race (Crenshaw, 1989, 1991) and class (Acker, 2006, 2012)—is also discussed, inclusive of the inseparability of gender, race, ethnicity, and class and their influence in participants' lived experiences. In related context, importantly,

race refers to physical differences that groups and cultures consider socially significant [In contrast,] *ethnicity* refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. . . . Race is a social construct that is not universal. (American Psychological Association, 2020, p. 142)

Thus, it is inappropriate to ascribe racial labels and/or constructs to ethnic groups (American Psychological Association, 2020, p. 142).

The third construct is that of academic medical culture, which includes the concepts of organizational culture and the evolution of academic medicine in the United States. This study considers the lived experience of women physician participants within an organizational culture—specifically through the lens of the academic medical culture. Academic medical culture has long been dominated by men and the masculine perspective (Lorber, 1993; Nye, 2009; Pololi, 2010). As such, academic women physicians have unique challenges in working effectively in these cultures. Figure 1 (presented in Chapter 1) illustrates the intersection of the three bodies of knowledge informing this study.

Exploring the Constructs

The literature review identifies and assesses literature relevant to and informing the design of this study. The literature search employed search databases including Academic Search Premier, ERIC, MasterFILE Premier, Medline, PsycARTICLES, PsycINFO, and Social Sciences Abstracts. These databases were selected due to either the breadth of books or periodicals covered or specific relevance to the study topic and the constructs introduced earlier. The terms “women physicians,” and “academic women physicians” were used in searching for extant literature. Additionally, references directly from articles were also followed in order to understand conceptual ideas that contributed to the articles. Articles and books were reviewed related to the three constructs that inform this study: women physicians in academic medicine, gendered organization, and academic medical culture. A number of articles were excluded based on the three exclusion criteria: articles or studies (a) related more specifically to patient care experiences, (b) focused outside of the United States unless used to illustrate broader themes, and/or (c) deemed irrelevant to this study.

Women Physicians

As mentioned in the introduction, women physicians have played an increasingly important role in medicine. As of 2022, women accounted for 37.6% of all physicians in the United States (AAMC, 2024b). In 2022, “pediatrics (65.6%) and hospice and palliative medicine (62.2%) had the highest percentages of female physicians, while sports medicine (orthopedic surgery) and orthopedic surgery (7.5% and 6.2%, respectively) had the lowest percentages” (AAMC, 2024b). As mentioned previously, in 2023, 55.4% (or almost half) of all matriculating medical students were women, and that matriculation percentage has slowly increased since 2014 (AAMC, 2023f).

However, the sheer increase in their numbers and prevalence is only a recent phenomenon. Historically, women have been excluded from entering the medical ranks, through the segregation of medical colleges, subsequent closure of women's medical colleges, and the systematic limited quotas for medical school entrance sanctioned by the American Medical Association (Lopate, 1968; Nye, 2009; Starr, 1982; Walsh, 1977). The rapid increase in the number of women entering medicine has not necessarily led to significant change in academic medicine, but has drawn more pronounced attention to the perspectives of women faculty (Pololi, 2010).

Literature specifically focused on women physicians began with the first published study by Lopate (1968). Lopate's research explored the challenges for women physicians and suggested solutions to increase the numbers of women entering medicine. Lopate advocated for increased scholarship aid to medical students, more flexible scheduling during the training years, and child-care tax deductions. However, the most relevant aspect of Lopate's book for this current study is her commentary on gender roles in the United States and their impact on women in medicine. Lopate said,

What seems necessary is that the national climate of opinion concerning sexual roles be changed so that many more high caliber women will, of their own choice, decide to become doctors and will squeeze their way into the medical world. (p. 188)

Although not necessarily a critical feminist treatise, Lopate (1968), a trained cultural anthropologist, noted that society needed to alter traditional roles allowing both sexes to reach their fullest potential:

Altering the traditional male and female roles so that members of both sexes can achieve their fullest potential will necessitate change on all levels, from rewriting children's books to include working mommy as well as daddy, to a shift in the educational curriculum away from home-arts for girls. (p. 188)

Lopate also highlighted the resulting disparities for women entering professional positions: "Little is being done by American society, however, to make the double burden any lighter. Becoming a professional woman still means, in most instances, taking on two jobs instead of one" (pp. 188-189).

Beshiri (1969) wrote *The Woman Doctor* to serve as a guide for women who want to be doctors, after noticing a decline in medical applicants along with tremendous disparities in the number of women physicians trained in the United States versus other countries. Beshiri rebuked the medical establishment for not tapping into women to meet the increasing shortages of physicians, and asked why "some medical educators openly admit they are against women in medicine" (p. 9). In directly confronting male hegemony in the medical profession, Beshiri proclaimed the United States as having the "harshest discrimination of any country in the world against the woman who wants to become a doctor and still enjoy a balanced life that includes marriage and motherhood" (p. 4).

Beshiri (1969) also outlined the process of becoming a physician and provided advice on careers especially suited for married women, specifically suggesting they go into academic medicine, where less opposition exists. Although her book seems to support a feminist point of view, Beshiri also discouraged women who were planning to marry and raise a family from going into the surgical subspecialty, "where considerable prejudice exists toward women, and sometimes with reason" (p. 156). Her reasoning related to the conflict between the demands of surgery and raising a family and the need for women to subjugate themselves to the existing establishment in order to be successful.

Four authors published influential books in the late 1970s to mid-1980s, tracing the historical positioning of women physicians within the medical establishment. First, Walsh's

(1977) *“Doctors Wanted: No Women Need Apply”*: *Sexual Barriers in the Medical Profession, 1835-1975* provided an abbreviated historical analysis and focus on the state of women physicians in the Boston area. Starr’s (1982) Pulitzer Prize-winning book, *The Social Transformation of American Medicine*, provided a historical narrative of the rise of the medical profession in America and highlighted the exclusion of women as early as the colonial period. Lorber’s (1984) *Women Physicians: Careers, Status, and Power* explored women physicians from the feminist perspective. Finally, Morantz-Sanchez (1985), in *Sympathy and Science: Women Physicians in American Medicine*, summarized the history of women physicians and connected their historical, social, and political positioning with the rise of feminism.

Although Morantz (1978) criticized Walsh’s (1977) narrow focus and vagueness on the role of professionalization in medicine, Walsh did note the impact of the Women’s Equity Action League (Pratt, 1987) filing “a class action complaint against every medical school in the country” (Walsh, 1977, p. 268; also see W. White, 1972, p. 77), claiming discrimination against women in the academic community, which ultimately led to increases in admissions of women beginning in the 1970s. Walsh also noted the influence of feminism on questioning the delivery of health care to women and suggested the debt women physicians owe to the feminist movement. Finally, Walsh suggested the need for more study in understanding how the professional socialization process (which equates in part to the concept of the medical culture) specifically affects women physicians.

Starr’s (1982) book, *The Social Transformation of American Medicine*, traced the rise and fall of women in the medical profession from the mid-1800s to the early 20th century, and specifically noted that women were limited to 5% of medical school admissions for the half-century following 1910 (excluding wartime). In the book, Starr discussed the role of feminism in

challenging the traditional paternalistic role of physicians in denying the rights of patients, nurses, and other health care role participants in medical decision-making. Starr also credited the feminist movement with the increased prevalence of women entering the medical profession—from 9% in 1970 to 25% in 1979. Further, Starr noted changes in generational expectations regarding women physicians, and how the prior generation wanted to prove that they were equals, whereas younger women physicians expected men to change their attitudes, behavior, and institutional practices to accommodate the needs of women. Starr also provided perspective regarding how childbirth was a major force for change, as the traditional role of midwives (primarily women) was suppressed by (overwhelmingly men) physicians, which led to a new “consciousness of rights” (p. 391) in the medical establishment for women physicians.

Moving away from the more traditional postpositivist approaches to studying women physicians, Lorber (1984) wrote a book from the feminist perspective: *Women Physicians: Careers, Status, and Power*. Near the end of the book, Lorber made some powerful statements and asked some provocative questions which influenced this current study’s research questions, to examine if and how the situation for women physicians has changed since the book’s publication. Lorber contended that

If women are to gain positions of power, the patterns of the informal organization of the workplace must *routinely* [author’s italics] include them. As a group, women must be trusted as colleagues, sponsored by advancement, given recognition for competence and accomplishment, and accrue the resources and reciprocal favors that advance careers. Paradoxically, women must act politically as a group in order to defuse gender as a status. (p. 112)

Lorber then asked a poignant question regarding the goal of advancing women physicians as a group, and further challenged how women should influence organizational structures:

Is it simply to put more women in positions of power in existing institutions, or is it to change the structure of institutions and their values and practices to reflect women’s special perspective? Do women have a different view of the world than men? (p. 112)

Lorber answered the question by stating that women physicians attain success when institutions operate with new values that reflect all needs and priorities for society, including women (p. 115). Lorber suggested that organizations must undergo fundamental change in order to institutionalize those new values.

Morantz-Sanchez's (1985) *Sympathy and Science: Women Physicians in American Medicine* provided a thorough history of women physicians and connected their historical, social, and political positioning with the rise of feminism. In this seminal study of the role of women in medicine, and the historical development of how medicine was practiced and taught in the 20th century, Morantz-Sanchez recognized and expounded upon the importance of feminism in furthering women's role in medicine and provided a critique of the status of women physicians:

Because most women are socialized to function primarily in the privacy of the family, where sentiment, intuition, feeling, and interrelatedness predominate, even single women who choose medicine experience unease with values purported to be rational, scientific, and gender neutral, but which are in reality masculine. (p. 357)

From the 1980s through the 2000s, the medical establishment itself produced much of the literature on women physicians. Many studies appearing in medical journals focused on characteristics of women physicians (e.g., Frank et al., 1998, 2001; Frank & Cone, 2000); particular areas of disparity or marginalization (Levine et al., 2011; Nonnemaker, 2000; Pololi & Jones, 2010); discrimination (Carr et al., 2000, 2003); or the general status of women physicians in academic medicine (Brown et al., 2003; Levinson et al., 1989; Nonnemaker, 2000). Many of these studies from the medical establishment were from researchers in the postpositivist research paradigm, who often relied on quantitative data from surveys to support their perspectives or pointed to disparities between the perceptions of women and men. These researchers focused less on qualitative aspects of the lived experience of women physician research participants, how

they perceived their institutions and professions, and where they wanted to see change toward greater inclusion of their needs.

However, glimpses into medicine through the eyes of women physicians also emerged in the popular literature, including Conley's (1998) description of her own abrupt resignation from the Stanford University faculty in *Walking Out on the Boys*, and Cassell's (1998) anthropological study of women surgeons in *The Woman in the Surgeon's Body*. Both Conley and Cassell provided valuable insight into the male-dominated subspecialty of surgery and highlighted blatant discrimination within their respective institutions and medical specialist cultures. Carr et al. (2000, 2003) supported the notion that gender-based discrimination and sexual harassment were still common in academic medical institutions. Brodsky (Kass, 2015; *Vineyard Gazette*, 2014) continued the focus on the issue of discrimination in medicine after a multiyear U.S. District Court case (*Brodsky v. Kaleida Health*, 2007) against the Buffalo Children's Hospital (and its successor organization) that began in 1998 (Precious & Watson, 2004). Brodsky became a leading advocate for women physicians, founding Women MD Resources (2024), an organization "dedicated to helping women physicians navigate the medical work environment" (*Vineyard Gazette*, 2014).

Looking beyond discrimination as the primary issue for women physicians, Boulis and Jacobs (2008) analyzed the impact of women physicians on health care in America and suggested that patients—specifically women—want a more compassionate and family-friendly way for medicine to be practiced. From the authors' perspectives, gender differences in work habits, interests, ambitions, and priorities had resulted in some women physicians having different expectations for their work-lives and different levels of satisfaction. Boulis and Jacobs concluded that women would change the way medicine is practiced on a daily basis, and

influence the structure of the profession and the health care industry broadly. However, they noted, such change to the profession would be incremental—especially in supporting meaningful work-family balance. Not very different from Lorber’s (1984) assertion 30 years earlier, Boulis and Jacobs forecast that women would constitute the critical mass to influence changes as they entered leadership ranks. Bowman and Allen (1990) provided a resource for women physicians in addressing the unique challenges facing women physicians, strategies for managing career and life, and practical advice for coping with work-related stress. In a renamed later edition, Bowman et al. (2002) continued the themes of career and life-management coaching for women physicians, with a more scholarly tone and data-analysis support.

As a further examination of the themes articulated by Morantz-Sanchez (1985), More et al. (2009) compiled a series of essays providing a historical narrative of women physicians in American medicine from the 19th century to the present, linking early women physicians to second-wave feminists, and analyzing the women’s health movement from the perspective of women as patients and providers. From the perspective of this current study, the most important aspect of More et al.’s anthology of essays was its acknowledgement of the gendered hierarchy in the medical profession. Similar to Boulis and Jacobs’ (2008) work, the final essay in More et al.’s collection discussed the obstacles women physicians still face in their environments and jobs—even as they make progress in their prevalence in medical leadership roles (Frank et al., 2009).

In additional studies, researchers have discussed obstacles in medical specialties and subspecialties. For example, Elta (2011) examined the underrepresentation of women in gastroenterology (which was actually lower than that of general surgery), and discussed the challenges of balancing family and career, the lack of encouragement in professional

development, discrimination, and the need to embrace the promotion of women, including women of color. Further, Foster et al. (2000) studied gender climate as an obstacle to professional development of women physicians, and found inclusive networking, access to child care, and improved faculty interactions as possible remediation.

The written history of women physicians is still relatively recent, having been truly examined only since the 1970s and 1980s. Since then, the number and prevalence of women physicians has certainly grown and the issues related this growth have evolved, from discrimination in basic inclusion and representation, to more diverse and complex issues of pay discrimination, inclusion in leadership roles, work-family challenges, and needs for professional development. It is clear from the literature that the complexity of navigating the profession of medicine and recognizing and addressing the unique needs of women physicians warrants further understanding to address Lorber's (1984) vision.

Women Physicians in Academic Medicine

Pololi's (2010) study, *Changing the Culture of Academic Medicine*, specifically focused on the positioning of women physicians in academic medicine, with a clear conclusion:

The basic message of this book is a call for a core change in medical school culture that encourages connections and trusting relationships among colleagues and supports the human needs of health professionals. (p. 165)

While acknowledging that men also “dislike the culture of academic medicine, they more readily achieve and are less alienated within the current system. Men do not share the same outsider status as women and do not feel marginalized in the same way women do” (p. 12).

Following the 2010 book, Pololi built upon themes identified in that study to call for change within academic medicine. Pololi and Jones (2010) concurred with the perspective of women physicians' outsider status, and Pololi et al. (2013) suggested that academic medicine does not support relatedness and a moral culture for many faculty members, potentially leading

to turnover. In a qualitative study of 20 women physicians who left a single institution, research by Levine et al. (2011) supported the themes found in Pololi (2010), finding that women physicians in academic medicine described a disconnect between their expectations and their experiences, and feeling undervalued.

Perhaps the disconnect between expectations and experiences found by Pololi (2010) and Levine et al. (2011), as described by women physicians in academic medicine, points toward the reasons those women chose academic medicine in the first place. Researchers Borges et al. (2012) found that a primary reason why women choose academic medicine is due to an interest in teaching. They also found that the interest in teaching arose during or after a fellowship, and was not necessarily a planned or intentional decision, which could support the need for more systematized career development, mentoring, and environments encouraging nurturing relationships.

Kalet et al. (2006) found that to have more flexibility, some women physicians in academic medicine may not fully optimize their careers. The researchers' findings suggested the need for more innovative approaches to support the career development of women physicians, such as allowing part-time employment for both scholarly and clinical work. Carnes et al. (2008) drew a link between the lack of advancement of women physicians in academic medicine and the evolution of women's health itself, and made recommendations related to systemic institutional approaches that address "the impact of unconscious, gender-linked biases that devalue and marginalize women and issues associated with women" (p. 1453).

At the beginning of the 2010s, the literature regarding women physicians, and specifically women physicians in academic medicine, expanded to include more personal narrative, such as Au's (2011) somewhat whimsical experiences in *This Won't Hurt a Bit (and*

Other White Lies: My Education in Medicine and Motherhood. Au provided a useful perspective into the challenges women physicians face when managing careers and motherhood.

One notably absent area in the literature relates specifically to minority women physicians and those in academic medicine, with some exceptions. Gamble (2000) wrote an essay about her experiences with discrimination, and Lumumba-Kasongo (2007) described her experiences with patients doubting her professional status. However, the lack of literature on Black physicians, and more specifically Black women physicians, is concerning. The AAMC (2024a), on its U.S. Physician Workforce Data Dashboard, reported that as of 2023, 5.2% or 51,444 of United States physicians were Black. Per a 2021 essay in the *Lancet* (Bajaj et al., 2021), only 2.8% of total active physicians (or 26,674) were Black women. This number is similar to an AAMC (2018b) report on diversity in the U.S. physician workforce. Black women physicians are significantly underrepresented, comprising only 2.8% of all physicians, and only 4.9% of all women academic faculty physicians (AAMC, 2018a). This is potentially problematic, as the Black population in the US is 13.6% (U.S. Census Bureau, 2023), of which roughly half are women.

The largest potential problem with the small numbers of minority physicians, and women physicians in academic medicine in particular, is the impact on the patient experiences and health outcomes. Research has shown that patients of the same racial identity as their physician experience their care differently than when racial identity differences exist. Patients with racially different physicians are likely to express lower levels of satisfaction with their care, and lower levels of trust and partnership with their physicians (Cooper-Patrick et al., 1999; Doescher et al., 2000; Saha et al., 1999). Interpersonal communication is one of the reasons cited for this difference (Collins et al., 2002). In one study, Cooper et al. (2003) found that increasing the

diversity of physicians may be the best strategy toward improving health care experiences for members of minority groups. Similarly, Chapman et al. (2013) found that “increasing the number of African American/Black physicians could reduce the impact of implicit bias on health care disparities because they exhibit significantly less implicit race bias” (p. 1508).

Again, it is concerning that so few minority physicians, and specifically women physicians in academic medicine, are available to support the needs of large minority populations. More research on the specific barriers to African American women physicians in academic medicine, as well as the experiences of other groups, would be beneficial. This current study focuses specifically on women physicians in academic medicine, and included participants from underrepresented groups.

Feminism

As has been evident in the literature on women physicians in general, and on women physicians in academic medicine specifically, their historical narratives, characteristics, and experiences cannot be separated from their unique experiences as women. It is with this understanding that another relevant construct, that of critical feminist theory or feminism, is reviewed and considered as it informs this study.

Critical feminist theory is a diverse and complex set of perspectives that originated as a social movement in the late 18th century to secure rights and political equality for women (Hekman, 2006). Feminist thinkers characterize the world as patriarchal with a resulting masculine culture that oppresses women—contending that women must attain social power as a group to challenge their treatment (Lorber, 1984). Structural inequality between men and women exists because social institutions build and maintain inequities that create socially constructed assumptions of different sex roles. Modern feminism consists of a range of theories. Beginning

in the late 1970s, researchers began looking beyond more traditional elements of economic, political, and legal structures to explore deeper explanations of women's oppressed status. Krollokke and Sorensen (2006) summarized feminism in terms of three waves. The first wave, they said, focused on the fight for women's voting rights in the early 1900s. The second wave, from the 1960s through the early 1990s, directed attention to women's empowerment and differential rights. And finally, the third wave, from the 1990s to the present,

seeks to overcome the theoretical question of equity or difference and the political question of evolution or revolution, while it challenges the notion of "universal womanhood" and embraces ambiguity, diversity, and multiplicity in transversal theory and politics. (p. 2)

Calás and Smircich (2006) traced and assessed the evolution of feminist schools of thought into liberal, radical, and psychoanalytic theoretical approaches, each having different epistemological assumptions, but sharing the same ontological assumption regarding the location of women's oppression. This assumption presumes a universally sexualized, transcultural, and transhistorical *woman* positioned against her other—*man*. Feminist analysis explores women's role in society from a woman's perspective, and how the two sexes can exist together or separately without oppression and subordination (Calás & Smircich, 2006; Hekman, 2006).

In addition, Black feminists such as Lorde (1984) challenged the traditional feminist approach as one-dimensional—representing the perspective of White, heterosexual, Anglo-Saxon women—to recognize the unique perspectives of African-American women as well as lesbians. The challenge of Black feminists evolved the theoretical notions of feminism and opened the door for discussions of intersectionality as a construct to examine the relationships among multiple dimensions of gender, race, ethnicity, class, and color (Johnson-Bailey, 1999; McCall, 2005).

These different feminist perspectives provide a theoretical foundation from which to understand why women physicians provide a unique perspective within the broader academic pediatric institution. The voices of these physicians may provide specific ideas to decrease oppression or subordination, resulting in greater organizational contributions, and perhaps improved patient care practices.

Gendered Organization

The discussion of gender is rooted in feminist theory. The term *gender* refers to the socially and culturally imposed divisions of the sexes (Rubin, 1975). Acker (1992) further defined the term gender as the “patterned, socially produced distinctions between female and male, feminine and masculine” (p. 250).

As women continue to make gains in their prevalence within academic medicine, academic medical structure and the culture that supports it are still heavily gendered toward the masculine. This contention is based on the theory that gender is socially constructed and maintained as a fundamental meaning-making societal structure (Alvesson & Billing, 2002, 2009; Hekman, 2006). In essence, this view suggests that gender is an organizing process (with a more indirect element of biological difference) rather than a fixed system with underlying gender-based assumptions (Aaltio & Mills, 2002; Alvesson & Billing, 2002).

A *gendered organization* is one in which gender serves as a basic principle present in “the processes, practices, images and ideologies, and distributions of power in the various sectors of social life” (Acker, 1992, p. 567). Medicine developed a strong masculine-based gender identity largely due to historical limitations placed on women in medical school admissions, and a strong cultural prejudice aimed at the suppression of women (Boulis & Jacobs, 2008; Chin, 2002; Group & Roberts, 2001; Morantz-Sanchez, 1985; More et al., 2009). Feminism’s rise in

the 19th and early 20th centuries, and its revival in the 1960s, were crucial in advancing the role of women in medicine. However, those women who did become physicians tended toward specialties seen as less threatening to the male-dominated medical culture (Boulis & Jacobs, 2008). Pediatrics is one of the areas of medicine most impacted by the increased prevalence of women among its ranks. Leadley and Sloane (2011) reported that women applicants to pediatric residency increased from 61.6% of all applicants in 1999 to 69.5% in 2011. More recent data from the AAMC (2021) showed that women now comprise 73.1% of all U.S. pediatric residents and fellows. Due to the shift in the prevalence of women in medicine and specifically in pediatrics, these historically gender-based medical disciplines and their subsequent gendered organizational cultures must change to ensure full inclusion and an environment of optimum advancement of women physicians.

The concept of the gendered organization as understood in this study reveals injustice through discrimination and ineffective utilization of women in the workforce. These types of evidence may be important concepts in linking the experiences of women physicians with their organizational environments (Alvesson & Billing, 2009).

Organizational Culture

Organizational culture is a complex concept with several different definitions and constructs (Cameron & Quinn, 2011). Denison (1990) referred to organizational culture as the underlying values, beliefs, and principles that serve as a foundation for an organization's management system as well as the set of management practices and behaviors that both exemplify and reinforce those basic principles. (p. 2)

Schein (2010) described organizational culture as a three-level construct consisting of artifacts, espoused beliefs and values, and basic underlying assumptions. Understanding culture from Schein's perspective is the process of deciphering the patterns of these three constructs.

Describing culture using constructs similar to Schein's, Cameron and Quinn also utilized explicit

behaviors, artifacts, conscious contracts and norms, and implicit assumptions, noting that culture is enduring, with “core values and consensual interpretations about how things are” (p. 20). Hofstede et al. (2010) described the construct of culture as “mental software” (p. 5): patterns of thinking, feeling, and acting. Alvesson (2013), drawing on previous perspectives of organizational culture, noted five key aspects of cultural phenomena, which (a) have relationships to history and tradition; (b) are deep, thus difficult to grasp, and requiring interpretation; (c) are collective and shared by members of groups; (d) are “ideational in character, having to do with meanings, understandings, beliefs, knowledge and other intangibles” (p. 3); and (e) “are holistic, intersubjective and emotional rather than strictly rational and analytical” (p. 3). Alvesson’s description of organizational culture provides a lens from which to view academic medicine and the role of women therein specifically. Alvesson posited that the key to understanding organizational culture is not simply social patterns, but collective symbolism, in which social interaction takes place. Culture then, through symbolism, creates meaning.

Academic Medical Culture

Academic medicine evolved from the formalization of medical training in the 19th century in the United States. Although women had played a historical role in caring for the sick, the process of medical professionalization through the rise of medical colleges and societies purposefully excluded women (Starr, 1982; Walsh, 1977). The exclusion which women in medicine have endured is crucial to understanding the current culture of academic medicine.

Utilizing Alvesson’s (2013) perspective of culture as described above, academic medical culture is unique in its relationship to history and tradition, and specifically its exclusion of women in the medical profession, governance, and teaching institutions. The culture of academic

medicine is also difficult to grasp and usually interpreted through those within it. Academic medicine as a topic of inquiry is not particularly accessible, as full-time faculty members in academic medicine comprise only 17% of all licensed physicians in the United States (Young et al., 2015). However, Leape et al. (2012a) called attention to the “pervasiveness of disrespect in health care” (p. 853) resulting from a culture in which physicians’ ethos of individual privilege and autonomy creates values that lead to disrespectful behaviors. These values and incumbent behaviors are certainly not the only descriptors of medical culture, but they do provide valuable insight, suggesting that academic medicine deserves greater study related to its organizational culture. Further, Pololi et al. (2009) suggested that serious problems regarding relational issues exist in academic medicine. They called for greater efforts in creating trusting relationships to support faculty in creating a more productive culture, suggesting that

A logical response to the findings of our study would be for medical schools to make efforts to instigate and support practices that encourage relationship formation among faculty and leaders. Supporting connection in trusting relationships and the human condition of health professionals would facilitate a core change in the medical school culture and contribute to realizing the potential of all faculty. (Pololi et al., 2009, p. 112)

A later study by Ovseiko et al. (2019) suggested that,

Women’s experiences of the university culture are not only different to, but are less positive than those of men A more supportive and inclusive culture is likely to benefit all faculty and staff, increase career satisfaction, and reduce faculty and staff attrition. (p. 186)

These studies suggest that building trusting, supportive, and relational organizational cultures are likely to help improve the experience of not only women in the academic medical setting, but of all faculty and staff. These studies further suggest that the more traditional hierarchical cultures are contributing to higher attrition and dissatisfaction and that a focus on creating a better experience for faculty and staff will improve satisfaction and retention.

It is clear that academic medicine has its own unique organizational culture, which either supports or constrains women physicians operating within it. Understanding aspects of academic medicine's organizational culture is key to understanding the experiences of women physicians in academic medicine.

Relationships Between the Constructs

This section provides a discussion of the relationships among the previously discussed constructs in order to demonstrate how this study adds to the knowledge of women physicians in academic pediatrics.

Women Physicians in Academic Medicine and the Gendered Organization

As stated earlier, the concept of the gendered organization recognizes an encoding of gender-based assumptions in the organizational setting. These assumptions are based on gendered structures, practices, and identities. *Gendered structures* include the key components of masculinity and femininity that “refer to the values, experiences, and meanings that are associated with men and women or that define a masculine or feminine image” (Ely & Padavic, 2007, p. 1128). Cheryan and Markus (2020) specifically suggested that many gendered structures are biased with “a hidden but powerful foundation of masculine ideas and values, policies, interaction styles, norms, artifacts, practices, and individual beliefs that prevent the full participation of women” (p. 1022). They concluded that, “Masculine defaults exist when characteristics and behaviors associated with the male gender role are valued, rewarded, or regarded as standard, normal, neutral, or necessary aspects of a given culture” (p. 1041).

As discussed earlier, historically, academic medicine has been gendered, with women having to “struggle for acceptance” (Pololi, 2010, p. 17). If these gendered structures and

“masculine defaults” (Cheryan & Markus, 2020, p. 1022) exist, it is valuable to understand how women physician in academic medicine manage and cope in these organizations.

This study explores the relationship between women physicians in academic medicine and gendered organizations relative to the experiences of the participants, their awareness of gendered aspects within their environments, and the approaches they take to navigating and/or traversing those environments.

Gendered Organization and Academic Medical Culture

Academic medical centers have their own unique cultures derived in part from the historical development of the medical profession beginning in the late 1800s, which clearly excluded, or at least severely limited, women in professional medical practice. Historians have ascribed the reasons for this exclusion as heavily based on gender roles and stereotypes during this period (see C. F. Epstein, 1970; Lopate, 1968; Morantz-Sanchez, 1985; More et al., 2009; Starr, 1982; Walsh, 1977). Considering that women did not begin to enter U.S. medical schools in substantial numbers until the 1970s, it is difficult to examine the medical profession (and specifically academic medicine) without considering the impact of gender (Riska, 1993).

Women Physicians and Academic Medical Culture

Women physicians in academic medicine operate within the academic medical culture. Organizational culture, discussed earlier, is critical in understanding behaviors, social events, and processes within the academic medical setting. Although women medical faculty members part of academic medical culture, they are constrained by the culture’s male-dominated history through shared meanings, beliefs, and ideation (Pololi et al., 2012, 2013). Thus, it is impossible to understand the experiences of women physicians in academic medicine without exploration and understanding of the meanings and values of academic medicine as expressed, reproduced,

and communicated at least in part by symbolic form in the environment of academic medicine (Alvesson, 2013). Thus if, as Alvesson posited, organizational culture creates meaning through collective symbolism, the lived experiences of women physicians in academic medicine can only be interpreted, at least in part, by understanding the organizational culture(s) in which they work. How women physicians in academic medicine are shaped by their profession's organizational culture, and how (or if) they perceive their roles in shaping the future culture of academic medicine, are valuable to explore in this study.

Women Physicians and Gendered Hierarchy

The literature establishes that academic medicine has been historically a male-dominated environment that excluded women. Lorber (1984) contended that

gender inequities are pervasive and long-standing because they are built into the social institutions and maintained by everyday assumptions about appropriate work for women and men in and out of the home. (p. 114).

One of the most interesting aspects of the status of women physicians in academic medicine in the US lies in the statistics: As of 2023, women comprised 44% of all medical school faculty (AAMC, 2023i), 28% of full professors in medical schools (AAMC, 2023i), and 27% of medical school deans (AAMC, 2023a). The distribution of women across the various medical specialties and subspecialties is even more interesting. As of 2021, women comprised the majority of active physicians in 10 specialties and subspecialties (out of 48): pediatrics; obstetrics and gynecology; dermatology; geriatric medicine; endocrinology, diabetes, and metabolism; internal medicine and/or pediatrics; neonatal-perinatal medicine; pediatric hematology and/or oncology; pediatric anesthesiology; and child and adolescent psychology (AAMC, 2021). Almost all of those specialties pay less than the majority of other specialties more dominated by men physicians. For example, pediatrics, the specialty in which women comprise 65% of active licensed physicians (AAMC, 2021), is one of the lowest paid specialties (Kane, 2023). Conversely, orthopedics, in

which women comprise of only 5.9% (and the lowest percentage of all specialties and subspecialties) of active physicians, pays the second highest, behind only plastic surgery (Kane, 2023). Based solely on the numbers, women physicians, and more specifically women physicians in academic medicine, although achieving degrees of professional success, still face injustice—at least based on compensation—as well as limited paths to power and influence in the academic medicine environment.

The gendered hierarchy in academic medicine is a result of the academic medical culture that developed with the historical systematic marginalization of women. Gendered hierarchy in academic medicine is also a byproduct of the gendered organization, or the idea that organizational cultures may be understood in terms of masculine and feminine values, ideas, and meanings (Alvesson & Billing, 2009). As the predominant masculine perspective through collective symbolism expresses gender value, gendered hierarchy, and subsequent marginalization of women, emerges. This study shines a light on the impact of gendered hierarchy on the experiences of women physicians in academic medicine. In this study, the lived experiences of the participants and their interpretations of their lived experiences inform the extent of the impact of gendered hierarchy on how the participants think about and practice medicine within the academic environment.

Summarizing the Literature Review

In summarizing the literature, this section provides competing perspectives on issues that are inconclusive in the gendered perspective. It also provides research synthesis and critical analysis from the literature. This summation demonstrates that the theoretical constructs critically examined herein support this study's research questions, the scientific merit of

examining the lived experience of women in pediatric academic medicine, and opportunities for transferability of this study's thematic constructions in informing practice.

Competing Perspectives

Studies have shown a difference between men and women physicians related to their work experience through several lenses. However, it is important to discuss the terms behind these work-experience lenses. *Job satisfaction* was characterized in seminal work by Lichtenstein (1984) as “the difference between what a worker experiences on the job and what he or she wants or expects to find” (p. 57). Researchers of *burnout* (Chesak et al., 2020) characterized *physician burnout* “as an occupational syndrome defined by emotional exhaustion, depersonalization, and a sense of reduced personal efficacy or accomplishment” (p. 2). Among various work experience aspects, Chesak et al. (2020) noted that burnout “is distinct from job dissatisfaction or work-related stress. It is also distinct from depression, though depression can map with the emotional exhaustion component” (p. 2).

Some researchers, such as Zuger (2004), Keeton et al. (2007), and Gibson and Borges (2009), and more recently Carvajal et al. (2018), Andrade et al. (2019), and Redmond and McGuinness (2020), drew seemingly innocuous conclusions that women physicians had either higher job satisfaction, or little or no difference in job satisfaction, based on gender. More recently, researchers Kabbash et al. (2020) suggested that women physicians in secondary and tertiary medical care levels had higher job satisfaction than men in similar roles. *Secondary care* refers to health care services provided by medical specialists (e.g., cardiologists, neurologists, etc.), who typically do not have first contact with patients; whereas *tertiary care* involves seeing more specialized care providers in an inpatient hospital setting for advanced medical diagnosis and treatment (Van Straten et al., 2017). Although discrimination and differences in gender

perspectives were prevalent in a number of studies (Carr et al., 2000; Chow et al., 2020; Lu et al., 2020; Rasmussen et al., 2021; Witte et al., 2006), women physicians in these studies recognized the challenges and obstacles of gender but still found satisfaction in their careers. This suggests that even though women physicians experience gender bias and discrimination, they may play a lesser role in their overall job satisfaction. Through its research questions, this current study explores understanding of women physicians' experience of gender in the context of academic pediatric medicine and how their experience is influenced by institutional and personal contexts. This study sheds light on the challenges and obstacles of gender and understanding of their impact on women physicians' careers.

Researchers of burnout have asserted that women physicians in general have 20% to 60% higher incidence of burnout (Dyrbye et al., 2017; McMurray et al., 2000; Shanafelt et al., 2015; Templeton et al., 2019) than men physicians. Yeluru et al. (2022) pointed to a number of burnout risk factors and remedies specific to women physicians, categorized as (a) workplace: unequal pay, lack of mentorship, limited leadership opportunities, and time constraints; (b) home: increased household and childcare responsibilities relative to male counterparts; and (c) health: childbearing, increased maternal age, and mental health (p. 4).

However, Dyrbye et al. (2017) admitted that, "It is currently not clear if burnout is actually more common among women, or if gender-based differences in its expression—such as emotional exhaustion—make it easier to identify among women" (p. 2). In their systematic review of burnout, Rotenstein et al. (2018) concluded that, "Because of inconsistencies in definitions of and assessment methods for burnout across studies, associations between burnout and sex, age, geography, time, specialty, and depressive symptoms could not be reliably determined" (p. 1131). Templeton et al. (2019) added that, "Understanding the role of gender in

burnout is complicated by the inconsistent use of terms such as sex, gender, male/man, and female/woman in publications on this topic” (p. 2). The increased complexity and pronounced difference between biological sex and nonbinary social constructions of gender have become more prominent (Templeton, et al. 2019).

Although there may be competing perspectives on job satisfaction and burnout specifically related to women physicians, this study sheds light on the experience of women physicians in academic pediatrics in the broader perspective of the gendered culture of academic medicine. The participants’ shared experiences in this environment may help to provide better understanding of the unique issues related to job satisfaction and potential for burnout for women physicians in academic pediatrics. The essential themes derived from the thematic categories of data analysis are discussed in Chapter 4.

Research Synthesis and Critical Analysis

Synthesis and critical analysis of the literature that informs (a) the development and specific concerns of women physicians as a force in medicine, (b) the notion of gendered organizations, and (c) the culture of academic medicine, are presented next, to add meaning to the contributions of this study and its participants’ experiences. Extant literature and this current study indeed inform one another. This study’s participants’ lived experiences are better interpreted through recognition of the social, professional, and organizational contexts in which they work and live. That is, participants’ lived experience is understood in the contexts of the institution in which they work and their personal lives outside of work. Table 1 summarizes these three bodies of literature that informed this study’s design and analysis, and provides a summative synthesis of the framing constructs’ foundations, key concepts, current forms and research findings, and interrelationships.

Table 1. Synthesis of Literature Informing This Study's Design

Framing constructs	Women physicians in academic pediatrics	Gendered organization	Organizational culture of academic medicine
Foundations	Women physicians first studied as having unique challenges in entering medical profession (Beshiri, 1969; Lopate, 1968). Morantz-Sanchez (1985) traced historical development of women physicians and their exclusion from the medical establishment.	Acker (1990) first defined gendered organization as one where advantage, disadvantage, exploitation, control, action, emotion, meaning, identity are patterned in terms of male and female, masculine and feminine.	Schein (1985, 2010) defined organizational culture as shared assumptions, espoused values, and artifacts. Hofstede et al. (2010) framed culture through six characteristics including a socially constructed phenomenon. Alvesson (2013) noted role of history and tradition in understanding culture.
Concepts	Disparities exist between men and women on medical school faculties, suggesting continued need for equal opportunity for women in academic appointments and promotions (Nonnemaker, 2000).	Organizations build on and reproduce inequalities of gender, race, and class. (Acker, 2006); the gendered organization's two-sided dynamic of gendering practices and practicing gender (Martin, 2003); new dynamics include intersectionality, the importance of organizational context, and developing mechanisms for organizational change. This concept is a framework for seeing inequalities (Britton & Logan, 2008).	Socially shared meanings and collective symbolism are significant concepts in cultural understanding (Alvesson, 2013). Academic medicine's culture is based on male-dominated structures, values, and assumptions. Certain aspects of institutional policy and culture in academic medicine pose challenges for women (Hamel et al., 2006; Palepu & Herbert, 2002)
Current forms and research findings	Women physicians have progressed but continue to cluster in lower tiers of medical hierarchy. Yet they are influencing how medicine is practiced, and will become more prominent in leadership positions (Boulis & Jacobs, 2008). Women in surgical academic medicine have still not attained the most powerful and prestigious jobs, and experience gender discrimination	Poststructuralist influence moved away from constructing gender through biological or other universal criteria, developing new conceptualizations, and integrating those with other ideas to create gender-sensitive but not gender-exclusive cultural studies. (Alvesson & Billing, 2009). Women have just begun to catch up to men in seniority and tenure, but women are still not adequately advancing their careers at the same rate as men. In addition, women	Faculty consider leaving academic medicine due to its nonrelational and unethical workplace culture (Lowenstein et al., 2007; Pololi et al., 2012). Women physicians specifically perceive themselves as cultural outsiders with barriers to advancement including bias and gender role expectations (Foster et al., 2000; Pololi & Jones, 2010). Early-career women physicians report disconnect between their

	(Longo & Straehley, 2008).	faculty in medical schools are still compensated less than men (Rotbart et al., 2012)	priorities and those of the dominant culture (Levine, et al., 2011)
Framing constructs	Women physicians in academic pediatrics	Gendered organization	Organizational culture of academic medicine
Construct relationships	Women’s representation in medicine will increase, challenging practice and structures (Boulis & Jacobs, 2008).	Organizational culture and gender are inseparable constructs that influence the construction and development of organizations (Mills, 1988). Women physicians feel marginalized and want to see changes in the culture of academic medicine (Pololi, 2010).	Culture can be a negative force that supports repressive ideas on gender—requiring critical exploration to facilitate liberation from ideation and normative constraints. (Alvesson, 2013).

Drawing on the informing literature, it appears that the integration of women physicians in medicine follows, to some extent, the evolution of feminist thinking through the three (or possibly four) waves of feminism. The first wave, from the mid-1800s to the first few decades of the 20th century, “mobilized around the idea of the “new woman”—an ideal of femininity that challenged limits established by male-centered society. The first wave relates to social campaigns that expressed dissatisfaction with women’s limited rights for work, education, property, reproduction, marital status, and social agency. It is associated with women’s suffrage—a movement advocating women’s entitlement to vote (Malinowska, 2020, p. 2). For women physicians, the first wave represented their slow acceptance into the medical community through admittance into medical schools, beginning with Elizabeth Blackwell, the first American woman admitted into a medical college (Lorber, 1984), to the gradual acceptance of women students through the midcentury (Lopate, 1968; Morantz-Sanchez, 1985; Starr, 1982; Walsh, 1977). The second wave, from the early 1960s to the late 1980s, “asked questions about the constituents of gender roles and women’s sexuality” (Malinowska, 2020, p. 3). This second wave aimed “to uproot the cultural inequalities, gender norms, and attempts to establish the egalitarian

role of women in the society” (Mohajan, 2022, p. 2). The feminist second wave also focused on sexuality and reproductive rights along with other demands for equal opportunities for education, employment; maternity leave, birth control and abortion rights, and more (Mohajan, 2022, p. 4). More specifically, as women physicians’ numbers and prevalence continued to grow (Butter et al., 1985; Lopate, 1968), they built the Women’s Health Movement (Morgen, 2009) and developed a consciousness of their unique differences from their male counterparts. Women physicians in the second wave also began to challenge the culture of exclusion in medical education and academic leadership roles (Boulis & Jacobs, 2008; N. Rogers, 2009). Conley (1998), a tenured full professor of neurosurgery at Stanford University, captured the experience of women physicians in the second wave, in her book *Walking Out on the Boys*, in which she described the sexist and highly gendered environment that led to her resignation in 1991.

From the 1980s to 2010s, the broadly defined third-wave feminism involved an expansion of diverse branches of feminist thinking, yet with goals similar to the second wave. However, third-wave feminism brought increased political activism and recognition of interrelated social justice concerns (i.e., range of exploitation and oppression through the intersections of race, class, gender, sexual expression, and sexual orientation; Crenshaw, 1989; Shields, 2008). Iannello (2010) described the third-wave movement as “power feminism” (p. 72) due to its refusal to accept the role of women as victims.

Some argue that the 21st century evidences the entrance of a fourth wave of feminism (Baumgardner, 2011; Blevins, 2018; Rivers, 2017), claiming that “fourth-wave feminism is fractured and complex, frequently reinforcing the advancement of the individual, and centering the seductive notions of ‘choice,’ ‘empowerment,’ and ‘agency’” (Rivers, 2017, p. 24). Blevins (2018) described fourth-wave feminism as “significant [in] that young people are self-identifying

as fourth-wave feminists who are active on social media, forming groups and tackling small-scale activism” (p. 102). Thus, the fourth wave has been characterized as technology-oriented, social-media activism, and as “a ‘call-out’ culture, in which sexism or misogyny can be ‘called out’ and challenged” (Muro, 2013, p. 23). However, this current study with the participating women physicians in academic pediatrics intentionally does not explore these emerging issues and the constructs of the various feminist waves.

The evolution in the discussion of women physicians’ development seems logical for women physicians in academic pediatrics; as they achieve a degree of social, economic, and professional status, they still face the same challenges facing women in all professions and facets of modern life, and they should continue evolving with the changes in society. This study provides insights through the shared experience of the participants regarding their development.

Although the numbers and prevalence of women physicians in general and in academic medicine specifically have certainly increased (AAMC, 2021; 2022a), the literature suggests that U.S. academic medical institutions do not appear to have reached Lorber’s (1984) point wherein the patterns of the informal organization of the workplace routinely include women—as trusted colleagues, sponsored by advancement, given recognition for competence and accomplishment, and able to accrue the resources to advance their careers. (p. 112)

Thus, there is more to learn, via the framing constructs that inform the intersection of women physicians in academic pediatrics, the gendered organization, academic medical culture (see Figure 1 in Chapter 1), and through this study of the shared experience of women physicians in academic pediatrics, as indicators of progress.

Based on Lorber’s (1984) vision and this study’s research questions, how may these issues be assessed, to indicate if and how the culture of academic medicine for women physicians has really changed, to be more inclusive and respectful of the unique needs of women physicians? This exploration of the lived experience of women physicians within a specific

setting may provide some insight as to if and how women have progressed (as described by Lorber) and how their experience may inform policy change to better support women physicians in academic pediatric environments.

This chapter has provided a critical review of literature related to and informing this study of the lived experience of women physicians in a pediatric academic medical center environment, as well as the theoretical constructs related to this study and the relationships among the constructs. The literature specifically related in the theoretical constructs supports the research questions and the value in examining the lives of women in pediatric academic medicine. The next chapter examines this study's paradigmatic approach, methodology, and methods guiding the study.

CHAPTER 3: METHODOLOGY AND METHODS

The purpose of this third chapter is to describe the methodology and methods used to conduct this study. The study was conducted utilizing guidelines presented by Guba (1990), Guba and Lincoln (1981, 1989, 1994, 2005), Lincoln and Guba (1985, 1986, 2013), and Lincoln et al. (2011) for naturalistic inquiry and, as later referred to, constructivist inquiry (Guba & Lincoln, 1989). This chapter highlights this study's informing issue (problem) statement and guiding research questions; describes and clarifies the study's paradigmatic positioning; describes the need for the study and its appropriateness; presents the research methodology, participant and site selection, and data collection and analysis methods; describes the pilot study, its results, and how those outcomes influenced the full study's design and conduct; and identifies quality criteria and how the study met those criteria.

Research Need and Questions

The research need driving this study's research questions is based on academic medicine's evolution from a distinctly male-dominated professional identity resulting in a hierarchical culture that has historically subordinated women. During that evolution, the numbers and prevalence of women physicians have increased dramatically, potentially challenging academic medicine's traditional culture and hierarchy. This expanding group of women physicians must finesse or navigate both the traditional male-dominated academic culture while also managing the response of other women in traditionally gender-oppressed roles such as nursing (Group & Roberts, 2001). The specific impact of academic medicine's culture on women physicians and how they navigate that culture are not well understood.

As mentioned in Chapter 1, this study examined the following research questions:

1. How do women physicians in pediatrics describe their experience of gender in the context of academic medicine?
2. What are the participants' experiences related to their inclusion in the patterns of formal and informal organization of the workplace?
3. Can women physicians in a localized setting confirm or disconfirm that gender has been successfully defused as an issue of status in academic medicine?

For best address of these questions, it is important to frame my approach to conducting this research inquiry. The concept of paradigms is considered next, and approaches to the research discussed and rationalized.

Inquiry Paradigm

A paradigm is “a worldview built on implicit assumptions, accepted definitions, comfortable habits, values defended as truths, and beliefs projected as reality” (Patton, 2008, p. 423). Lincoln and Guba (1985) described how paradigms have particularly shaped scientific research and how a researcher’s paradigm influences numerous aspects of a study. Specifically, a researcher’s ontological, epistemological, methodological, and axiological beliefs, or axioms, comprise the basis of their paradigmatic approach to research (Lincoln et al., 2011). These axioms build upon and are interdependent with one another, and connect the philosophical beliefs or reality and knowledge acquisition to the process, posture, and methods for which the inquiry is conducted.

Per Guba and Lincoln (Guba, 1990; Guba & Lincoln, 1994, 2005; Lincoln et al., 2011; Lincoln & Guba, 1985, 2013), the ontological question asks, “What is there that can be known or what is the nature of reality?” (Lincoln & Guba, 2013, p. 37). This question can help the

consumers of research understand the researcher's stance toward the physical and metaphysical elements of the inquiry.

Epistemology comes from the Greek word *epistēmē*, meaning “skill, expertise, knowledge” (Merriam-Webster, n.d.-b), and *epistasthai*, meaning “know, know how to do” (Oxford Learners Dictionary, n.d.). In the context of knowledge and inquiry, the epistemological question asks, “What is the nature of the relationship between the knower and knowable?” (Lincoln & Guba, 2013, p. 37; also see Guba, 1990; Lincoln et al., 2011; Lincoln & Guba, 1985). The answer to the epistemological question is limited by the answer to the earlier ontological question (Guba, 1990; Lincoln et al., 2011; Lincoln & Guba, 1985, 2013).

The methodological question asks, “How can one go about acquiring knowledge?” (Lincoln & Guba, 2013, p. 37). This question is essentially a process question, constrained by the answers to the ontological and epistemological questions (Guba, 1990; Lincoln et al., 2011; Lincoln & Guba, 1985, 2013).

The final axiom of a paradigm, as stated by Lincoln and Guba (2013), answers the axiological question, “Of the knowledge available, which is most valuable, truthful and life-enhancing?” (p. 37; also see Guba, 1990; Lincoln et al., 2011; Lincoln & Guba, 1985). *Axiology* is the study of the nature, types and criteria of values, and value judgments; the term is from the Greek word *áxios*, meaning “worth, equal, of an equal status” (Merriam Webster, n.d.-a).

The impact of a paradigm is especially inherent in social science research; as Greene (1994) noted, different paradigms have different research purposes. Guba (1990) identified four inquiry paradigms: *positivism*, *postpositivism*, *critical theories*, and *constructivism*. In addition, Guba and Lincoln (2005) and Lincoln et al. (2011) identified and expounded upon the distinct *participatory* paradigm, based on the work of Heron and Reason (1997). The inquiry paradigm

of constructivism, sometimes referred to as the *naturalist* or *interpretivist* paradigm, argues that “all research is interpretive: guided by a set of beliefs and feelings about the world and how it should be understood and studied” (Denzin & Lincoln, 2011, p. 13).

Following is an overview of these different paradigmatic stances. This study of the lived experience of women physicians in academic pediatrics was approached from the constructivist paradigm and informed by feminist critical theory. As such, this overview provides the rationale for blending aspects of these theoretical paradigms for this study.

Constructivism and Critical Theory

This section provides discussion of the constructivist and critical theory paradigms, to position the study’s axioms, including its methodology and methods.

Constructivism

Constructivism, also known as interpretivism or naturalist inquiry, is anchored in five governing axioms or “basic beliefs” (Lincoln & Guba, 1985, p. 33) that provide the building blocks for a conceptual or theoretical structure or system. The axioms of constructivism explain the nature of reality (ontology), the relationship of the knower to the known (epistemology), the possibility of transferability, the possibility of association linkages, and the role of values in inquiry (Lincoln & Guba, 1985, pp. 37-38).

Ontology in the constructivist paradigm is relativist—that is, that reality is based on multiple mental constructions that exist socially and are experientially based, local, and specific, dependent for their form and content on the persons who hold them (Guba, 1990, p. 27).

Epistemology is subjective—wherein the relationships between knower and known merge, and findings are based on the process of interactions between the two. In other words, knowledge is based on the dynamics of identifying and interpreting new ideas. Generalization is

not the aim of constructivist research, as knowledge is co-created between the researcher and participant together. Instead, transferability, or the degree to which the contexts are similar and potentially applicable, is more the aim (Lincoln & Guba, 1985).

In a constructivist study, additional key concepts serve to inform the conceptual approach and development of the study, as summarized in Table 2. One key concept is that the researcher serves as the instrument (Guba & Lincoln, 1981, 1989; Lincoln & Guba, 1985) to co-construct knowledge by understanding and interpreting the meaning of the participants' lived experiences (Lincoln & Guba, 1985). A second key concept relates to the methodological process in the use of dialectical hermeneutics. Concepts developed from the lived experiences of the participants are defined hermeneutically, that is, as an unveiling through interpretation, and "compared and contrasted dialectically with the aim of generating one (or a few) constructions on which there is substantial consensus" (Guba, 1990, p. 27). Analysis in a constructivist study is driven inductively, in that theoretical categories are forged from interaction with the data, rather than deductively from predetermined hypotheses or concepts. Categories have meaning because of interaction between the data and the researchers.

Table 2. *Summary of the Constructivist Paradigm*

Ontology	Epistemology	Methodology	Axiology
Relativism–localized and specific co-constructed realities	Transactional/subjectivist; co-created findings	Hermeneutical leading to an understanding of lived experience	Propositional, transactional knowing is instrumentally valuable as a means to social emancipation, which is an end to itself intrinsically valuable

Note. Adapted with permission from "Competing paradigms in qualitative research," by E. G. Guba & Y. S. Lincoln, 1994, as cited in Table 6.1 (p. 109) in N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Sage. Copyright 1994 by Sage Publications; permission conveyed through Copyright Clearance Center, Inc.

Another critical concept in the constructivist paradigm is goodness or quality criteria. Trustworthiness of the theoretical concepts is based on the authenticity of the process and interpretation of the data. The process of goodness is reached through agreement and understanding between the researcher, participants, and other actors in the process of dialogue, shared conversation, and construction (Lincoln et al., 2011). This study explored understanding of the experience of women physicians in academic medicine at a nationally ranked pediatric institution allowing for the co-creation of understanding through the dialogue between the researcher and participants.

Critical Theory

First coined by Horkheimer (1937/2002) in 1937 (Daly, 2006; Ingram & Simon-Ingram, 1991), *critical theory* refers to a school of thought characterized by radical social theory and sophisticated cultural criticism (Ingram & Simon-Ingram, 1991). Critical theory focuses primarily on the integration of knowledge and purposeful action (Smith, 1990). Guba (1990) asserted that critical theory is “ideologically-oriented inquiry” (p. 23) that rejects the claim of a values-free role of the researcher. In critical theory, the researcher is an activist and advocate, tasked with uncovering the hidden assumptions derived from historical circumstances, traditional thought, and absolutist claims (Bronner, 2011).

Critical theory’s ontology is historically situated and shaped by context and values—which may involve social, political, cultural, economic, ethnic, gendered, and/or other perspectives suppressed by majority or traditional thought. Critical theory’s epistemology is subjectivist in that values mediate the inquiry findings wherein reality cannot be seen but through values (Guba, 1990). Kincheloe et al. (2011) asserted that “facts can never be isolated from the domain of values or removed from some form of ideological inscription” (p. 164).

Methodologically, critical theory utilizes a dialogic approach, meaning that the inquiry requires a dialogue between the researcher and research participants. The dialogic process engages the researcher and participants in a joint learning process, to increase consciousness of the world around them, and to interact and take responsibility for the development of the world (Abma & Widdershoven, 2011). This dialogue is *dialectic* in that it involves an uncovering of historically situated and subjugated knowledge of suffering and oppression through critique of the status quo, leading to a transformational new reality. Table 3 presents a summary of the critical theory paradigm.

Table 3. *Summary of the Critical Theory Paradigm*

Ontology	Epistemology	Methodology	Axiology
Historical realism– virtual reality shaped by social, political, cultural, economic, ethnic, and gender values: crystallized over time	Transactional/ subjectivist; value-mediated findings	Dialogic/dialectical	Values-laden leading to social emancipation, which is an end to itself and intrinsically valuable

Note. Adapted with permission from “Paradigmatic controversies, contradictions, and emerging confluences, revisited,” by Y. S. Lincoln, S. A. Lynham, & E. G. Guba, 2011, in N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 97-128). Sage. Copyright 2011 by Sage Publications; permission conveyed through Copyright Clearance Center, Inc.

Much of critical theory accepts a basic assumption that thought is mediated by socially and historically constituted power relations, and explores meanings that serve hegemonic or ideological interests (Crotty, 1998). As such, there are many lenses from which the relationship between power and culture through social critique may be viewed. Critical theory typically includes critical race theory, disability studies, feminism, gender and queer theory, indigenous knowledges and postcolonialism, Marxism, poststructuralism, and psychoanalysis (Hamera,

2011). Critical theory is related to critical feminist theory as feminism is one form of social critique, albeit an important one and key to this study.

Critical Feminist Theory

Feminist literature offers a framework from which to consider analysis of literature of women physicians in academic medicine. Calás and Smircich (2006) described three schools of thought related to women's condition: liberal feminist, radical feminist, and psychoanalytic. Their feminist schools-of-thought heuristic notes at the categories of intellectual roots, conception of sex/gender, conception of "the good society," epistemological positions, favored methodologies, conceptualization of sex/gender and organization, needed organizational change, and favored interventions (p. 289). The authors described how, in the liberal feminist tradition, the majority of gender-based organization literature falls under the category of women in management. Women in management literature tied to the liberal feminist tradition focuses on explanations for the continuation of organizational gender-based segregation. The literature has a positivist bent in assuming the intent of gender-neutral organizational justice through a primarily quantitative analytical lens.

Radical feminism, particularly when relating to organizations, provides a different interpretation of gender and sexuality in organizations. *Gender*, to the radical feminist, is a social construction intended to subordinate women to men. It assumes that organizations are patriarchal in nature in order to maintain gender discrimination and sexual oppression. The goal of women in organizations then, to radical feminists, is to eradicate oppression through gender separatism and empowerment (Calás & Smircich, 2006).

Psychoanalytic feminism assumes a third perspective of gender and the organization. The psychoanalytic feminist perspective perceives organizations as reproductions of patriarchal

psychosexual development and embraces the belief that organizations should have no gender structuring—valuing both the feminine and masculine (Calás & Smircich, 2006).

Both the radical and psychoanalytic feminist perspectives suggest the possibility of a different form of analysis when considering women physician in academic medicine. There is a gap in extending feminist theory to academic medicine, beyond what may be described currently as women-in-medicine literature. Although women physicians such as Brodsky (Kass, 2015; *Vineyard Gazette*, 2014) and Conley (1998) described and exposed the discrimination they experienced in the academic medical setting, much of the literature on women physicians still appears more quantitative, descriptive, and positivist in nature (Richter et al., 2020; L. W. Roberts, 2020), rather than being focused from the liberal feminist perspective. As so challenged, the strongly ingrained positivist and postpositivist nature of academic medicine (Goldenberg, 2006; Park et al., 2020; Zaidi & Larsen, 2018), with its strict cultural gendered norms, may explain why different feminist perspectives are underrepresented in academic medicine and health care in general.

Rationale for This Study

The underlying paradigm for this study is constructivism, informed by feminist critical theory. The rationale for this dual approach is explained herein from the perspective of HRD, and in light of the perspective which emerged from the pilot study (described later in this chapter), which revealed themes warranting further and deeper interpretation of the shared experience of women physicians in academic pediatrics.

Rationale From the HRD Perspective

Academics have long debated the definition of HRD, without resolution (Han et al., 2017; Kuchinke, 2010; M. Lee, 2001; McLean et al., 2008; Woodall, 2001). However, McLean

and McLean's (2001) definition of HRD resonated for me and provided the linkage of HRD with this study of the shared experience of women physicians in academic pediatrics. McLean and McLean defined HRD as

any process or activity that, either initially or over the long term, has the potential to develop adults' work-based knowledge, expertise, productivity and satisfaction, whether for personal or group/team gain, or for the benefit of an organization, community, nation or, ultimately, the whole of humanity. (p. 322)

Utilizing this definition, the study of women physicians in academic pediatrics provides the participants the opportunity to share their lived experience, potentially to inspire policy changes, and to increase their work environment satisfaction and subsequently their contribution and productivity to and within the organization.

Rationale From the Pilot Study Perspective

An unpublished pilot study conducted for my doctoral studies' preliminary examination (Wukitsch, 2012) confirmed the need for this study. The pilot study utilized a constructivist grounded theory methodology and semistructured interviews as the data collection method. Although the pilot study exposed some data analysis challenges in utilizing grounded theory methodology, it also yielded at least four themes from participants' lived experience: (a) navigating through gendered hierarchy, (b) gendering subspecialty choices, (c) managing the polarities of work-life balance, and (d) creating a supportive and relational environment (Wukitsch, 2012). These themes and their respective descriptions from participant experience support the notion that women physicians have unique experiences in gendered organizational environments worthy of further research and understanding.

Research Approach

The research methodology in the context of qualitative inquiry refers to the approach employed by the researcher in conducting the study. The approach or research design shapes the

researcher's choice and use of particular methods in order to achieve the desired outcome (Crotty, 1998). The research design for this study was hermeneutic phenomenology. Phenomenology is a complex set of ideas originating with Husserl (Husserl & Husserl, 1910/1965), and built upon by Heidegger (1962/2008), Sartre (1956, 1963), Merleau-Ponty (1962/2013), Gadamer (1978/2008), Schutz (1970), and others (Denzin & Lincoln, 2011; Van Manen, 2014). Phenomena are the appearances of, or what gives or shows itself in, experience or consciousness (Van Manen, 2014). Hermeneutic phenomenology focuses on the exploration of meaning through an interactive process of description and interpretation.

Site Selection

Based on the axioms of constructivism outlined earlier in this chapter, there is a set of entry conditions which ensure that the methodology of the study aligns with the constructivist paradigm. Guba and Lincoln (1989) asserted that in order to align with the relativist ontological perspective, the study must be conducted in the natural environment of the participant. The research site of an independent, Midwestern pediatric academic medical center provided a logical place to identify and select women physicians in academic pediatrics, both specialists and subspecialists. Practically speaking, because I lived in the area, the site location provided me relatively convenient access to participants and enough pediatric specialists and subspecialists to identify potential participants. The proximity of the site to my home also allowed access for member checking during various phases of the study.

Participant Selection

Participant selection for the study was conducted to yield the best possible data on the lived experience of women physicians in academic pediatrics. Typically, pediatric institutions are affiliated with medical schools. The chosen institution allowed for access to possible

participants due to proximity, while avoiding a potential conflict of interest in my former human resources role at a nearby adult health system. I identified a list of pediatric specialists and subspecialists available from the pediatric institution's website and/or its related medical school website. As available, age, ethnicity, class, color, specialty, and subspecialty area of each faculty participant were considered to ensure the broadest potential starting point for the study. The use of a single organization for participants ensured that "constructions [were] necessarily based on local circumstances and experiences" (Lincoln & Guba, 2013, p. 71), thus consistent with the constructivist paradigm.

Pilot Study

As part of a PhD program requirement, I conducted a preliminary, constructivist, grounded theory study at an academically affiliated pediatric hospital to understand how women physicians navigate through the complex and gendered academic medical culture (Wukitsch, 2012). The study utilized interviews for data collection and unitizing and coding for data analysis and theming interpretation.

Four compelling themes were constructed from the pilot study, and written implications of the themes were shared with faculty as part of the program requirement and course completion. The interest from study participants was significant and data from the study suggested support for further research. Challenges with the grounded theory methodology, specific to the use of coding and the methods for constructing themes, were also identified and later utilized to explore new methodologies within the constructivist paradigm for the main dissertation study. Working with the study advisor and dissertation committee, we determined that heuristic phenomenology provided a more natural method to interpret and construct themes from the participant data.

The pilot study allowed for exploration of the constructivist paradigm, qualitative research methodology, methods, and overall interest in the topic of women physicians in academic pediatrics. The theoretical constructs were revised for greater depth and the research questions were honed in order to construct more abstract and deeper interpretations. As the pilot study provided an opportunity to explore qualitative research methodology and methods, none of the data nor results of the pilot study was used in any way for the dissertation study. In addition, this current study was conducted in an entirely different location, several years later, due to a job change. The pilot study informed this dissertation study's topic and led to a refined and more organic methodology with less reliance on a strict coding regiment for theme construction. While utilizing the learning from the pilot study, this dissertation study is an entirely distinct effort.

Methods of Data Collection, Participant Sampling, and Analysis

This current study was conducted using a hermeneutic phenomenological process of data collection and data analysis, with intentional consideration of consistency with paradigmatic quality criteria detailed later in this chapter. Ethical parameters were followed, also as detailed later in this chapter, and the study had IRB approval. I provided each participant with oral and written information regarding the study and evidenced their respective informed consent in writing. This section details the data collection approach, participant sampling, as well as the methods of data analysis including transcripts, coding, categories, and themes.

Data Collection

I conducted participant data collection utilizing semistructured interviews which lasted 45 to 90 minutes. Semistructured interviews (Appendix A) served as the study's data collection method to align with the constructivist paradigm, specifically, as interviews provide useful data for interpretation and co-construction of two thematic categories and corresponding eight

essential themes. In-depth interviewing aligns with the constructivist paradigm's goal of probing for essential meaning through language in collaboration with the participants, seeking to understand their lived experiences and the meaning they make of their experiences (Seidman, 2006). In-depth interviewing method also provides an open-ended, detailed exploration of an aspect of life in which the participant has rich experience and insight (Charmaz & Belgrave, 2012). The semistructured approach created a more informal environment, soliciting direct answers to the study's research questions, while also allowing flexibility in follow-up questions and a more organic flow of the conversation with each participant.

Participant Sampling

Consistent with the constructivist paradigm, purposeful sampling was the sampling approach utilized in this study (Lincoln & Guba, 1985, 2013). Lincoln and Guba (1985), citing Patton (1980), recognized six purposes, or types of sampling that focus beyond generalization (for which statistical random sampling is utilized): extreme or deviant cases; typical cases; maximum variation; critical cases; politically important or sensitive cases; and convenience sampling. As such, the purpose of sampling in constructivist hermeneutic phenomenology "will most often be to include as much information as possible, in all of its various ramifications and constructions; hence, maximum variation sampling will usually be the sampling mode of choice" (Lincoln & Guba, 1985, p. 201). Lincoln and Guba (1985) defined characteristics of purposeful sampling utilizing maximum variation: emergent sampling design that recognizes the specific context of the studied phenomenon where "there can be no a priori specification of a sample" (p. 201); serial selection, which suggests that the selection of each participant informs the need for further information from subsequent participants; continuous adjustment of the sample for focus or refinement; and selection to the point of redundancy or saturation where no new information

is introduced (see pp. 201-202). The sampling approach for the study was considered in two phases. In the first phase, purposeful sampling (Lincoln & Guba, 1985) was used, by obtaining referrals from the physician education leader whom I knew professionally. From those referrals, I engaged in conversations with a handful of medical school faculty regarding the study, determining interest in participation, and/or inquiring about other potential participants known to the faculty member. Snowball sampling (Glesne, 2011; Lincoln & Guba, 1985) helped identify additional candidates to explore broader experiences further. Snowball sampling from key stakeholders or through the networks of earlier participants identified potentially interested participants. Snowball sampling operates similarly to social networking, in that people with a particular set of interests tend to know others with a similar set of interests. The second phase of sampling engaged in maximum variation sampling (Patton, 1980) to provide breadth for interpreting localized understanding and to bound the study. Guba and Lincoln (1989) posited that maximum variation sampling displays two characteristics: (a) samples are selected serially, wherein new participants are included only when data collection from the convenience sampling is mostly completed; and (b) the sample is conditional on the direction of the study. In some cases, additional participants may be sought to ensure saturation of ideas or to probe specific areas of the research questions.

Data Analysis

As the data collection process occurred, the data analysis phase began. Lincoln and Guba (1985) described data analysis as “open-ended and inductive” (p. 224) analysis that facilitates the “continuing unfolding of the inquiry” (p. 225) and leads to a maximum understanding of the phenomena being studied. Interview data from each participant were captured in audio recordings; prepared in written form by a transcriptionist; and then unitized, coded, categorized,

and themed. The constant comparative method provided by Glaser and Strauss (1967) and further advanced by Lincoln and Guba (1985) was used to hone the development of categories and themes constructed from participant data. These processes are detailed below.

Transcripts. The interviews were digitally recorded and the recordings provided to a transcriptionist. I reviewed and compared the transcripts to the recordings and corrected them to assure accuracy of the interviews to the actual words of the participants. Each of the participants was offered their own respective transcript, if needed to clarify any questions or make corrections to the transcripts without altering the content. However, none of the participants requested their respective transcript. My dissertation advisor, Dr. Susan Lynham, served as co-investigator for the study and was given access to the transcripts for review if needed to provide a point of triangulation in support of the inquiry's trustworthiness (Lincoln & Guba, 1985).

Coding. Codes are words or short phrases that symbolically depict the interpretive essence and/or prominent, evocative, or emotive attribute of a portion of written or spoken data (Saldaña, 2009). Each participant's interview transcript was coded using methods described by Corbin and Strauss (1990, 2008). Gibbs (2007) described these methods as three stages: (a) *open coding*, wherein the transcript text is read reflectively to identify relevant categories; (b) *axial coding*, wherein categories are refined, developed, or related or interconnected; and (c) *selective coding*, wherein the central category that ties all other categories together into a story is identified and related to other categories (p. 50). Codes were reviewed and improved upon based on (a) my comfort with the initial coding method, (b) constant comparison with each additional interview, and (c) with my co-investigator, and further as new ideas emerged from the data.

Categories and Themes. Codes were placed on note cards, sorted, and analyzed within each interview by identifying concepts constructed as either significant ideas or those that

instilled curiosity. Using the constant comparison methods provided by Glaser and Strauss (1967), described by Lincoln and Guba (1985), and advocated by Charmaz (2006), codes and ideas from each interview were compared across all of the interviews and developed into theoretical categories. The categories were analyzed further and developed into themes. The themes were shared with available participants, and with my advisor, to triangulate and further refine the themes. The themes, supported by thick and rich description, are presented in the next chapter in this dissertation.

The data analysis for the study utilized transcripts, coding and categorizing, and theming. However, the process of data analysis alone does not determine the quality and applicability of the study. Quality criteria within the constructivist paradigm, as well as study applicability, are discussed here and in a later chapter, utilized to assure study quality and relevance.

Quality Criteria and Study Applicability

Swanson (2005) defined research as “an orderly investigation process for the purpose of creating new knowledge” (p. 4). The goodness or quality of a study is determined by stakeholders’ trust inherent in the inquiry approach as well as the utility in the findings, interpretations, and outcomes (Lincoln & Guba, 1985). Quality criteria are determined by the study’s research paradigm. The research paradigm is expressed by its stance or axioms on ontological, epistemological, and methodological questions. As this study was conducted in the constructivist paradigm, the quality criteria were consistent with a relativist ontology, transactional/subjectivist epistemology, and a hermeneutic/ dialectic methodological approach (Lincoln & Guba, 2013).

This study utilized Lincoln and Guba’s (2013) quality criteria of authenticity. These criteria and inquiry methods are embedded in the axioms of constructivism. The following

subsections further explain each element of the authenticity criteria and its respective supporting method, followed by a summary of all elements.

Fairness

Fairness as a quality criterion refers to the balance of all stakeholder views, perspectives, values, claims, concerns, and voices relative to the study (Lincoln et al., 2011). Thus, competing constructions are accessed, considered, and deconstructed to shape the inquiry as emergent reconstructions (Lincoln & Guba, 2013). As the researcher, I did not *direct* the study, but instead served as a human instrument of co-construction with each of the participants. The point of fairness is to ensure that participant voices are truly heard and that the construction process is equitable.

Fairness in this study was ensured using Lincoln and Guba's (2013) methods. Informed consent procedures confirmed participant willingness to be involved in the study as well as an understanding of the study's intent, process, and potential harm. Prolonged engagement and persistent observation by me as the researcher ensured (a) building of appropriate levels of rapport and trust with each participant, and (b) focus on situational elements important to understanding the research issue (Guba & Lincoln, 1989; Lincoln & Guba, 1986). When possible, member checking was done with each individual participant to involve them in the construction process; and to test ideas, categories, and interpretations (Guba & Lincoln, 1989). In addition, I used my advisor, co-constructors, and other committee members or classmates as peer debriefers to test out and discuss my tentative analyses and/or findings (Guba & Lincoln, 1989). Member checking with participants was limited due to my relocation and subsequent job change. However, I utilized peer debriefers frequently as part of group advising within the PhD program at Colorado State University.

In the early part of the study, participants were communicated with on some initial constructions and themes and they were provided an opportunity for feedback or input. Unfortunately, feedback became increasingly difficult due to my personal and professional changes.

Ontological Authenticity

As the basic ontological presupposition of constructivism is relativism, authenticity in research requires that the inquirer and participants develop greater sophistication or enrichment in their understanding and awareness of their own constructions. Lincoln and Guba (1986) described *ontological authenticity* as “improvement in the individual’s (or group’s) conscious experiencing of the world” (p. 81).

Methods employed to ensure ontological authenticity included dialectical conversations between me as the inquirer and each participant, openness to and awareness of my own pre-understandings, development of trusting and caring relationships with each of the participants, processes to compare the researcher’s and each of the participants’ constructions, and final introspective statements of researcher’s and participants’ growth (Lincoln & Guba, 2013).

Educative Authenticity

The criterion of *educative authenticity* relates to the “extent to which individuals, including the inquirer, have become more understanding of, more sophisticated about, and more tolerant of the constructions of others” (Lincoln & Guba, 2013, p. 70). This criterion was met by using dialectical conversations, peer debriefing, and comparison of respondents and my introspective statements about understandings of others’ constructions (Lincoln & Guba, 2013). I maintained an audit trail of the constructions.

Catalytic Authenticity

Guba and Lincoln (1989) defined the criterion of *catalytic authenticity* as “the extent to which action is stimulated and facilitated by the inquiry” (p. 70). A call to action, whether in the form of assignment of accountability for action, policy, or process change, or as programmatic development, provides support of catalytic authenticity. The study findings were utilized in dialogues in the author’s workplace in order to challenge policy and processes. In a transferable setting, a leadership program specific to women in health care and including women physicians, was created and implemented to ensure dialogue and understanding of issues specific to women in the health care setting.

Tactical Authenticity

Empowering individuals to take the action the inquiry implies or recommends is the critical component of *tactical authenticity* (Guba & Lincoln, 1989). This requires that stakeholders have input into the process and a role in its emergence. This was done through methods of negotiation of data collection, interpretation, and reporting; dialectic conversations; member checking as mentioned earlier; and discussions about power which may have inhibited certain individuals (or groups) to act (Lincoln & Guba, 2013). For this study, discussions with the participants prior and during the interviews were open and negotiated and member checking was available to them, although used sparingly due to participant schedules and my personal and professional changes. However, utilizing the input that was available and recognizing the criticality of the participants’ voice remained paramount throughout the process of analysis and write up.

Study Applicability

Given this study’s basis in the constructivist paradigm and reliance on the hermeneutic/dialectic methodology, the constructions and subsequent interpretations from a

participant are applicable only to the local context in which the constructions were created. As a result, the burden of proof for transferability of the findings falls on the reader or stakeholder (Guba & Lincoln, 1989).

Thus, these various quality criteria provide the basis of accountability for the appropriate degree of systematic rigor and how the criteria were met. Table 4 summarizes these criteria. Self-assessment against these criteria is presented in Chapter 5.

Summary of Methodology

Consistent with the foregoing discussion of the research issue and questions, inquiry paradigm, theoretical paradigm and study rationale, research approach, participant selection, pilot study, data collection and analysis methods, and quality criteria, this dissertation study of the shared experience of women physicians in academic pediatrics was centered primarily in the constructivist paradigm using hermeneutic phenomenology to collect, analyze, interpret and write up the data. This study is informed further by critical feminism, intended to expose unique perspectives of women in a traditionally male-dominated, hierarchical academic environment.

The study was conducted with participants from a large, independent, academically-affiliated pediatric institution in the Midwest. Study participants were invited to take part in the study from convenience sampling initially, then through purposive sampling to bound the study and seek additional data on specific themes constructed from the data analysis.

The data were analyzed applying Lincoln and Guba's (1985) content analysis, utilizing the constant comparative process in concert with the author's quality criteria of authenticity (Guba & Lincoln, 2005; Lincoln & Guba, 1985, 2013). Themes resulting from the data analysis and interpretation are detailed in the next chapter.

Table 4. *Summary of Quality Criteria*

Criterion	Requirement	Assessment of methods
Fairness	Competing constructions have been accessed, exposed, deconstructed, and taken into account in shaping the emergent reconstructions.	<ul style="list-style-type: none"> • Informed consent procedures • Prolonged engagement and persistent observation by the inquirer • Prior explication of the inquirer's etic position • Individual and group member checking • Use of peer debriefer and post facto auditor
Ontological authenticity	Individual constructions, including the inquirer's, have become more informed, or where individuals themselves become more aware of the prior unrealized constructions until the inquiry brought them from the tacit to the propositional level.	<ul style="list-style-type: none"> • Dialectical conversations • Openness of purpose • Explication of inquirer's etic position • Caring and trusting relationships with respondents • Comparison of respondents' and inquirers' initial & final personal constructions • Respondents' and inquirers' introspective statements about their own growth
Educative authenticity	Individuals, including the inquirer, have become more understanding of, more sophisticated about, and more tolerant of others' constructions.	<ul style="list-style-type: none"> • Dialectical conversations • Use of peer debriefer and auditor by inquirer • Comparison of respondents' & inquirer's assessment of others constructions • Respondents' and inquirer's introspective statements about their understandings of others' constructions
Catalytic authenticity	Action (clarifying the focus at issue, moving to eliminate or ameliorate the problem, sharpening values) is stimulated and facilitated by the inquiry.	<ul style="list-style-type: none"> • Development of a joint construction, including assignment of responsibility and authority for action • Respondent/inquirer collaboration • Accessibility of final report to all stakeholders • Evidence of practical applications
Tactical authenticity	Individuals are empowered to take the action that the inquiry implies or proposes.	<ul style="list-style-type: none"> • Negotiating data to be collected, their interpretation and reporting • Maintenance of confidentiality and use of consent forms • Dialectical conversations • Member checking • Inclusion of representatives from all at-risk groups as respondents • Prior agreements about power • Training in accessing the corridors of power, if necessary

Note. Adapted with permission from *The Constructivist Credo*, by Y. S. Lincoln, & E. G. Guba, 2013 (pp. 70-71). Copyright 2013 by Left Coast Press (now owned by Sage); permission from Sage conveyed through Copyright Clearance Center, Inc.

CHAPTER 4: DATA OUTCOMES AND DISCUSSION

The purpose of this chapter is twofold. First is presentation of the data outcomes. Second is discussion of the categories and themes constructed from the participant interviews related to the essence of their shared lived experience as women physicians in academic pediatrics.

Data Outcomes

Eight essential themes—literally expressing the *essence* of experience—were constructed through a multileveled process (as described in Chapter 3) of analysis from the participants' interview transcripts. These constructions are interpretations of the participants' lived experiences as captured in the text of the transcripts (Lincoln & Guba, 1985, 2013; Vagle, 2014a, 2014b; Van Manen, 1990). Subsequently, the themes were sorted into two main thematic categories which inform understanding of the participants' lived experience from both agency and structural perspectives (Cockerham, 2005). The purpose of developing the two thematic categories was that with each review of the transcripts, analysis, and card sort, the experiences of the participants shared a duality of their individual perceptions, coping mechanisms, and alignment with their profession—along with struggles of navigating legacy-gendered cultural structures at the institutional level. The classic sociological issue of agency-structure (Cockerham, 2005) appeared to be playing out in the participants' lived experience and in the thematic categorization construction. Agency-structure theory explores the concept of the impact or choices of individual actions versus the influence of structures. For the purposes of this study, the structure is interpreted as the academic medical institution.

Yin-Yang Thinking

The manner in which the themes were constructed exhibited a duality of components—specifically, institutionally oriented themes in contrast to personally oriented themes. This

duality can be expressed through *yin-yang thinking*, a central notion from the Taoist religion and philosophy which “teaches us how to act in accordance with nature” (Luo & Zheng, 2016, p. 3). P. P. Li (2008) explained yin-yang thinking as endorsing “the logic of duality (opposites in unity) in contrast to that of dualism (opposites in contrast) embraced in the West” (p. 416). Yin-yang is represented in Figure 2. “The two forces are assumed to be mutually dependent and reciprocal, and they complement one another in striving to create harmony in the universe” (Craddick et al., 1971, p. 338).

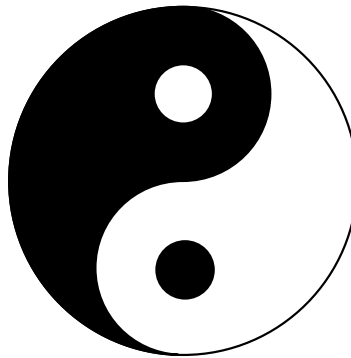


Figure 2. *Yin-Yang Symbol*

Note. The yin-yang symbol representing duality of forces. The symbol is in the public domain.

P. P. Li (2008) provided three tenets of the yin-yang duality: holistic duality, dynamic duality, and dialectical duality. *Holistic duality* requires that “a phenomenon . . . cannot be complete unless it has two opposite elements” (p. 416). *Dynamic duality* suggests that these opposite elements balance one another under various conditions. Finally, *dialectical duality* follows the logic of paradox in that “two contrary (relatively contradictory) yet interdependent (relatively compatible) elements exist as opposites in unity” (p. 416). The Chinese or Eastern approach to duality presents *in unity* as harmony—rather than the distinction of opposites in conflict—as is more pervasive in Western duality logic (P. P. Li, 2008).

Although this study is not intended as an analysis of yin-yang thinking per se, the themes constructed in this study are framed within two categories as represented in the yin-yang diagram (Figure 2). The themes as constructed satisfied the three tenets of the Eastern duality. The analysis of the themes recognizes the harmony and potential overlap among them, and categorizes them in a manner that represents the phenomenon as a synthesized whole.

The yin-yang symbol that visually depicts the two thematic categories and essential themes is used with great respect to the Chinese and Taoist philosophies. It provides a more holistic approach to depicting the phenomena as lived experience, with duality between the institutional or workplace experience and the personal or home-life experience. It is a more accurate and complex way of depicting the concept of work-life balance. A more linear framework is inadequate to capture the more complex meanings of the institutional and personal duality.

Introducing the Themes: Institutional and Personal

The two thematic categories—institutional and personal (Figure 3)—acknowledge those essential themes that are informed by institutional and organizational experiences, in contrast to (yet interdependent with) those that are more personal in nature. The two categories also suggest how the issues derived from the themes can be addressed through policy change in academic institutions, or support provided for individual contexts (Dey, 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985; Torrance, 2011). The institutional structures, and the cultural components that support and sustain those structures, influenced the manner in which participants navigated their organizations and influenced their personal decisions to either conform to or diverge from their organizations. However, there are also personal issues that women physicians in academic pediatrics experience and try to cope with which are independent

of their organizational structures. An introduction to these personal themes follows those of the institutional themes.

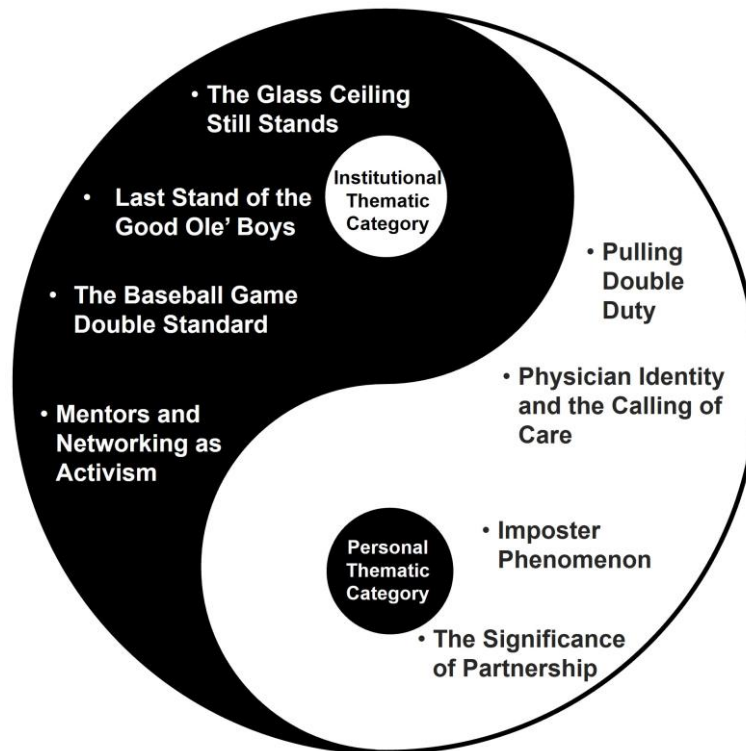


Figure 3. *The Essential Themes in the Institutional and Personal Thematic Categories for Women Physicians in Academic Pediatrics*

The institutional themes explore academic pediatrics’ cultural reluctance to accept women into the fabric of institutional power—a point that Lorber (1984) claimed was necessary to eliminate discrimination in health care. The four essential themes in the institutional category are as follows:

- **The Glass Ceiling Still Stands:** This theme describes and explores the participants’ experience of the lack of women in senior leadership positions, their importance in influencing organizational culture and specifically their role supporting junior faculty and their unique needs.

- **The Last Stand of the Good Old Boys:** This theme describes and explores the participants' experiences of the challenges they encountered in navigating the gendered hierarchy and traditional structures of medical academe.
- **The Baseball Game Double Standard:** This theme describes and explores the participants' experiences of double standards, role expectations, and traditional gendered norms permeate women's roles at both home and work and how they managed those expectations.
- **Mentoring and Networking as Activism:** This theme describes and explores how the participants utilized mentors, professional and social networks, and growing self-advocacy to prepare themselves for leadership roles and the challenges they faced in their organizations.

In contrast to the institutional themes, the personal themes point to the challenges this study's women physicians in academic pediatrics had experienced in establishing new values for themselves in the social patterns of work (Lincoln & Stanley, 2021; McKinsey & LeanIn.org, 2021; Pololi, 2010; Pololi et al., 2012; Sandberg, 2013 [with Scovill]). Often, these women physicians in academic pediatrics were conflicted between managing their personal lives, dreams, and career goals and their feelings of inadequacy and the reality of women still managing their children and home-life disproportionately—even with strong spousal or partner support. The four essential personal themes are as follows:

- **Pulling Double Duty:** Describes the participants' shared challenges of managing work and home life as well as disproportionate child-rearing responsibilities, which in turn influenced how they experienced their work organizations.
- **Physician Identity and the Calling of Care:** Describes the participants' shared experiences of purpose, professional identity, and norms in providing meaning; also describes how participants' professional identities as physicians—and specifically pediatric physicians—influenced their priorities and how they chose to experience their organizations.
- **Imposter Phenomenon:** Describes the participants' feelings of inadequacy, self-doubt, and perfectionism as barriers in navigating their work lives.
- **The Significance of Partnership:** Describes the importance of participants' spousal or partner support as a key coping mechanism for managing the challenges of their work.

Figure 3 is a representation of both categories and their respective essential themes. The figure visually represents the dualistic, yet interdependent, relationship of the institutional and personal themes. The institutional themes underscore the influence of structures that “empower and constrain social action” (Sewell, 1992, p. 22) and represent the challenges these women physicians in academic pediatrics navigate working in the academic sector. The organizations and culture of academic pediatrics provide the structural boundaries within which these participants work, and influence their home lives. As the yin-yang diagram (Figure 2) denotes, the participants’ academic pediatric organizations influence how they operate within those organizations’ structural boundaries, whereas their individual lived experiences in turn influence their work experiences and organizational dynamics. These institutional themes can be impacted through changes in policy, culture, and climate (Daniels et al., 2009; Grigsby, 2009) of academic pediatric institutions, as discussed in Chapter 5. The personal themes cluster around the participants’ own choices and intentions as women physicians in academic pediatrics, and how they can find greater fulfillment in their changing work worlds, which in turn will challenge existing norms and bring about Lorber’s (1984) vision of “the establishment of new values which reflect the needs and priorities of all members of society—female and male, old and young, rich and poor” (p. 115).

Discussion of Institutional Themes

This section describes the essential institutional themes constructed through the analysis process from the participants’ shared experience. These themes represent different institutional boundaries which this study’s women physicians in academic pediatrics have had to navigate, and these themes point to the structural issues in need of address in academic pediatrics in order for women physicians to feel truly equal.

The Glass Ceiling Still Stands

We had this crisis management course, and they divided us into small groups, and I was the only woman in this group with three or four guys. And when you speak, it's as though nobody listens. (Participant D)

The metaphor of the glass ceiling, often attributed to Marilyn Loden in 1978 (Vargas, 2018) or Katherine Lawrence in 1979 (Zimmer, 2015), describes an invisible barrier to the career advancement of women—the biased judgments women collectively experience in attempting to ascend to leadership or other advanced roles (Isaac et al., 2011). The metaphor of the glass ceiling has been used in popular media, and business management, and academic literature (Powell & Butterfield, 2015).

The specter of the glass ceiling and its existence in the shared experience of this study's participants was evident—although in more subtle ways. Participant C explained one of the new forms of the glass ceiling in action:

Almost nobody in the Department of Pediatrics is on the tenure track. Tenure-track, I think, for all practical purposes now, is you're just guaranteed to have a job, right? If you get on the tenure track, but I think even if you are on the tenure track and you get tenured—that potentially you can still get, not have a job anymore if you don't have funding. But tenured-track people have to be able to bring in a lot of grants. I just don't think that's the name of the game anymore, at least in our department. The only ones that I think are tenure track now are the basic science people. (Participant C)

The process of tenure and decrease in tenured positions over the last 40 years provide good examples of how women are kept out of the influence structure of academic medicine. Tenure, a promotional process that grants an indefinite academic appointment, is essentially advancement into a special class of academics with safeguarded academic freedom and economic consistency (American Association of University Professors, 2019). The American Association of University Professors (2019) confirmed that the percentage of tenured faculty within the U.S. academic labor force has declined to 21%. In academic medicine, specifically, tenure-track clinical faculty dropped from approximately 60% in 1984 to 30% in 2010 (Mayer et

al., 2014). However, the rate of decline for women is faster than that of men (Mayer et al., 2014). This decline means that untenured academicians are less protected in both economic terms (indefinite appointment) and academic freedom. The reasons for this decline vary, but include increased dependence within academic medicine on the generation of clinical income along with declines in grants from the National Institutes of Health (Xierali et al., 2020). However, research does indicate that “women are particularly disproportionately represented in non-tenure-track academic jobs” (Rennane et al., 2022, p. 13; see also Franks et al., 2022).

Paradoxically, as tenure is disappearing in academic medicine, the prevalence of women on a new *clinical-educator* track is increasing. Mayer et al.’s (2014) research findings showed that 77% of the U.S. medical schools offering the clinical-educator track had a higher proportion of women than men full-time faculty; in contrast, only 20% of schools with the traditional tenure track had a higher proportion of women than men.

Ironically, this drop in overall tenure opportunities has occurred during a time when women have overtaken men as new matriculants in academic pediatrics and as career and family issues have become more complex. These complexities that many women physicians in academic pediatrics must consider include child-rearing duties, coping with illness, and other family concerns (Dyrbye et al., 2013; Ely & Meyerson, 2000). For example, one participant recovering from a serious illness was impacted by the full-time “requirement” for tenure from her institution:

The promotion and tenure committee realized that I was part-time, and so the first letter I got . . . (the promotion and tenure process is very long, it takes like a year and a half). The first letter I got was congratulating me on being a clinical assistant professor, and I had already been an assistant professor. So, basically, I got a demotion to clinical assistant professor at the time that I submitted my application to be promoted. I thought, “Okay, not only have they turned me down, but they have reduced me to this.” But at the time, the only thing a part-time person could be was a clinical; the clinical came in front like you weren’t considered really an academic at all because you didn’t work full-time.

They have gotten rid of that now, but still part-time people are treated as not as invested and serious about what they do. (Participant B)

Apart from the previous full-time requirement, the overall reduction of traditional tenure track positions did not seem to be concerning to the participants in this study. One participant explained her perspective on traditional tenure track specific to her family situation:

I am not on the tenure track and that's fine with me. I don't know what tenure means anymore for physicians. It's kind of an obtuse sort of thing. I think it depends, from institution to institution. Having kids has definitely changed the way I work. (Participant P)

None of the participants in this study was on a traditional tenure track. In addition, none seemed concerned with any negative implications or consequences for themselves as women physicians in academic pediatrics. Some saw the transition away from tenure track as positive, in that it allows for greater career flexibility, a less demanding timetable for research and publication, and less rigidity around promotion (Mayer et al., 2014). It was clear that the half or so of the participants on the clinical-educator track saw the new track as positive for them, as it aligned with their passion for teaching and allowed greater flexibility with their schedules and home-life needs. However, the new track does raise the question as to how voices in academia are heard—and specifically women's voices. It is curious from a gendered organization perspective that this change in tracks is occurring in academic medicine at the same time that women are overtaking men in admission to medical school (Woods et al., 2018). It will take some time to understand if the development of the clinical-educator track limits or increases the influence of women in the institutional power structure of academic medicine. If clinical education is viewed as equally valuable and both women and men on this track rise to positions of influence, that would suggest that women in academic medicine will have broken through at least an element of what has constituted the traditional glass ceiling. However, if the clinical-educator track is not a real or perceived path to leadership, then the medical academe may be

playing bait and switch—trading one gendered hierarchical structure for another. In that case, the result will be the same: fewer women rising to positions of power and influence in academic pediatrics.

The Last Stand of the Good Old Boys

It's something very, very subtle, but I've been in medicine long enough to recognize it when I see it, and to sidestep it I hate to tell you this, but (this institution) is known to be the bastion of White male dominance. (Participant D)

As noted in the discussion of the previous subtheme, *The Glass Ceiling Still Stands*, the much-discussed glass ceiling is still a barrier for women physicians in academic pediatrics, even though the prevalence of women has increased significantly. Despite their increased prevalence in academic pediatrics, women physicians are still challenged in navigating the gendered hierarchy and traditional structure of the medical academe—a structure still dominated by men, and a structure that avoids the uncomfortable issues of class, race, and ethnicity. The euphemism of the “good old boys” resulted from listening to the study participants and analyzing their transcripts. Good old boys, in this context, refers to the gendered alignment that men have utilized to explicitly and implicitly set the rules for how the organization will run—including who is included and what is acceptable and unacceptable (Alvesson, 2013). As academic medicine has historically been governed by men (Bowman, 2002; Pololi, 2010), the introduction and development of women into academic pediatrics positions them as *others* (Prasad & Prasad, 2002). So, although the prevalence of women in academic pediatrics has increased, the good old boy network is alive and well—although perhaps more subtly. Participants in this study noted that the good old boys, or *boys club*, still exists in academic pediatric medicine in a number of ways, and is perpetuated by cultural norms such as dress, office space, participation in national meetings and research symposiums, and even, still, in the selection of subspecialty. These

cultural norms serve as barriers to an atmosphere of equality and provide additional layers and barriers for women physicians in academic pediatrics to navigate when working in academic pediatrics.

As demonstrated in the data which follow, organizations dominated by good-old-boys or boys-club thinking utilize a number of methods and practices to maintain gendered cultural norms that disproportionately keep men in power. These include style of dress, office space, professional groups, subspecialty choice, and pay practices, each discussed in more detail below. In addition, specific challenges for women of color in a good-old-boy atmosphere are discussed.

Dress as a Symbol of Power. Academics at national meetings wear a “uniform,” as Participant A noted—and the most perceived-to-be-distinguished academics are typically older men:

You walk into a meeting and all the men are in their bow ties and they are all older. They are all venerable and impressive and sometimes they walk and they can be a little bit arrogant; you know neurologists can. It’s just the nature of some of us. (Participant A)

Two issues are notable in Participant A’s description. First, this participant specifically mentioned the bow tie as a symbol of seniority and honor. Secondly, she referred to “us” in describing neurologists as arrogant. Thus, the specific symbol of arrogance falls strictly on the older, male physician, but she still wanted to identify as being part of the neurology group. The bow tie is somewhat particular to the male physician. It is differentiated from the regular tie more associated with business, and serves as a symbol of venerability. There is no equivalent symbol of dress for women physicians and especially those in academic pediatrics. One study indicated that male physicians wore these ties to avoid passing on potentially harmful bacteria, and to reduce the temptation of precocious children from pulling on them (Frei, 2015).

Ironically, research has shown that ties, including bow ties, carry harmful bacteria regardless, and that patients are ambivalent to the professional dress of their physician (Hueston & Carek,

2011). However, the bow tie also symbolizes a place in the hierarchy of physicians. It is seen more frequently on academic physicians and suggests an unquestioned degree of respect and expertise. Given that the bow tie is worn distinctly by men, women cannot participate in this dress-as-respect program. The good news is that with all of the studies noting the risks (e.g., Frei, 2015; Gartmeier et al., 2019; McGovern et al., 2010; Shabbir et al., 2013), physician dress has moved toward “business casual.” Although a dying symbol, older male physicians in pediatrics (and in other specialties as well) still cling to the venerable bow tie and have used it to exclude the importance and voice of women in professional groups. The participants in this study, like those in other areas of medicine (Billick et al., 2022), seemed keenly aware of these symbols and their representation of traditional power in the academy.

However, progress is occurring for women, as the dress code in academic pediatrics is changing. More institutions are moving to casual dress to reduce infection risk, and to appear more approachable by patients and children. The physician’s white coat remains the distinctive status symbol to differentiate the physician from most other care providers (Blumhagen, 1979; Karnieli-Miller et al., 2013). The coat, viewed as a status symbol with clearly identified organizational affiliation, provides a hierarchy of sorts in the academic hospital setting. From my own experience, some hospitals do not provide these coats to independent physicians and those from non-employed physician practice groups as a way to delineate the degree of affiliation. However, the coat itself is unisex, and although still a symbol of physician hierarchical power, it is no longer an exclusive differentiator between men and women.

Office Space. Another symbol of the systemic devaluation of women physicians in academic medicine—one difficult to ignore—also arose with one participant: the issue of office space. As an administrator, I am aware of the challenges of having enough space for physicians, as well as other providers and administrators. However, the situation described by one participant, a board-certified neurologist, showed a clear gender-based standard in the distribution of office space:

So, my colleague and I are sharing a space, and they wanted to put two other people in here, and I said, “Well, the other two male child neurologists have their own offices, nice large offices, by themselves. Why aren’t they doubled up?” (Participant A)

Participant A had described herself as shy, and struggled with voicing her opinion in a way that was not perceived as too assertive. It would have been easy for administrators to take advantage of her personality style in determining the allocation of office space rather than using a more transparent method. It is possible that male physicians in academic pediatrics would not have been placed in this situation. Was it based on seniority, or the assumption that the women physicians were less likely to insist on their own space? Why were the female pediatric neurologists expected to share office space when their male colleagues were not? Perhaps, the administrative decision-makers were blind to the potential appearance or perception of gender discrimination.

It is as if the women physicians in academic pediatrics should be grateful for the office space at all, whereas the men would require or expect their own space. This discrimination against the women physicians in determining office space provides an example of how women often suffer from distributive injustice.

Theories of distributive justice focus on the ways, means, and outcomes of scarce resource allocation among groups or individuals (Roemer, 1996). Folger (1977) suggested that the outcome of the distribution of resources like office space may be fair when different

members receive benefits at the same rate proportional to their contributions. In other words, equivalent contributions equal equivalent benefits. However, the possibility that both of the male neurologists were contributing disproportionately higher than both the women was not clear. The apparently unjust situation placed the women physicians in academic pediatrics in a moral dilemma—accept the decision as-is, supporting the apparently gendered hierarchy without understanding the rationale—or speak up and risk being seen as difficult.

Additionally, the distribution of visible artifacts and symbols such as office space sends a message to others in the organization about the perceived comparative value of different physicians. Intentionally or unintentionally, Participant A being placed in shared space versus her male counterparts reinforces a gendered hierarchy and perception of success. Senge (1990) described the organizational system archetype, “Success to the Successful” (pp. 385-386), in which competition for resources and support results in one individual or group becomes successful whereas the other struggles. From a gender perspective, the office space situation with Participant A symbolizes a perception of status and success with male organization members clearly positioned at the top.

As noted in this and the previous subsection, dress and office space were two areas in which the study participants experienced the continuation of the good-old-boys’ behaviors and preferences. A third area that participants experienced, the good-old-boys’ network, relates to gendered dominance in professional groups.

Dominance in Professional Groups. National meetings provide a venue for sharing research findings and establishing reputations as experts in the various medical specialty fields. Although many of the meetings are held in person, some are held via video conference or phone. Despite more women in the various medical specialties, attendance is still disproportionately male—and the men seem oblivious to the lack of female participants:

So, I do a lot of research, so a lot of my interactions during my typical research days are, you know, with research studies that I'm actually leading or participating in. But more often leading, and there's a cadre of physicians that are part of them. And a lot of that is very give-and-take intellectual conversations and thoughts, and very collegial . . . I realized I was the only woman in that group of about 10 people. This is all by phone, because it's a national group, and I very methodically brought in other women to that group. Due to, you know, if we come up with a new idea of their interest. I brought in men to that group—but I've sort of pointed out where we need to, you know, bring in women without pointing out to them that there are no other women. (Participant F)

Although this study's participants noted that gender played less of a role when men and women of the same age group participated in professional groups, one noted that senior male academic physicians are still typically viewed as superiors, even when older women participate in the groups (Participant G). In these settings, the boys club perpetuates—with uniforms, academic demeanor, and the historical patriarchal structure of academic medicine. It is clear that younger women physicians in academic pediatrics, although clearly established in their own right alongside their male colleagues, still feel inferior to the more established and older male academics. They feel more comfortable around the older women physicians who have paved the way before them:

I think pretty much everyone in our group is like, between 30 and 40. Mostly my age, I mean. We've all known each other for a long time, so I don't think there's much of a difference between men and women in that scenario. I think probably there is a difference—I want to say there isn't—but I think there is a difference with some of the older male physicians, I think. Probably in that I feel a little more like they are my superiors, like, you know, I think if there was a senior woman and a senior male physician, I would feel more comfortable with the woman, if that makes sense. (Participant G)

Women physicians in academic pediatrics rely on other women to create comfortable spaces for them to explore these historically male-dominated professional settings, build relationships with similarly aged colleagues, and develop their own professional voices. This also suggests that as the post-baby-boom generation begins to exit leadership roles in professional organizations, the newer generations experience less gendered professional cultures. It is also interesting to note that although the president of the American Academy of Pediatrics (2019; the largest professional organization for pediatrics) was a male at the time of this writing, both the incoming president and immediate past presidents were women. This study's participants were unaware of some of these symbolic changes in the structures of the national professional associations. However, the perceptions of this study's participants that national professional organizations are still heavily male-dominated suggests that the visibility of women physicians in academic pediatric leadership remains problematic and up-and-coming women physicians in academic pediatrics need to see a more inviting atmosphere in these organizations.

Like professional dress and office space, professional organizations provide another example in which a gendered hierarchy still exists. These areas are visible symbols of the male-oriented good-old-boys' hierarchy in academic pediatrics. Further exploration of gendered hierarchy exists in the choice of subspecialty itself, in academic medicine, and academic pediatric medicine specifically. This subtheme is discussed next.

Choice of Physician Specialty and Subspecialty. Specialty and subspecialty choice is very important in academic medicine, and in physicians' careers in general. Specialties are disciplines within medical practice that focus on a defined group of patients (e.g., family medicine or pediatrics), disease states (e.g., cancer), bodily systems (e.g., gastroenterology, otolaryngology), or specific skills (e.g., radiology, pathology), and require specific medical

education (“Medical Specialty,” 2024; see also Cassel & Reuben, 2011). Specialization can be categorized as family medicine, internal medicine, general surgery, obstetrics and gynecology, pediatrics, along with dermatology and radiology (Bunton & Henderson, 2013). Cassel and Reuben (2011, p. 1172), utilizing criteria adapted from American Board of Internal Medicine’s (Blackwell et al., 2006) report on point, described a subspecialization (or subspecialty) as representing a unique body of knowledge that cannot be fully incorporated into the parent discipline; a distinct clinical practice, based on and contributing to the research base of medicine; offering evidence that the discipline improves patient care; requiring supervision and direct observation in formal training settings; involving complex technology or specific site-of-care skills; and having positive value for certification in the new discipline (Blackwell et al., 2006, pp. 6-7).

In medical school, physicians rotate through various subspecialties and choose a practice specialty prior to residency. There are at least 19 medical specialties (Cassel & Reuben, 2011; St. George’s University School of Medicine, 2021). In addition, physicians may select a subspecialty that requires advanced and specific training for part of the body. Pediatrics, the practice of medicine on children, is a medical specialty, whereas pediatric neurosurgery would represent a subspecialty.

Historically, women physicians tended toward medical practice in a cluster of specialties and subspecialties including pediatrics, public health, child psychiatry, pathology, and dermatology (Boulis & Jacobs, 2008, Lorber, 1984). Lorber (1984) found that women were encouraged to enter these specializations due to their high patient interaction and compatibility with women’s interests in people. Women were also steered to other specialties that allowed for working hours more compatible with family responsibilities, such as pathology and

anesthesiology. In the 1970s, for example, over 65% of all U.S. women physicians were in pediatrics, public health, child psychiatry, or internal medicine (Bluestone, 1978). However, this gender-oriented typing practice often showed the prevalence of men in the higher revenue-producing areas like surgery, cardiology, and orthopedics. Physician pay in the higher revenue-producing areas tends to be higher (Boulis & Jacobs, 2008; Kane, 2023).

Today, rise of the hospitalist role also has a tendency toward gendered typing. Hospitalists in pediatrics provide for and coordinate care for children in the hospital setting. They bring together different specialists and/or subspecialists to coordinate the care plan for the child. They do not have patients that see them per se. Instead, hospitalists manage the care for their patients while on shift, and hand off to another hospitalist when they go off shift. They provide more of a navigator or coordinator role, and do not have expertise in a specific organ or bodily system. They also do not conduct research. As such, and due to the nature of how they work, they are often seen as “less than” the expert subspecialists.

The 16 participants interviewed for this study were either in the general specialty of pediatrics or in different subspecialties within pediatrics (Table 5). This study’s selection criterion did not focus on subspecialty, instead focusing on securing a sufficient number of willing participants in academic pediatrics. The study participants came from general pediatrics and a fairly wide range of subspecialties within pediatrics. The inclusion of experiences of participants spanning this variety of subspecialties supported the construction of a theme related to physician specialty in pediatrics and its perceived perpetuation of the boys’ club.

Participant I described her role as a pediatric hospitalist and her observation of the gendered nature of the role:

So, I think it’s hard being, like, a generalist in the hospital; and I think subspecialists and proceduralists [typically critical care physicians who perform nonsurgical procedures

such as intubation, paracentesis, and thoracentesis] are more men in this hospital and [its] leadership. So, it's hard to know whether . . . it's the chicken or the egg. Why are they that [more often subspecialists and proceduralists]? Is it because they are men or because that's the career they like? Who knows which came first, kind of thing? But I think the result is, most of the hospitalists are women. Like, there are fewer male hospitalists, whereas if I was in, maybe, cardiology or GI [gastroenterology] or, like, if I were a surgeon. I think even in pediatrics there are more male [subspecialists]. So, by virtue of that, we are not only at the bottom of the totem pole from a medical standpoint, but also from a gender standpoint, and there are a lot of issues, and I'm sure you've heard this, maybe, from others in our division. (Participant I)

Table 5. *Study Participants by General Pediatrics or Pediatric Subspecialty*

Pediatrics or Pediatric Subspecialty (<i>N</i> = 16)	<i>n</i>
Cardiology	2
Critical care	1
Emergency medicine	3
Gastroenterology, hepatology & nutrition	1
General pediatrics	1
Hospitalist	3
Medical education	2
Neonatology	1
Pediatric neurology	1
Public health & medicine	1

Participant I clearly asserted that hospitalists are at the bottom of the hierarchy based on both their subspecialist role (i.e., hospitalist) and the fact that they are women. She questioned how it got that way—because of the nature of the role, or the issue of gender? She later described how she, as a hospitalist, had been ignored by the surgical care team and questioned if the snub was due to her role or her gender:

But about [a typical day interacting with other academic pediatric subspecialists], getting consults, or doing certain things or work, or asking questions, or having somebody do something for you. Or like a surgeon coming. I don't know what it would be like if I were a man, but, like, when I am in the obs[ervation] unit downstairs, like I'll ask . . . we'll be co-managing a surgical patient. And, like, the whole team will come walking by . . . and see the patient, and then just, like, leave. And I don't know if they would or wouldn't come talk to me if I were a man, or is it just, they just don't really talk to the [nonspecialist] pediatrician? (Participant I)

These behaviors of the specialists toward the pediatric hospitalists have elements of both role hierarchy and gender, yet most likely, they are intertwined. The specialists see their role as superior to the hospitalists—the specialists complete a higher degree of training and often are attached to research, whereas hospitalists are navigators for the patient. Hospitalists focus less on specific clinical expertise, and more on process optimization and ensuring that the patient's care is coordinated throughout their hospital stay. Jones and Whatley (2016) reported that women hospitalists comprised an estimated 33% of all U.S. hospitalists in 2016, but their percentage was growing at a faster rate than that of male hospitalists. Herzke et al. (2020) confirmed this, and found, in their study of hospitalists in academic medicine, that the numbers of faculty women and men were approximately equal, but 80% of hospitalist leaders were men versus 20% women, and 37% of male hospitalist leaders were professors, whereas no female leaders were professors. Although status, social power dynamics, individual personalities, and exogenous factors appear to play a role in how physicians treat one another (Conrad et al., 2010; Leape et al., 2012b; Vanstone & Grierson, 2022), women are faced with the challenges of navigating these hierarchies, seemingly more so than men.

Like dress, office space, and professional organizations, subspecialty demonstrates yet another example of the good-old-boy atmosphere with which women physicians in academic pediatrics have to contend. Those organizational challenges are difficult enough, but another area of significant challenge is unequal compensation in academic pediatrics.

Unequal Pay. The boys' club is also still prevalent in medicine as a whole, academic medicine, and academic pediatric medicine, due to the compensation differential between men and women. A number of this study's participants understood this as their reality. In more general terms, the subject of equal pay for the same or similar work has received significant attention in the last decade (Aragão, 2023; U.S. Government Accountability Office, 2023), and specifically in medicine (Catenaccio et al., 2022; Hoff, 2021; Lin et al., 2021; Lyons et al., 2021; Whaley et al., 2021). A study by the Institute for Women's Policy Research (2018) found that full-time females made only \$0.82 for every dollar earned by male counterparts. Blau and Kahn (2017) found that many of the traditional explanations for the wage gap continued to explain the differences. However, a study by Lo Sasso et al. (2020) regarding starting salaries for male and female physicians found that specialty choice and hours spent in patient care could explain approximately 60% of the gap in salaries. Even with extensive statistical analysis adjusted to account for a number of variables, Lo Sasso et al. suggested that workplace biases—whether intentional or unintentional—affected pay for women. One of the most traditional explanations (outside of education levels) is the quantitative percentage representation of women in traditionally male occupations, as well as gendered roles and gendered divisions of labor. Specifically, Blau and Kahn noted how “current research continues to find evidence of a motherhood penalty for women and a marriage premium for men” (p. 49), as well the challenges of dual-career families and location of the family, dependent on which spouse's career is viewed as the priority. If the woman is the trailing spouse or “tied mover” (p. 25), her pay may be decreased and not reflect the appropriate experience or job skills.

This current study's participants were well aware of the gender gap in their academic pediatric organizations. Participant H noted the blatant differences in her compensation versus that of one of her male colleagues:

I found out that one of my male colleagues, who is a couple of years ahead of me, his starting salary was higher for a job that was exactly the same in theory. Which was like, I am sure that there is some reason on paper or something, but that felt like a really obvious thing that was not really fair. (Participant H)

Participant I, a hospitalist, noted the existence of a hierarchy in salaries, with hospitalists at the bottom of the academic structure. In describing a conversation with her husband, Participant I mentioned how her choice of subspecialty impacted her earning potential:

I chose [to be] a hospitalist in an academic center, right? So I mean, even if I was a general pediatrician doing, like, well-child checks and vaccines . . . in private practice, you could make at least \$250K, \$300K if you're a partner. And that is not where we are. (Participant I)

Another participant, Participant K, was hopeful about where pay equity is headed, now that more women are represented in pediatrics. Notably, however, she did not say that women were at pay equity yet:

I think [I'm] trying to be optimistic about this time in medicine for women. I mean, when you compare to the number, the percentage of women, I mean, in pediatrics or even just in medicine in general to where it was even 20 years ago, were almost half of the or over half I think of physicians. And so, knowing that the numbers are there now and I think the mentality and the pay equality and everything that comes with that is hopefully coming soon after. (Participant K)

Participant K acknowledged the pay schemes that were based on productivity, that is, the number of patients a physician sees on a given day: "I think, in a lot of the outpatient settings, it's very productivity-based, and so whether you're a male or female, it's how you work and how many patients to see" (Participant K). Although Participant K noted the change in pay schemes in the outpatient setting as being based on productivity, and thus suggesting greater equity, productivity-based pay may still disadvantage women

who may have a disproportionate role in managing domestic activities and children. The productivity-based pay scheme can leave women with a difficult choice: equal compensation or management of the family.

Women physicians may also be disadvantaged in productivity-oriented compensation schemes due to the relational aspect of their roles. Women physicians and women patients both tend to prefer meaningful interactions, as “gendered expectations shape health care interactions and experiences” (Kilminster et al., 2007, p. 44). These expectations may come from the patient’s gendered expectation of care (Linzer & Harwood, 2018; Schmittiel et al., 2000) or by “gender-socialized values” (Ku, 2011, p. 223). As a result, women physicians tend to place more emphasis on the overall patient experience, and tend to practice in specialties that are more consultative rather than procedurally oriented (Ku, 2011). This emphasis on the experiential side of care may require more time with patients than the highly procedural and standardized aspects of medicine. What this approach means is that patients expect more time spent with women physicians during the typical visit (Rouse et al., 2020) which may lead to lower volume-based productivity, subsequent inadequate performance metrics, and, in turn, compensation for the physician (Butkus et al., 2018).

Issues of Intersectionality and Barriers for Women of Color

Organizational inequality has been defined as the “systemic disparities between participants in power and control over goals, resources and outcomes” (Acker, 2006, p. 443). Intersectionality considers inequalities relative to categories of gender, ethnicity, and class (Acker, 2006; Crenshaw, 1989) that “mutually constitute, reinforce and naturalize one another” (Shields, 2008, p. 302). Crenshaw (1989, p. 140) stated that “the intersectional experience is greater than the sum of racism and sexism,” and analyzing it is necessary to understand how

women of color are particularly marginalized. It is difficult, then, to explore issues of gender without considering the intersectionality of gender with ethnicity and class as well.

Babbitt (2013) provided recommendations for researchers related to intersectional content and challenged researchers to increase the representation of people of color in their research. This current study had a diverse group of participants ($N = 16$), all women physicians in academic pediatrics, self-identified as nine White, one Black, two Latina, one Asian, two Asian-Indian, and one multiethnic. However, although acknowledging the challenges of intersectionality, the interviews and subsequent data analysis focused more on the challenges of gender, specifically, in the academic pediatric sector.

Although admittedly rare for this study's participants of color, some did comment on the added challenge of proving themselves to patients, and sometimes coworkers, who might perceive a woman physician of color as less intelligent. The participants who described this experience seemed to downplay intersectionality issues pertaining to treatment by coworkers or administrators, but the issue of *patient* discrimination emerged as potentially more significant:

I think it [perception of patient discrimination] is a bit different because you kind of have to, I guess, I mean, I am an intelligent person, but I think I have to reveal my intelligence in a bigger way than other people. You know, kind of like pulling things out of the air in terms of statistics and studies. So, it seems like I'm well-read but sometimes you've got to put that in there so that they will realize you're well-read. (Participant A)

Another example pointed to the assumptions that both patients and staff make regarding women of color in hospital roles—demonstrating the continued prejudice that women of color cope with on a regular basis:

I would say it's [prejudice is] probably even more acute with Black women than it is with White women for, absolutely for sure. For me, they assumed I was the nurse; a Black woman they might assume they are the environmental services. Seriously, absolutely, or a Hispanic woman they might think of her as a translator. (Participant B)

Yet another example reinforced the ethnic issues between physicians and patients of color. This difference in how patient ethnic groups are treated spilled over to assumptions people make of physicians of color:

Because institutions would not like to think of themselves as racially divided or racially unfair, but they are, and [in] people, there is subtle bigotry and there is overt bigotry. And in medicine, you probably don't see overt bigotry. You can't, because as a doctor you have to deal with multiple populations. But even in our practice, sometimes, you would have a parent come in who is articulate and well-read, and they would demand things, and what we saw in our group is people were giving in to these people, and yet, you know, an African American patient with the same problems and the same risks [is] treated differently. (Participant D [multiethnic])

Although women of color are well represented in this study, their reluctance to make patient discrimination a larger issue may have been due to their affiliation with a nationally recognized institution, or may have required greater probing by the researcher to better capture their experiences. The point is that if they know that prejudicial assumptions are happening with patient groups, then it is likely that women physicians of color are coping with it too, and have learned to adapt or ignore it. Interestingly, as physicians, they are taught to provide care regardless of gender, sexual identity and orientation, ethnicity, socioeconomic status, and other factors. However, it seems ironic that they still experience degrees of prejudice from the institutions and patients that they serve.

Again, the participants of color did not necessarily indict their institution for overt ethnic discrimination which they personally experienced. They seemed to feel that the undercurrent existed, suggesting that the issue of ethnicity and related discrimination is not openly discussed, regarding the physicians themselves and their patient populations. The recent rise in discussions related to the social determinants of health, the need for greater “cultural competency” (see Abrishami, 2018; Brottman et al., 2020; Flores, 2000; Khanna et al., 2009; S. E. Lee et al., 2020; Sue, 2006; Williams, 2007), and the increased prevalence of women physicians of color,

collectively, may begin to break the ice on the subject of ethnicity in medicine. However, it is clear from this study's participants that ethnicity and intersectionality with other inclusivity dimensions are still not openly discussed in the academic pediatric atmosphere. Their described experiences suggest the need for further study from a critical perspective.

Only one participant openly self-identified as LGBTQIA+, and described their experience as highly positive and without feelings of prejudice or discrimination by their colleagues or the institution. Although their experience was encouraging, it also suggested to me that further probing specific to the LGBTQIA+ experience, beyond the scope of this current study, would be needed to provide a more thorough understanding of related barriers and challenges. Having described and discussed the second institutional theme of The Last Stand of the Good Old Boys, the next section turns to the third theme in the institutional category.

The Baseball Game Double Standard

We just got into this whole conversation about the way in which women apologize for everything, and men do the same thing and do not apologize, and no one is offended by it. But when women do something similar, if you are not apologizing, people think that you are cold or insensitive or, you know. So, it's a little bit of a double standard.
(Participant K)

Strains of male-oriented cultural expectations still permeate behaviors in academic pediatric medicine. Study participants noted from their experience how certain behaviors by men are considered normative and acceptable, and often overlook the different needs or expectations of women. Double standards, gendered role expectations, and gendered norms continue to permeate women's roles at work and home, challenging some of these women physicians in academic pediatrics to manage their roles more intentionally and with greater complexity. When these women physicians in academic pediatrics have behaved outside of cultural norms, they reported often being expected to apologize for doing so, as Participant K shared above.

Participant G described a particularly frustrating experience she had regarding attendance at department meetings:

I recently took a role as an Associate Program Director, and there are two other Associate Program Directors, both men, and then our Program Director. Our boss is a woman and the three of them have been doing these roles for a long time. I just started 3 months ago, and we have a weekly meeting every single Monday from 1 o'clock to 4 o'clock, and it's very much set like, "This is very important. You will be there at every meeting. This is pretty much the main part of your job because we cover all the residency related stuff that day." So, I kill myself trying to make it to these meetings. It would have been great just to not go to this 3-hour meeting, and I made it. I got there and the Program Director, the woman, she was like, "Oh, just so you know, sorry the other two males, they are going to bail (out) today because they are going to the (local baseball team) game. They just decided to go an hour ago." And I was, like, livid and everyone was just laughing about it. They were like "Oh, those two!" Call them Bobby and Jimmy or whatever. "Oh, that's just Bobby and Jimmy. Don't worry." (Participant G)

There may have been a good reason that the woman leader was complicit in permitting the men to miss their department meeting to attend a baseball game. However, the meetings were supposed to be important and required; the decision to attend the game was made at the last minute, but it was permitted even though the newest team member, a woman, went to great lengths to attend. The double standard was not necessarily harmful or blatant per se; however, it did reinforce the power dynamics and hierarchy of the men—technically equals in position power—on her team. It is these seemingly innocent actions that men take for granted, but the women physicians like Participant G recognize as inhibiting. Participant G's experience is a "game" in which she is in a quandary. She reported that, had she been vocal in her critique of her male colleagues, she would be seen as trite, and likely "punished" for pointing out this double standard. The men would have likely supported each other, and in turn appealed to the female director, who would have been in a dilemma: she could side with her male subordinates to secure her place as the team's leader, or support her female subordinate and risk her place in the social hierarchy.

This situation exemplifies the challenges that some women physicians in academic pediatrics face as participants in team dynamics. Do they challenge existing group norms that favor the needs and behaviors of men? And risk ostracizing themselves or being ridiculed for highlighting gendered norms? Do women leaders side with existing norms—especially since those norms may have helped elevate them to their leadership positions? Women physicians in academic pediatrics, as newer team members or as leaders, have to navigate such cultures very thoughtfully, whereas their male colleagues are likely to do less so.

Another point related to the institutional theme The Baseball Game Double Standard is that the women physicians in this study did not seem to have anything similar, in terms of acceptable social gatherings that are permitted to circumvent work priorities. This is not to say that the women did not enjoy professional sporting events, but for men it was assumed to be acceptable. Could a different type of social gathering directed at women be prioritized over an important department meeting? As Participant G stated later, “If I just said, hey, I think I am going to just go get a massage or a manicure or something like that, that would never be okay. Nobody would certainly be laughing about it, right?”

Having described and discussed the third institutional theme of The Baseball Game Double Standard, the next section turns to the fourth institutional theme, namely Mentors and Networking as Activism.

Mentors and Networking as Activism

Some of the people who have provided mentorship for me in my research world—those kinds of interactions, I think—have been influential to me. (Participant P)

The study participants deeply appreciated the role that other women physician leaders in academic medicine played in supporting their careers. Whether as formal or informal mentors or coaches, the study participants valued having women leaders within their organizations who

shared their experiences and helped them cope with and navigate the academic pediatrics culture. The participants also valued the support their mentors provided in career development as well as in strategies for managing dual-career situations and childcare.

For purposes of this dissertation, the terms *mentoring* and *coaching* are used interchangeably. Although there has been debate as to differences in applications of these terms, both mentoring and coaching share a similar nature and draw on notions from humanistic philosophy and the human potential movement (Garvey et al., 2018). The human potential movement, led by C. Rogers (1951), drew on the notions of person-centered therapy and self-help that influenced current coaching practice and methods.

Relationships with other academic women leaders, either through more personal coaching and mentoring, or via experience in professional networking groups, provide women physicians a platform in which to discuss their challenges, and learn from others who have experienced and navigated academic medicine before them. In the process of engaging with other women physicians, this study's participants reported having discovered their voices, which in turn built their confidence to challenge traditional norms—especially gendered norms. This discussion focuses on the different means by which this study's participants engaged with other women leaders through mentors, networking, and formal professional development programs.

Mentors. Mentors for this study's participants played critical roles in helping up-and-coming women physicians learn to navigate the organization. In negotiating for a new job within the institution, one participant tended to lead with family needs and limitations on her work schedule. This approach was putting her at a clear disadvantage:

So, when I am interviewing for a job, and when I am saying, “X and X hours, and I can do this or I can do that,” a lot of what I say is, “I have a 2-year-old at home. I am trying to figure out what I can do, and I want to do it well.” Interestingly, Joan [a pseudonym]

across the hall, she tells me this, she says, “You don’t even have to bring that up. Why is it you feel you have to bring that up?” (Participant E).

Participant E’s experience exemplifies the value of mentors and advisors for women physicians. For one, it is important for women with longer tenure and greater influence and power to help more junior women physicians navigate the cultural expectations of their organizations. How would a woman physician know that it is unnecessary to bring up child-rearing-based limitations in an interview? Would a male candidate bring up the same issue? Only another woman physician who has participated in conversations related to candidate selection can understand the impacts of a candidate being forthright about schedule limitations or other personal concerns. Also, women physician leaders understand, through the experience of interviewing male and female candidates, that men are less likely to bring up the issue of schedule limitations due to child care. These limitations influence the selection process, and shift the focus from qualifications related to knowledge, skills, and abilities to one’s limitations and personal needs. That shift almost always disadvantages the woman physician with domestic or child-rearing responsibilities. Women mentors provide the guidance to ensure that up-and-coming women leaders focus their interviews on their qualifications and contributions, not their limitations or work-life-balance needs.

In Participant D’s experience, her boss (and department chair) served as a mentor who helped her learn how to build a significant subspecialty program. Her situation changed when her boss left to pursue a promotion:

I was the Medical Director of the unit here. I had a boss, who was a fantastic boss. She gave me opportunities and I worked with her. I came into the program when it was a very, very small program and I knew that she wanted to build this program. I supported her through that, helped her, anything, and we worked together. When she left, it was this huge program . . . and then it was given to someone else. I knew from the moment I met [the new director] that he was uncomfortable with me. (Participant D)

Participant D's department head was invested in her, and when she left, so did that support. This participant also felt that her director's replacement was uncomfortable serving in a mentoring role:

When I first started, I had [two higher level mentors here, which] was fantastic. I would go to [one of them] if I had any problems. [Each of them had extensive experience in these roles.] [They were phenomenal, and . . . were my two support systems. Now they have both left, so who do I have? Actually, I don't. I sort it out myself. (Participant D)

The value of a mentor relationship in providing a support system was apparent with this and other participants. The sense of loss shared by this participant was profound and suggested that more formal programs would be beneficial to women physicians, especially earlier in their careers.

Networking. Professional and social networks and growing self-advocacy are empowering women in their work and organizations. The support they receive in these areas is significantly meaningful in changing their self-awareness and ability to deal with and exercise political voice within their institutions. Lorber (1984) noted that "women must act politically as a group in order to defuse gender as a status" (p. 112), and she feared that

when women have succeeded in forming effective "old-girl" networks and in placing representative numbers of women in existing institutions, they will relax their efforts or disband entirely. Women will still need support from other women if they are not to be co-opted. (p. 114)

This study's participants described networking as critical in connecting women physicians in academic pediatrics to share their unique experiences in the traditional academic arena, find commonality in research interests, support career development, and advocate for a greater influence in academic medicine.

The women physicians in academic pediatrics in this study recognized the importance of participating in national professional networking and advocating for themselves to ensure their voices are heard in academic medicine:

You can form your own network, or you can be like me, a loner. There is this concept of the insider and outsider, right? So, until the new chief came, I was the insider, and now I'm the outsider. (Participant D)

National networking creates the avenue for women physicians in academic pediatrics to share their experiences, and develop support and advocacy for their work and accomplishments. Some of these groups already exist, such as the American Medical Women's Association (2024), Association of Women Surgeons (2023), the American Association for Women in Radiology (2022), and the related American Association of University Women (n.d.). Most of these groups exist within the framework of larger specialty organizations.

In 2007, Brodsky (Kass, 2015; *Vineyard Gazette*, 2014) founded WomenMDResources (2024), an organization initially dedicated to creating a progressive health care workplace for all women physicians, and subsequently an expanded dedication "to creating a progressive healthcare guidance for all women" (About Us). Brodsky had experienced discrimination firsthand, resulting in three related federal gender-based discrimination and Equal Pay Act lawsuits with two employers. Brodsky was a pioneer in specifically recognizing the unique needs of women navigating medical careers and providing resources to them. A number of networking organizations exist for women physicians, which would include women physicians in academic pediatrics. These and other groups provide an opportunity for women physicians in academic pediatrics to increase their networks and enhance their professional development.

Leadership Development Programs. As women physicians in academic pediatrics become more focused on self-advocacy for their development, they are also becoming more intentional in how they choose to manage their careers and position themselves for future leaderships roles. A number of this study's participants recognized their own potential and affirmed their interest in leadership.

Leadership development programs specifically designed to support women physicians in academic pediatrics are becoming more prevalent and have been supported by their institutions. These programs have had a tremendous impact in helping such women address their own self-doubts and find their own unique voices:

I think that program helped me, like, learn my own leadership type, in learning how to have my own voice and being able to speak up. Now I speak up during meetings and, you know, because you kind of assumed that sometimes research is more important than clinicians, but we need clinicians out there, otherwise the world would fall apart. So that's why I learned a lot more over the years to realize my own value. (Participant A)

Women physicians in academic pediatrics who are engaged in mentoring, networking, and formal development programs serve as activists for the role of women in positions of influence in academic medicine. This study's participants, earlier in their academic careers, recognized the power of community with other women physicians, and saw these relationships as a means to develop their voices and position themselves for leadership roles in their respective institutions.

In developing their own voices, it is noteworthy that women who network, and are mentored and sponsored for development, are more likely to provide the same opportunities for others (Ragins & Cotton, 1993). Woods et al. (2018) supported that contention, noting that "advocating for mentorship is essential because empowered women empower women" (p. 21).

As Participant P stated,

There is another woman physician, a leader physician who does a lot of work in research. And she is like, "I try to lift up all the people around me. Because the more I lift up everyone around me, the more everything elevates." And I think that's another really important lesson that I've learned. I think that's a little bit about paying it forward too. (Participant P)

The need for ongoing support of up-and-coming women physicians in academic pediatrics is still evident, as are the need for encouragement of women to serve as support for one another, along with organizational support for participation in professional groups.

Beyond the personal support and professional growth that mentoring, networking, and professional development programs offer, they also provide a platform for activism in challenging cultural norms and addressing perspectives pertaining to women specifically. This activism is critical in ensuring that women physicians are heard, and their needs addressed throughout their institutional career paths.

As discussed next in this dissertation, four personal themes were constructed from the interview data. These personal themes address specific challenges that this study's participants faced at the intersection of professional work-life and personal life. Mentors, networks, and professional development programs offer the platform to address this intersection, as discussed in Chapter 5.

This section explored academic medicine's cultural reluctance to accept women into the fabric of institutional power through the four institutional and four personal themes. The next section focuses on the personal themes, which point to the challenges this study's women physicians in academic pediatrics faced in establishing new social patterns of work.

Discussion of Personal Themes

This section turns to discussing the personal categorical theme and its four essential themes. As was mentioned at the beginning of this chapter, as women physicians in academic pediatrics, the study's participants were often conflicted between managing their career goals and demands along with their roles as the primary players in their domestic lives—managing their children and homelives disproportionately—even with strong spousal or partner support. The four essential themes, Pulling Double Duty, The Power of Physician-ness and the Calling of Care, Imposter Phenomenon, and The Significance of Partnerships highlight these conflicts and challenges.

Pulling Double Duty

Now I am pregnant. So, now I think differently. It was more like thinking, I guess, like a man would. Like ‘Oh, I don’t have to worry about child care, going home; doing all of those kinds of things.’ But now I kind of think differently. I understand . . . the stress of trying to do more than one thing. (Participant A)

Work and life harmony are a real challenge for women professionals today. The complexities in balancing work-life and home-life demands are quite prevalent for women physicians in academic pediatrics. Based on the interviews with this study’s participants, the challenges that they face in managing their work and home lives influence how they experience their work organizations and vice versa. Women physicians are forced to manage challenging careers with disproportionate domestic duties, unequal responsibility for child-rearing and domestic duties, while simultaneously trying to grow their careers (Jolly et al., 2014; Spector et al., 2019; Tawfik et al., 2021). Interestingly, participants in this study seemed to accept their dual roles—grateful for their spouse or significant relationship—while still owning the role of primary caregiver to their children. The importance of the supportive relationship is addressed in a later theme, *The Significance of Partnership*.

However, it is also clear that this study’s participants paid a “motherhood penalty” (Correll et al., 2007, p. 1298), in that their ability to advance their academic careers, especially into leadership roles, was hampered by their decision to have children. It is ironic that, in a profession specifically focused on the health and well-being of children, the children of the care providers are perceived in the academic pediatric culture as a barrier to professional advancement:

All of our work time, [which] had been the mix of days, evenings, and weekends, switched to all evenings and weekends. That was really challenging, because childcare really is only mostly available during the day; and young infants are very difficult to put in childcare because they have to be a certain age . . . to put them in childcare; and I had

to go back to work in 6 weeks [after having the baby] and no daycare center takes a child at 6 weeks. I already mentioned I have no family. (Participant B)

Balancing motherhood with work is challenging enough (Kane, 2020; McKinsey & LeanIn, 2021; Mobilos et al., 2008), but Participant B did not have family nearby to help her care for her infant, and was working evenings and weekends when childcare was unavailable. Scheduling for clinical physicians is multifaceted, to meet requirements of patient care (Erhard et al., 2018). The challenges of physician scheduling in general include staffing for optimal workforce size, rostering for optimal assignments to shifts over specific time horizons, and replanning issues related to unexpected events or problems (Mansini & Zanotti, 2019). Although women academic physicians may have some influence in their scheduling due to their specialized training and skills (Erhard et al., 2018), this study's participants faced challenges unique to them: managing their work scheduling around motherhood (as Participant B highlighted), and making career decisions based on their motherhood. Participant P made a clear choice in not attending networking and professional opportunities or working more clinical hours due to her motherhood commitment:

[I] turned down a lot of professional opportunities or conferences because I didn't want to leave my kids. How my clinical schedule looks has been greatly influenced by having kids and wanting to be there at night when they go to bed. (Participant P)

Participant P clearly experienced an example of the *motherhood penalty* and made the choice to place her career as second to her family's needs. In a conversation with a male colleague,

Participant A did not hear of him having to make the same choice:

I remember one of my colleagues I said one time, "Well you know, don't you want to be home for dinner with your family?" And he says, "Well you know, the children don't need me as much as they need their mom." I said, "No, that's not true. They need a dad just as much. Yeah, they need you. You are just as important." And he didn't understand his importance I guess A lot of the men were there late as well . . . but the female physicians and the nurses were always gone. They had to do things at home or with the children, so that's the kind of thing a man does. Because maybe in that aspect he didn't have to rush home. (Participant A)

Participant A's male colleague was able to put his career choices ahead of his family based on his own gendered perception of his children's needs and perhaps his own experience of the institution's perceptions for men versus women. Participant A had to manage both work expectations and family needs, and may have felt a degree of resentment that her male colleague did not have to balance both.

The challenges of trying to manage motherhood and work-life in the academic pediatric hospital or clinic setting require some women physicians to find childcare. For study participants, they were challenged in finding babysitters or nannies that could support their long work hours:

Having kids has definitely changed the way I work. I had my kids by myself, so I had two kids as a single person, and then I got married. And my work process changed a lot. Like, I had to leave at a certain time, because I had to get home to get the babysitter out because she had been there since 7 o'clock in the morning. So, a lot of that changed when I became a mother. (Participant P)

Another aspect is the additional expense that single mothers and mothers in general need to cover in finding appropriate care for their children. Although women physicians in academic pediatrics are better positioned economically to be able to afford childcare, the challenges of selecting and managing it usually falls on them (Jolly et al., 2014; Starmer et al., 2019). The cost of childcare, however, is also a financial consideration, as Participant I explains:

[My husband and I have] talked about me with my salary . . . because we have a nanny and we have daycare . . . for our 3-year-old. And we still have an 18-month-old, so these would be the two and . . . post-tax, and no daycare, no nanny; I barely make more than that. We pay the nanny and the school and the taxes for the nanny He feels very strongly about my career. He is like, "You need that. You would be a disaster if you stayed at home." (Participant I)

In the case of Participant I, she is in a dual-income situation with a non-physician male, and this couple chose to utilize a nanny over traditional childcare. So, although this woman physician in

academic pediatrics is in a generally higher than average socioeconomic status, based on her salary, the decision regarding childcare still falls primarily on her.

No single-parent physicians participated in this study, but it is like that childcare issues for single parents are even more severe. The participants in this study, with the exception of one, were straight women in marriages. Eight of the participants were married to physicians and eight were married to nonphysicians.

This personal theme of Pulling Double Duty points to the challenges these women physicians in academic pediatrics had in balancing work and family needs. They had also faced decisions regarding prioritizing career growth or family responsibilities and childrearing. Even though half of the study participants were married to physicians (who appeared to understand the career requirements and shared some duties), they still carried the bulk of domestic duties and made a disproportionate set of sacrifices. The next section moves from the work-family challenges to the second personal theme, related to the unique professional identity of women physicians in academic pediatrics.

Physician Identity and the Calling of Care

I really wanted to take care of kids. Adult medicine was never super exciting, like, appealing to me. I think it was [that] I enjoyed being around children. I like[d] some surgical-type stuff in medical school, but I'd rather do surgery in kids if I was going to do surgery anyway Everybody really comes to work in a children's hospital that wants to do the best that they can for kids, and that's what they come to work with wanting to do every day. (Participant H)

Being a woman physician in academic pediatrics is a unique and special occupation. Those in such occupations operate as social identity groups in that “a group uses a social category (group) to define . . . themselves” (Alvesson, 2013, p. 37). These social identities can be expressed through occupations and in turn create occupational cultures (Alvesson & Billing, 2009; Pololi, 2010). Occupational cultures include “focusing on identity issues around who we

are and what is distinct for us and what we identify with” (Alvesson, 2013, p. 38). As illustrated in Figure 4, Hofstede et al. (2010) noted how occupational culture is a mix of values and practices, and broke out various levels of culture and their balance of values and practices. Hofstede et al. used “the terms *practices* for answers about culture ‘as it is’ and *values* for answers about culture ‘as it should be’” (p. 43). Occupational culture (such as physician culture), then, is balanced equally between the values and practices, and aligned to the “kind of education chosen” (p. 347). In essence, Hofstede et al. suggested that the education for an occupation influences values and practices, and thus occupational culture, and this can apply to medical education or physician training.

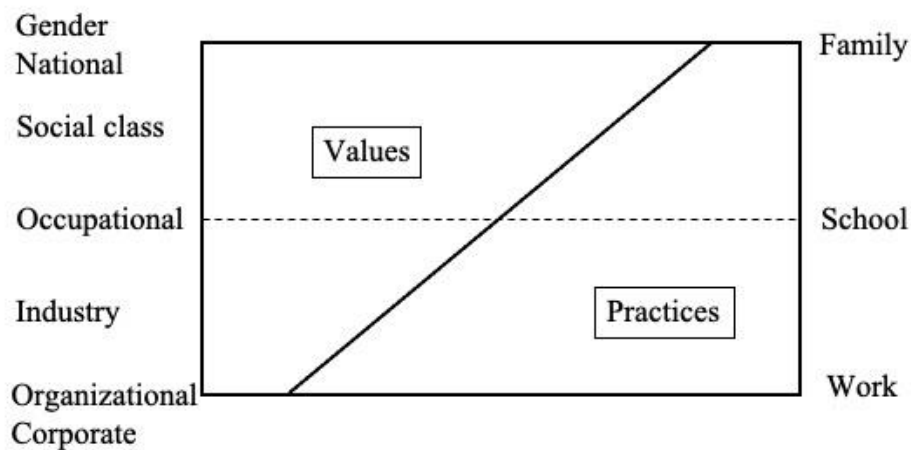


Figure 4. Hofstede et al.’s (2010) Balance of Values and Practices for Various Levels of Culture

Note. Used with permission of McGraw Hill LLC from “The Balance of Values and Practices for Various Levels of Culture,” Figure 10.1, by G. Hofstede, G. J. Hofstede, and M. Minkov, M., in *Cultures and Organizations: Software for the Mind* (3rd ed., p. 347). Copyright 2010 by McGraw-Hill; permission conveyed through Copyright Clearance Center, Inc.

Merton (1957), in seminal work, discussed specifically how medical education links to occupational culture, stating that the purpose of physician training is “to transmit the culture of medicine and to advance that culture” (p. 7). Education thus serves two purposes: to provide both medical knowledge and skills, along with “a professional identity so that [one] comes to think,

act, and feel like a physician” (p. 7). Although the gendered nature of Merton’s 1957 work is problematic, the notion of physician professional identity as embedded in medical school applies across the gender spectrum.

More contemporary scholars such as Cruess et al. (2014, 2018) have suggested a theoretical framework of medical education as a “community of practice” (Lave & Wegner, 1991, p. 111), emphasizing learning as a situated, social practice. Barab et al. (2003) defined *community of practice* as “a persistent, sustaining social network of individuals who share and develop an overlapping knowledge base, set of beliefs, values, history and experiences focused on a common practice and/or mutual enterprise” (p. 238). Cruess et al. (2018, p. 186) supported Barab et al.’s definition as “appropriate for medicine.” Communities of practice as defined by Barab et al. and supported by Cruess et al. suggest a strong link between medical education and identity formation, which in turn influences occupational culture. This linkage is important when considering women physicians in academic pediatrics and the context of their occupational culture and identity.

In considering occupational identity, the process of becoming physicians in academic pediatrics has been described as a *calling* due to the moral motives and more societal ends that the work serves (Gustafson, 1982; Jager et al., 2017; Serwint & Stewart, 2019; M. T. Stewart & Serwint, 2019). Kao and Jager (2018) found that 87% of medical students in their study specializing in pediatrics agreed or strongly agreed that medicine is a calling. In pediatrics, the nature of the work involves caring for the most vulnerable, and academic pediatrics provides a place where physicians are exposed to the broadest possible range of cases and the potential to participate in or access research in support of their cases (Olympia, 2021). This calling was

significant for the participants in this study as it provided for them personal meaning and a sense of purpose aligned with a strong occupational identity (Gustafson, 1982).

The shared experiences of this study's participants included purpose, professional identity, and norms which provide meaning for these women physicians in academic pediatrics. The participants' professional identities as physicians, and specifically pediatric physicians, influenced their priorities and how they experienced their organizations. Regardless of background, this study's participants were consistent in their compassion and desire to help children (values) while working in a profession that provided them purpose and meaning (practices).

Thunborg (1999) provided a theoretical framework that informed the interpretation of physician identity components in this study. Thunborg's framework for physician identity distinguishes three levels: (a) occupational level; (b) operational level; and (c) individual-related level. The *occupational level* focuses on characteristics that are common to the medical physician profession. The *operational level* includes "characteristics emerge that can be related to the different care units in which the staff groups work. There are thus differences that have to do with the content and organization of the activities" (p. 222). Finally, the *individual-related level* assumes "that there are differences between staff [physicians] that are independent of activity and occupation" (p. 222). These levels are present equally or differently with each other and "interact as the formation . . . into a profession" (p. 222). Thunborg continued, noting,

[T]here is a relationship between the professional and the operational level that is central to the formation, maintenance and development of professional identities. It is at the operational level that actors must translate their profession into practical work, while at the same time the business has its own way of functioning. Thus, these levels affect each other. At the same time, it can be assumed that there is a contradiction between these levels. (p. 222)

Andersson (2015), building upon Thunborg's (1999) framework, clarified that at the occupational level, "the basis of physicians' work is medical science, which they should use to make competent medical decisions. Their decisions are made using their judgment, implying a high level of autonomy and individual responsibility" (p. 87). Andersson also described the operational level, as

the activity-related level, which, on the one hand, focuses on differences in physicians' identities because of division into subspecialties, meaning variations in activities. However, similarities between subspecialties mean that physicians' activities are self-governed to a higher extent than in other professions. (p. 87)

Finally, Andersson posited that the individual-related level "concerns how far the physician has come in [their] career. The more experienced tend to be more involved in research, education and clinical development. Common to all three levels is the "endeavour for professional fulfilment" (p. 87).

For purposes of this current study's analysis, Thunborg's (1999) model, aided by Andersson (2015), was adapted further, to include the relational aspect of medicine as constructed from this study's participants' shared experiences. Thunborg (personal communication, March 1, 2024) gave me permission to build upon the theoretical framework. Figure 5 illustrates four supportive aspects of physician identity including science/academic achievement, procedural, career and status, and relational. In the adapted model, Thunborg's (1999) level of occupation identity is reinterpreted as scientific/academic achievement to note the knowledge required for medical practice and licensure—as well as research requirements for some in academic medicine. Thunborg's (1999) operational and activity-related level acknowledges the procedural nature of physician subspecialty and self-governing practice. Career and status refer to Thunborg's (1999) individual-related level and its focus on career. The additional fourth area of physician identity, relational, acknowledges the importance of the

physician-patient relationship as well as those within medical teams, practice partners, administrators and other stakeholder relationships (Dudley et al., 2022; Krupat et al., 2000; Levinson & Lurie, 2004; Pololi et al., 2009).

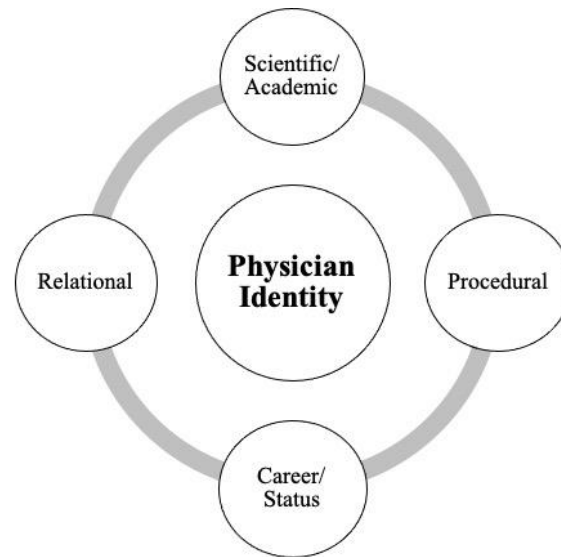


Figure 5. *Interpreted Components of Physician Identity*

Note. Adapted with permission (C. Thunborg, personal communication March 1, 2024) from “Figur 10:1. En sammanfattande analysmodell över hur yrkesidentiteter lärs i samspel mellan tre nivåer” [Figure 10:1. A summary analysis model of how professional identities are learned in interaction between three levels], p. 221, by C. Thunborg, 1999, *Lärande av yrkesidentiteter: En studie av läkare, sjuksköterskor och undersköterskor* [Learning occupational identities: A study of physicians, nurses and assistant nurses]; Doctoral thesis, Linköping University, Sweden]. <https://um.kb.se/resolve?um=urn:nbn:se:liu:diva-143154>, p. 221.

Participant P provided a good example of how she described her identity in the context of procedures:

And sometimes I will do a procedure and I’ll be like, “Oh, I feel like such a doctor today.” The other things that I do that are very doctory, I guess; you know I make a lot of medical decisions, so I guess that’s all very doctory (Participant P).

To Participant P, the term *doctory* alluded to notions of physician identity, and specifically the procedural and medical decision-making part of the physician’s work.

Conducting procedures on live human beings is a unique practice that differentiates the physician

from other occupations. Often, the procedural aspect of physicians' work is seen as gendered and associated with the more masculine connotation of medicine because of the gendered segregation of medical specialties. In contrast, women have been underrepresented in the procedure-intensive areas such as surgical subspecialties, orthopedics, cardiovascular and gastroenterology (Boulis & Jacobs, 2008; Kane, 2020). Participant P's use of "doctory" has an almost uncomfortable tone and hints at her own acceptance of proceduralists as more acceptable as doctors than hospitalists or other more coordinative or consultative areas of medicine. As Pelley and Carnes (2020) posited,

women are likely to be seen—by themselves and others—as a better fit for specialties viewed as requiring stereotypically female-gendered attributes like being nurturing and valuing relationships, while for men this sense of fit occurs for specialties viewed as requiring stereotypically male-gendered attributes like technical skills and physical strength. (p. 1501)

The areas of medicine that are less procedural or operational in nature fit in the physician identity component of relational. The relational aspect of medicine is more associated with women due to women's higher percentage representation in areas of medicine such as pediatrics, obstetrics and gynecology, psychiatry, and infectious disease among other areas (Boulis & Jacobs, 2008; Pelley & Carnes, 2020).

The women physicians in academic pediatrics who participated in this study had diverse backgrounds and influences regarding their choice of pediatric medicine and academics. They had diversity in age and ethnicity, yet limited in sexual orientation. However, it became clear in hearing their voices that the identity of the pediatric physician had meaning to them and supported their interests, values, and life purpose.

Participant C explained why she chose pediatrics as a specialty:

I like working with kids. I have done it my whole life, pretty much. I like the fact that kids are resilient. So, you can have a child that's ill one day, and 2 or 3 days later they are smiling and happy. (Participant C)

Earvolino-Ramirez (2007) described the outcomes of resilience in adolescents and children as “effective coping, mastery, and positive adaptation” (p. 78). For example, Participant C appreciated the coping and positive adaptation of children as they can be ill and then present as “smiling and happy” days later. The resilience of her child patient allows her to witness the outcome of care, affirming her ability to create happiness and a better life. Put simply, this participant was able to make a difference in the life of a child. Participant C pointed to the relational aspect of being a physician as an important part of her identity.

Participant C also focused on prevention as a means to creating higher quality of life for the child and reducing health inequities: “I really liked the prevention aspect. The thinking about the big picture and how . . . the social determinants of health and . . . how they affect family and people’s lives” (Participant C). Participant C saw herself as supporting “the big picture” in reducing social determinants of health in which inequities with patients result from factors such as ethnicity, gender, and socioeconomic status. Due to these factors, patients receive less access to quality care, leading to higher incidence of disease and other health conditions. Participant C’s ability to support “prevention” challenges these unjust traditional health inequities due to socioeconomic factors like ethnicity, gender, and socioeconomic status. For Participant M, the notion of prevention referred first and foremost to access to quality care for socioeconomically disadvantaged child patients, and the scientific aspect of her own identity:

I never really, truly owned any other idea, and in fact went to medical school to be a pediatrician. I have just always loved working with kids. I find grown-ups to be a little bit whiny, and I’m less empathetic towards them, right? It’s perfectly natural for a 2-year-old to yell at you, but it’s not for a 41-year-old to yell at you. I just have much more patience with children. I am not a terribly patient person otherwise. (Participant M)

Again, the relational aspect of connecting physician identity (i.e., the honest reciprocal relationship with child patients) was described as part of Participant M’s motivation to be a physician:

From a really early age, probably about 7 or 8, I knew I wanted to work with kids . . . which is kind of weird, because I was a kid myself. That was sort of what I was drawn to and so . . . I was either going to be a doctor or a math teacher was sort of my plan early on. (Participant H)

Participant H intimated the notion that as a child, she could relate to other children, and that relationship influenced her desire to work with children. However, Participant H also showed an interest in the scientific aspect of her interests, in identifying both mathematics and medicine as her career interests. It seemed that she chose medicine, in part, as a means to support her scientific and relational interests.

Participant H also identified another relational aspect of her identity as a physician: that of working with others of similar positive motivations to help children. She explained:

Because what we do is hard, but it makes it a whole lot easier to know that, like, everybody around you is really motivated to, like, it's hard to have bad motivations in a place where there are sick children that you're trying to take care of, so. I think that's a big part of it. (Participant H)

Participant H identified as a physician primarily out of her ability to relate to children, as well as the motivations of her coworkers. She did not share her interest in status, career growth, or her procedural interest in medicine. Instead, her motivations were based on her primary identity as physician through relationships with patients and coworkers.

Participant L's physician identity began as a patient, due to a car accident that cemented her interest in becoming a physician. She explained:

I got hit by the car. The paramedics arrive[d]. What they did on the scene was the most incredibly painful experience I will ever remember . . . [They] brought me to one ED [Emergency Department], [and] decided that I was too sick for that ED. Brought me to another ED. Then it was a community hospital where pediatrics was small . . . and from the beginning, I was going to be a pediatrician. That was the plan. It was a small ward of an adult hospital and every aspect of what was done to me and done to the children around me, it just didn't seem like that's how you should treat kids. And that they just . . . like the nurses were very kind, but the processes, it didn't seem right. It just didn't seem like it was the best way to have done things. (Participant L)

As Participant L expressed her personal experience in the pediatric ward in an adult hospital, she recognized the procedural issues in caring for patients. Her “painful” experience, and that “every aspect of what was done to me and done to the children around me . . . didn’t seem right,” point to her empathy for others and concern for the process of care. Participant L’s personal experience shaped her identity as a physician through the lens of a terrible experience—and in turn, she recognized the need to create a more positive experience of care for children. So, although her identity was tied to her procedural interests, she was also clearly influenced by the relational aspect of care and the physician’s role in it.

Participant G summarized the increasing importance of the relational aspect of medicine versus the scientific and procedural components of physician identity:

I think I realize more and more that there is not always a right answer, and more about the art of medicine rather than the science of medicine, and the *interpersonal part of medicine* [emphasis added] and the ambiguity of medicine. (Participant G)

The participants in this study strongly identified as pediatric physicians. Their connection to their patients—as vulnerable, relatable, and resilient children—is unique in that few participants identified with the procedural or clinical parts of their jobs. They described even less about career and status concerns. Instead, this study’s participants most identified with the vulnerability of the patients themselves, and the relational aspect of caring for children. Levinson and Lurie (2004) suggested that the feminization of medicine would change care itself by placing greater emphasis on patient-centric care. Patient-centric care was described by the Institute of Medicine (2001) as having “qualities of compassion, empathy, and responsiveness to the needs, values and prepressed preferences of the individual patient” (p. 48). This concept emphasizes the relationship between the physician and patient (and often family) while meeting patients in their own contexts (R. M. Epstein & Street, 2011). However, patient-centered care is most challenging in pediatrics—as children often cannot advocate for themselves, and their parents may be unable

or unwilling to address their care sufficiently. Participant G was especially aware of this vulnerability with her patients:

A child, they don't have control over their illness or . . . they didn't live in a healthy lifestyle and that's why they are where they are, or they didn't decide to do drugs and that's why they are why they are. (Participant G)

For this second personal theme, the study participants clearly shared a deep respect for children as patients and held a deep responsibility for serving as their advocates. This study celebrates the spirit of these women physicians in academic pediatrics, their personification of the patient-centered care ethos, and the expanded importance of the relational aspect in physician identity.

So, whereas the study participants were deeply committed to their profession and strongly identified with the positionality of their vulnerable patients, conversely, they were also challenged with how they felt about themselves in the contexts of the roles they were playing. This pattern of self-doubt, or imposter syndrome (Harvey & Katz, 1985), is the next personal theme discussed.

Imposter Phenomenon

Although the study participants were all high achieving, driven, and intelligent women, a surprising number of them expressed feelings of inadequacy, self-doubt, and perfectionism in reflecting upon themselves and their self-worth. The term *imposter phenomenon*, first described by Clance and Imes (1978; Langford & Clance, 1993) as the experience of women who, “despite their earned degrees, scholastic honors, high achievement on standardized tests, praise and professional recognition from colleagues and respected authorities . . . do not experience an internal sense of success” (Clance & Imes, 1978, p. 1). High-achievement women (which would logically include some physicians) experiencing the imposter phenomenon believe themselves to be less intelligent or accomplished, and even deceitful to those who think otherwise (Clance &

Imes, 1978; Langford & Clance, 1993). Kumar and Jagacinski (2006), using a sample of 135 college students, found that “women endorsed far more imposter fears than men” (p. 155); their research was consistent with that of King and Cooley (1995), who had also used a college student sample. Participant P gave an example of the imposter phenomenon, having started her career as a dancer. She expressed self-doubt related to her ability to pursue a medical career and gain acceptance into medical school:

I was pre-med, so I started thinking down the road I wanted to go to medical school. But I did a lot of dancing as an undergrad, and after I finished my undergrad degree, I wanted to spend some time working as a professional dancer. . . . So, I got a job actually dancing [abroad] . . . after I graduated. . . . I moved to [U.S. city] for the year that I was applying to medical school, and I danced during that time. . . . I felt a little different from my peers because I had been out for a couple of years. . . . At the time, I thought people thought it was a little bit kooky that way. I thought there was no way in God’s green earth that I would get into [name of] Medical School. (Participant P)

Rather than recognizing and internalizing her academic achievements with her special talents in dance as uniquely qualified for medical school, she viewed her time dancing and exploring her interests as “kooky” and ‘less-than’ her peers.

In the institutional theme discussion of Mentors and Networking as Activism, I noted the value of greater involvement in national professional groups, and how women have not always felt included. Participant A explained how she first felt when exposed to a national academic specialist group:

At first, I was afraid thinking they would be sort of geniuses and all this stuff, and do research. And *I’m just the clinician* [emphasis added]. But it’s been better with that, so I think [it] was great learning how to navigate through that. (Participant A)

It is comforting that Participant A was able to overcome her initial discomfort and “navigate through that.” However, her self-description within the broader professional structure was self-deprecating, suggesting an unworthiness to participate with “geniuses.” This is a strong example

of the imposter phenomenon at work with high-achievement women physicians in academic pediatrics.

Although both women and men have appeared in the literature to be “susceptible to imposter feelings” (Rohrman et al., 2016, p. 2), it surprised me how open this current study’s participants were with their feelings and frequency of self-doubt. I had expected that women physicians, who represent socioeconomic and academic success, would be more self-assured.

Participant L specifically raised the term *imposter syndrome* in her description of her lived experience, and explained why she believed imposter syndrome was more common for women: “Well, you don’t see men so much who would have that imposter syndrome because they maybe aren’t as introspective” (Participant L).

Participant L’s description of the term alone requires some interpretation. Whereas “imposter syndrome” and “imposter phenomenon” are both commonly referred to somewhat interchangeably in the literature, some authors have suggested that designating the term a *syndrome* has a more negative connotation, which “implies a medical model of dysfunction within the individual” (Feenstra et al., 2020, p. 2), and recalls the medical overtone of the “‘female hysteria’ diagnoses of the nineteenth century” (Tulshyan & Burey, 2021, p. 4). In contrast, although self-doubt, a lack of self-confidence, and a tendency to underestimate their accomplishments were prevalent in this study’s participants, their descriptions and self-characterizations seemed to come from a place of humility (“introspection,” as Participant L noted), rather than serving as a psychological barrier. Participant P described her experience in finding self-confidence in a leadership role as, “You are not proving yourself; . . . you are proving more to yourself than to other people.”

Despite the accomplishments of each of this study's participants, many still expressed self-doubt. Building the confidence of women physicians in academic pediatrics, like this study's participants, will be necessary to continue challenging gendered structures and culture in pediatric academic medicine.

Moving from this discussion of this third personal theme, the imposter phenomenon, examined next is the fourth and final personal theme, regarding the importance of personal relationships as support mechanisms for this study's participants.

The Significance of Partnerships

My husband is wonderful, and he was going to be active. I probably wouldn't have married a person who wasn't like that, so I guess I was lucky or smart . . . to marry someone who was going to share the load, and we continued to do that. When both of us got our first jobs, we worked alternate weekends, alternate nights. If he was on call, then I would work at night, and vice a versa. We each spent more time with the kids and less time with each other, but we agreed that was our priority. (Participant B)

The shared experience of women physicians in academic pediatrics in this study included that of a supportive spouse or significant other. Every one of the participants interviewed shared this commonality and these spousal relationships proved to be a key coping mechanism in helping manage the challenges of work and academic medical culture. Although most of those relationships seemed to have a more traditional gender role associated with child-rearing, not all of them did.

So, you have to figure out what you are going to do and what your partner is going to do to make it work for you . . . [and it] works great for me. My husband is a general pediatrician in private practice and he is home one day a week. He works a lot of Saturdays, so he has Wednesdays off. So, that has worked very nicely for us; I mean I work full-time. But when our kids were younger, I would drop [them] off at school sometimes, my husband would drop [them] off at school sometimes, and . . . some of the women [at school] who didn't work knew him as well as they knew me. (Participant C)

Participant I described her division of duties more specifically:

What's weird about our relationship is that I do all of the house stuff, and . . . we have a nanny. And our nanny does all our family laundry . . . and we have a housecleaner that

comes every 2 weeks I do all the gardening. I do all the maintenance. I do all the hardware store He is not handy He does a lot of other things He does the investing and the big financial choices of our taxes; he does our taxes, pays our nanny, and does all the investing. But I do all the day to day . . . like all the little things, because he would totally, it would be a disaster. We divide it enough, but I do feel like when he is home and the kids are in bed, I am usually doing something in the house and he is not. But he gets up every morning and I sleep, so. We share most things. (Participant I)

These relationships seemed to include a clear understanding of roles related to work and home life, and there were two distinctions in the roles of spouses: about half of the participants had spouses or partners directly working in medicine themselves, whereas the other half had spouses working specifically outside of medicine. These distinctions provide two different but valuable perspectives for the women physicians in academic pediatrics in this study. Those with spouses or relationships in medicine shared a unique understanding of the demands, lifestyle, and atmospheres of medicine, providing support through degrees of common experience and understanding. Those participants with spouses or relationships outside of medicine highly valued the ability of their spouse to listen with objectivity, serve as supporter, counselor, best friend, and as an escape from their work experiences.

I learned everything about being successful from my husband, who is an MBA. I mean he is, like, I think that he has, like, made my career, honestly. I mean I haven't told him that . . . maybe I should, . . . but he is just very skilled at interacting with people and knowing when to escalate things and went to, like, back off and calm down. (Participant I)

An interesting perspective is that none of the participants was divorced, and the dual-physician relationships were most understanding of the specific challenges related to practicing medicine. However, although the participants described their relationships with varying degrees of partnership with and empathy for them, it was equally clear that the participants still had disproportionate responsibility for domestic and child-rearing responsibilities. So, although the participants experienced a more contemporary division of home and child-rearing duties than previous generations, an underpinning of traditional gendered roles remained. Those roles may

have been based on the dynamics of the individual relationships, the evolution of the more “progressive” male, or the personal decision of the woman physician regarding child-rearing and home life.

The participants’ primary relationships mattered as a critical support mechanism, whether they were married to physicians or not. Each such relationship had its own unique characteristics of support. Although the distribution of domestic duties still appeared disproportionate for women, their supportive relationships provided stability, perspective, and balance to the women physicians in this study and demonstrate the importance of work-life management in navigating the academic pediatrics arena.

The personal themes of Pulling Double Duty, Physician Identity and the Calling of Care, Imposter Phenomenon, and The Significance of Partnerships demonstrate the challenges of this study’s women physicians in academic pediatrics in navigating their work worlds and establishing new values and expectations for themselves. They described their conflicts between managing their personal lives with their feelings of self-doubt, and the reality of disproportionate domestic duties. However, they appreciated the value of strong spousal or partner support.

Summary

All eight of the themes discussed herein were constructed through analysis of the participants’ interview transcripts, interpreted from the text as the participants’ lived experience (Lincoln & Guba, 1985, 2013; Vagle, 2014a, 2014b; Van Manen, 1990). Member checking of the themes and thematic categories was conducted to help support the authenticity of the constructions. The eight themes were subsequently sorted into two thematic categories, personal and institutional, utilizing agency and structural perspectives (Cockerham, 2005) to help interpret the participants’ lived experience. Then, personal and institutional thematic categories were

represented in the yin-yang duality. Utilizing the Eastern yin-yang duality, the analysis of the themes recognizes the harmony and potential overlap among the themes, while also categorizing them in a manner that views the phenomenon as a synthesized whole.

Having explored the eight essential themes in the institutional and personal thematic categories, the next chapter turns to discussion of the implications of this study's findings and conclusions. The next chapter revisits the research questions; reconciles the study's findings with the bodies of literature which informed the study's design; and discusses implications for theory, practice, and future research, including the study's limitations, and review of the study's quality criteria for authenticity. The next chapter also provides thoughts on my experience as the human instrument of this research, and overall conclusions from the study. This study concludes with an Epilogue, which situates the study in the context of the related social change that has occurred since the study was undertaken.

CHAPTER 5: IMPLICATIONS OF FINDINGS AND CONCLUSIONS

This chapter has multiple purposes: (a) reflecting on how the study's findings inform its three research questions; (b) reconciling the findings with the study's informing bodies of literature; (c) discussing the study's implications for theory, practice, and future research; (d) reviewing the study's quality criteria of authenticity; (e) reflecting upon my lived experience as the human instrument of the research; and finally (f) drawing conclusions.

The key question that stoked my curiosity on the topic of women physicians in academic pediatric medicine came from the challenge initiated by Lorber (1984), suggesting the explicit connection between gender equality and inclusion in the academic medicine power structure:

If women are to gain positions of power, the patterns of the informal organization of the workplace must routinely include them. As a group, women must be trusted as colleagues, sponsored for advancement, given recognition for competence and accomplishment, and accrue[d] the resources and reciprocal favors that advance careers. (p. 112)

Given that 40 years have passed since publication of Lorber's (1984) book, it is useful to revisit her vision, wherein

the ultimate goal is not for women to join men in inner circles imbued with the male perspective on work, family life, and social service, but for the establishment of new values which reflect the needs and priorities of all members of society—female and male, old and young, rich and poor. (p. 115)

This study was designed to gain understanding as to whether or not Lorber's vision has come to fruition, or at least progressed, as expressed in the voices, shared experiences, and perspectives of women physicians in academic pediatrics.

How the Study's Findings Inform its Three Research Questions

My interest and curiosity in Lorber's (1984) goal prompted three research questions to explore in this study:

- How do women physicians in pediatrics describe their experience of gender in the context of academic medicine?
- What are the participants' experiences related to their inclusion in the patterns of formal and informal organization of the workforce? and
- Can women physicians in a localized setting confirm or disconfirm that gender has been successfully defused as an issue of status in academic medicine?

The research questions were informed by exploring the literature on the theoretical constructs of women physicians in academic pediatrics, gendered organization, and the culture of academic medicine to understand the experience of women physicians in academic pediatrics and gendered hierarchy. The constructs were the basis of the inquiry explored through the lens of the constructivist paradigm, with its ontology of relativism, epistemology of transactional subjectivism, methodology of hermeneutic dialecticism, and values-driven axiology (Lincoln & Guba, 2013). As detailed in Chapter 3, the study methodology utilized hermeneutic phenomenology in alignment with the constructivist paradigm. The three guiding research questions, inspired by Lorber (1984), also aligned well with the constructivist paradigmatic approach. I conducted participant interviews in a specific academic pediatric medical center, and transcripts of those interviews served as the basis for data analysis and theming as discussed in Chapter 4. Building upon the results of the analysis in the previous chapter, the findings of the study in the context of the research questions are discussed next.

Overall, from analysis, interpretation, and meaning-making of the participants' lived experiences, the eight themes constructed in the two thematic categories—institutional and personal—suggest that (a) academic organizational structures and culture, (b) societal expectations of personal relationships, and (c) recognition of the individual needs of women have

shifted toward better reflection of the egalitarian values Lorber (1984) intended. However, as described in Chapter 4, the constructions of the shared lived experiences of this study's participants also point to the persistence of gendered roles at home and double standards in the workplace.

The first two research questions were answered through interpretations of the participants' interviews, resulting in the constructed institutional and personal thematic categories, each with four corresponding themes. The four themes in the institutional thematic category—The Glass Ceiling Still Stands, Last Stand of the Good Old Boys, The Baseball Game Double Standard, and Mentors and Networking as Activism—highlight participants' voices from the structural perspective, as to how the participants navigated the gendered academic medical culture. Although not as pronounced as overt sexism and sexual harassment, the study participants experienced double standards regarding dress, office space, team-based expectations, and limitations of career growth through the erosion of tenure. They were empowered when they had mentors and support, participated and/or had leadership roles in professional organizations, and had opportunities for career development in leadership and/or other roles that best supported their work-life balance.

Similarly, the four themes in the personal thematic category—Pulling Double Duty, Physician Identity and the Calling of Care, Imposter Phenomenon, and The Significance of Partnership—illuminate the participants' individual perceptions, relational support structures and systems, and alignment with professional identity. Although it is clear that traditional gendered roles of child-rearing and domestic responsibilities still fell disproportionately on the participating women physicians, it is also clear that the participants' spouses and partners were more aware of

and supportive in home and childcare responsibilities, and that the participants recognized the value of partnership in managing dual-career relationships.

It is surprising that a few of this study's women physicians in academic pediatrics struggled with self-doubt and feelings of inadequacy, even though they were socioeconomically advantaged and employed at a highly reputable, nationally respected pediatric institution. However, this self-doubt seemed in part related to those participants' high achievement orientations and tendencies toward perfectionism. Those participants also saw themselves as helping and providing voice for the vulnerable—children—and deeply identifying with the responsibilities incumbent in being pediatric physicians.

How do women physicians in pediatrics describe their experience of gender in the context of academic medicine?

Regarding the first research question, in describing the experience of gender in the context of academic medicine, a significant number of the study participants did not present gender as a significant organizational limitation in how they do their jobs nor in their career success. For example, Participant J's responses are particularly illustrative of this finding:

Interacting with other physicians is positive; it's nice, it's very collaborative here
But I can say, going into a shift knowing that I work with, you know, a man versus a woman, I don't walk into the shift thinking anything different. (Participant J)

In describing the differences within her work team, Participant J also downplayed gender: "But that's a personality; I don't think that's the gender thing necessarily." However, when probing further, she also noted,

I guess there are things that I notice . . . a lot of, that leadership is more men than women. Our division head, our department head are all men, which is interesting in a place where men are generally the minority. That always makes me think, "C'mon, why? Why is it more? Where is our representation?" Not that I ever feel like I am disadvantaged. I feel like I've gotten the career advancements that I wanted. (Participant J)

Participant J highlighted a characteristic of academic medicine for women physicians: the atmosphere is team-oriented and focused on the common mission of providing care for children. The women physicians in this study described men physicians in positions of authority in academic pediatrics as supportive and seemingly not overtly discriminatory in their behavior toward the women physicians. The study participants strongly voiced this attitude.

What are the participants' experiences related to their inclusion in the patterns of formal and informal organization of the workforce?

Based on this study's participants' descriptions, and using Lorber's (1984) aspiration as a guide, these women were "trusted as colleagues, sponsored for advancement, [and] given recognition for competence and accomplishment" (p. 112). Yet that description of these participants' experience is incomplete. Per their voices, these women physicians in academic pediatrics had yet to "accrue the resources and reciprocal favors that advance careers" (p. 112), and were still underrepresented in the positions of institutional power. This more recent element of the glass ceiling, as constructed from participant data, is playing out as clinical education is replacing tenured positions in the hierarchy, leaving women on an unclear path into higher leadership levels.

Can women physicians in a localized setting confirm or disconfirm that gender has been successfully defused as an issue of status in academic medicine?

Answering the third research question was more complicated. The participants did not share experiences of blatant sexual harassment or discrimination that one might have expected in a study of women's institutional experiences in a traditionally gendered hierarchy. The participants were not overtly critical of their work environments—claiming that, for the most part, their leaders and the organization as a whole were supportive of their personal needs and career goals. However, the descriptions within the institutional thematic category indicate experiences of more subtle methods of keeping these women physicians in academic pediatrics

out of the institutional patterns: from dress to office space, unequal pay, male dominance in professional groups, and women clustered within specific pediatric subspecialties. Such institutional norms still present barriers and added complexities for women physicians in academic pediatrics in navigating the academic pediatric institution. Added to these issues are the challenges of child-rearing and domestic responsibilities while under the scrutiny of the academic enterprise, and with the decline of tenure. So, from both institutional and personal perspectives, gender has not been defused as an issue of status in academic medicine.

From a quantitative perspective, women physicians in academic pediatrics have made tremendous strides, now comprising 54% of all academic pediatricians compared to men at 46% (Saboor et al., 2022). Women physicians in academic pediatrics have surpassed men in lower-level academic positions such as instructors, assistant professors, and associate professors, but still lag in positions of chairpersons and full professors (Saboor et al., 2022). Saboor et al. (2022) attributed the reason for slower progress to factors such as differential family responsibilities, fewer authorships, workplace harassment, personal preferences, fewer work hours per week, unconscious gender bias, reduced faculty employment rates, and funding opportunities (p. 7). Again, women physicians have made solid progress and may be filling the pipeline for future leadership roles. However, the lower percentages of women physicians' representation in the higher echelons of power and influence, along with the phenomenon described and constructed in this study's institutional and personal themes, suggest that Lorber's (1984) vision has not been realized. Progress is evident since her 1984 book, but her vision is not yet fulfilled, over 40 years later.

Reconciling the Findings With the Study's Informing Bodies of Literature

This study explored the intersection of women physicians in academic pediatrics, the

gendered organization, and academic medical culture, thus informing the research questions developed in support of these bodies of literature (see Figure 1 in Chapter 1). Pertaining to women physicians in academic pediatrics, the findings of this study support Boulis and Jacobs' (2008) notions that the increased representation of women in medicine will challenge existing practice and structures, and that there is continued need for equal opportunity in academic appointments (Nonnemaker, 2000; Saboor et al., 2022). Relative to academic appointments, the recent structural changes of tenure and subsequent migration of women to clinical educator roles are both a blessing and a curse. The change in tenure practices—which disproportionately impact women who now constitute an increasing percentage of academic pediatric faculty (Saboor et al., 2022)—resembles a new aspect of the glass ceiling which could be the newest barrier keeping women out of the echelons of power in academe. However, the women physicians in this study interpreted this structural change in tenure practices as positive, in that it provides them great flexibility in managing career and family life, and allows them to focus on their combined affection for children and education. It is also noteworthy that clinical educator roles could be utilized to influence up-and-coming physicians through their training by eliminating gendered practices and incorporating more intersectional perspectives.

Implications for Theory, Practice, and Future Research

This study's results indicate a number of implications, specifically for future theory, research, and practice. Each is considered below.

Implications for Theory

The constructs from this study—namely, The Glass Ceiling Still Stands, Last Stand of the Good Old Boys, The Baseball Game Double Standard, Mentors and Networking as Activism, Pulling Double Duty, Physician Identity and the Calling of Care, Imposter Phenomenon, and The

Significance of Partnership—explore how the institutional and personal issues must be addressed in concert for women physicians in academic pediatrics to thrive and achieve Lorber’s (1984) “ultimate goal . . . for the establishment of new values” (p. 115). Perhaps the most significant implication for theory arising from this study is that although significant progress has been made, this study’s institutional themes point to the participants’ shared experience of still-gendered organizational cultures, from visible symbols such as dress, and structural issues such as representation in leadership, to the significant change in tenure and the rise of the clinical educator. Although less overt than sexual harassment and blatant discrimination, these more opaque symbols, roles, and structural changes suggest a shift in the traditional concept of the glass ceiling for these women physicians in academic pediatrics. Powell and Butterfield (2015) claimed that “the nature of glass ceilings has remained essentially stable despite all of the scholarly attention they have received” (p. 319). The constructions from this study suggest otherwise. Instead, the nature of glass ceilings may be more dynamic, adapting as organizational forms through structures, changes in job design, and other symbols of power and hierarchy.

Another implication for theory lies in building upon how the *yin-yang* model may be utilized as a construct to express the experience of gendered structures. The study participants, through the constructs of the institutional and the personal thematic categories, recognized the interplay between their work and personal lives, and how each influences the other. So, although academic pediatric culture is inseparable from the gendered organization (Acker, 1988; Alvesson & Billing, 2009; Mills, 1988), the personal life situations of the study participants interplayed with their organizational experience as well. This interplay suggests that inclusion of participants in the patterns of formal and informal organization in the workplace has a personal element that should not be ignored.

Implications for Practice

Based on the data and subsequent interpretations from the lived experience of the participants in this study, women physicians in academic pediatrics still confront significant barriers to overcome on the path to achieving Lorber's (1984) vision. The institutional and personal themes from this study, especially utilizing the yin-yang framework, recognize the interdependence of institutional influence and personal dynamics on the perceptions of these women physicians in academic pediatrics. As this study demonstrates, women physicians in academic pediatrics are challenged in navigating the institutional culture and structure of academic life, in tandem with the challenging nature of managing home life with disproportionate distribution of duties. In addition, some of the women physicians in this study were coping with their own confidence and feelings of inadequacy. The study's institutional and personal themes also highlight hope: that increased mentoring and networking provide opportunities for women physicians to challenge the traditional hierarchy and gendered academic culture to elevate women to more leadership roles and greater influence. These themes provide implications for stakeholder groups including academic medical center physician leadership, administrative leadership, all medical staff, and patients.

One of the personal themes points to the unique identity, or calling, that the study participants have within their professional discipline, which results in building deeper relationships with their patients and families. This high identification with their calling, and the relational aspect of their identities, may be a key element in improving patient experience, which has become an increasingly important measure for hospitals (Ahmed et al., 2014; Bleich et al., 2009; Bull et al., 2019; Larson et al., 2019) and a requirement for certain hospitals in order to receive full reimbursement for services from the Centers for Medicare and Medicaid Services

(2024). Promoting women physicians into leadership positions may influence clinical care and patient experience, leading to improvements and better reimbursement.

The importance of healthy personal partnerships as a theme in this study highlights how spousal and life partner relationships (and perhaps other relationships as a whole) provide a means of critical support and a coping mechanism for women physicians in academic pediatrics. Supportive relationships as a means to leading a balanced life may likely apply to all physicians regardless of identity dimensions (e.g., gender, ethnicity, sexual orientation, religious beliefs, marital status, parental status, age, education, physical and mental ability, income, etc.). Creating flexible and supportive paid-time-off policies that allow for sickness, recovery, and/or mental and emotional health recharge would reduce burnout and likely support higher productivity and performance for a longer career (Vander Weerd et al., 2023). Ensuring reasonable standards that “protect against long work hours and heavy workloads” (Olson et al., 2019, p. 9) also supports physicians in their well-being and life balance. Another implication for practice is the inclusion of spouses or significant others in social activities related to the work group, to acknowledge and appreciate these relationships and their impact on the physician.

Providing access to and encouraging the use of employee assistance programs (EAPs) to help physicians going through various life challenges may also demonstrate support for physician well-being. An EAP is a “work-based program that encompasses a wide spectrum of helping services to address aspects of work, life, and health, and is intended to remedy existing employee difficulties as well as mitigate future adversities” (Long & Cook, 2023, pp. 2-3). Historically, the use of EAPs by physicians and health professionals has been low due to perceived confidentiality issues, time availability, and stigma (Brown-Berchtold et al., 2024; Milot, 2019), but more effective and proactive methods for access, as well as normalization

through leadership role modeling, may demonstrate its value and provide another avenue for physician support. These and other work-life supportive practices and interventions recognize the value of healthy relationships and work-life balance (Morganson et al., 2014) and that physicians have life challenges similar to the general population.

One impetus for undertaking this study was to gain better understanding, within my own positioning as a health system administrator, of the potential policy implications for medical school and health system administrators. This study's institutional and personal themes provide guidance for improving the lived experiences of women physicians in academic pediatrics, and potential transferability of this study's findings, as discussed below.

Administrators must scrutinize policies and practices that produce barriers that complicate balancing of work and home life. The need for balance was clear for the women physicians in this study, and it does appear that working mothers carry disproportionate domestic duties. However, recognizing and supporting more balanced and holistic employees, regardless of marital or partnership status, may be reciprocated in more satisfied, engaged, and productive employees (Boamah et al., 2022; Haar et al., 2014; Saks, 2022; Wood et al., 2020). Recognition of the value of part-time work, providing onsite child care with extended hours, and providing flexible time off are practices supportive of the needs of working physicians regardless of gender. Redesign of ineffective processes, job controls, and systems, in addition to supportive work-life practices, also contributes to physician job satisfaction, as these factors can often be conditions that influence the imbalance (Gardner et al., 2019; Khairat et al., 2018; Linzer et al., 2020; Waddiimba et al., 2019; also see Grow et al., 2018; Maslach & Leiter, 2017; Maslach et al., 2001; Rotenstein et al., 2018 on the related topic of physician burnout).

Another potentially valuable option for administrators is the development of structured coaching and mentoring programs to allow physicians to explore and discover their career interests. Seeking, including, and supporting physicians in internal or external leadership development programs can provide a useful mechanism to encourage physicians to explore their leadership interests and considerations. Recognizing the imposter phenomenon and related lower confidence, self-doubt, and unwillingness to internalize one's own accomplishments (Clance & Imes, 1978; Langford & Clance, 1993), administrators could be more intentional in encouraging and developing physicians who express interest in leadership roles. Specific programs to build confidence and reduce self-doubt would be a reasonable place to start as part of leadership development curricula. Helping physicians see and appreciate their own accomplishments and the humility incorporated into self-doubt are increasingly more important elements of good and effective leadership (Hoekstra et al., 2008).

Administrators should also acknowledge past practices that may have been exclusionary, and ensure inclusion in policy, process-based, and practice decisions, by taking into account different perspectives and life experiences and engaging a diverse group of people to help in policy and practice development and implementation.

Implications for Future Research

The results of this study point to a number of opportunities for future research. Further exploration and development of Thunborg's (1999) physician-identity framework might build upon that framework to cultivate understanding of meaning and purpose in support of physician resilience, job satisfaction, and career satisfaction. Thunborg's original framework comprised three levels: occupational-related, activity-related, and individual-related identity. This study adds a fourth component to Thunborg's framework, to include the *relational-related* identity

elements of medicine and health care. There are opportunities for further expansion and depth regarding intersectionality with greater understanding of how class, ethnicity, and gender inform the interpretation of physician identity components as described by this study's participants through the lens of Thunborg's model.

Another implication for further research is the specific impact of the loss of tenure and positioning of clinical education as the new glass ceiling. This significant structural change to the organizations and cultures of academic medicine come at a time when academia has become increasingly "corporatized" with an emphasis on revenue generation and commercialization (see Chan & Fisher, 2009; Churchman, 2002; Lieberwitz, 2005; Lincoln, 2011, 2012, 2018a, 2018b; Schrecker 2010; Steck, 2003). The gendered implications of this change cannot be overlooked and deserve additional inquiry.

Another area for future research is in the synthesis of studies of organizational justice; organizational culture; and diversity, equity, and inclusion. In listening to the participants, their experiences trigger another area to explore when considering women physicians in academic pediatrics: organizational justice. Traditionally, *organizational justice*, first coined by Greenberg (1987), has been understood as an employee's perception of fairness regarding their organization's behaviors, decisions, and actions. The construct of organizational justice can include either three or four components: (a) procedural, (b) distributive, (c) relational, and (d) informational justice. Specifically, *relational justice* (also referred to in the literature as *interactional justice*) is the fairness one receives in interpersonal treatment (Cropanzano, 2001) and reasonable expectations for treatment in the organizational context.

Intersectionality is often addressed in critical race studies (see Arifeen & Gatrell, 2013; Allison & Banerjee, 2014; Atewologun, 2018; Hearn, 2014; Hearn & Louvrier, 2015; Özbilgin et

al., 2011). As mentioned in Chapter 4, and based on the voices of this study's participants, ethnicity, intersectionality, and other inclusivity dimensions were still not discussed openly in their respective experiences of academic pediatric culture. This opportunity to delve further into intersectionality, and its application in diversity, equity, and inclusion programs, may be highly useful in fostering the new values Lorber (1984) mentioned in her vision, and beneficial in the increasingly diverse physician population.

Having considered the implications of this study for future research, reviewed next are the study's quality criteria of authenticity. These quality criteria ensure alignment with the study's paradigmatic position.

Review of the Study's Quality Criteria of Authenticity

As mentioned in Chapter 3 of this study, Lincoln and Guba's (2013) quality criteria of authenticity were used to ensure that the study was conducted with integrity and rigor. Constructivism's axioms embed these criteria and subsequent inquiry methods. Addressing each authenticity criteria and its supporting method demonstrates the study's integrity and usefulness to the researcher, participants and readership.

Fairness Criteria

Fairness as a quality criterion assesses the extent to which all competing constructions, values, claims, concerns, and voices are accessed, exposed, and deconstructed into the emergent reconstruction of a research study (Lincoln & Guba, 2013; Lincoln et al., 2011). As mentioned in Chapter 3, fairness ensures that participants' voices are truly heard, and that the construction process is equitable. Fairness also restricts the researcher to serve as the human instrument of co-constructions with participants, not as study director in predetermining constructions (Guba & Lincoln, 1989; Lincoln & Guba, 1986, 2013).

The fairness quality criterion as actualized in this study followed Lincoln and Guba's (2013) methods. Informed consent procedures were utilized to confirm participant willingness in engagement in the study as well as an understanding of the study's intent, process, and potential harm. Correspondence, prolonged engagement, and persistent observation were used to build and establish appropriate levels of rapport and trust by and with participants. Situational elements important to addressing the research questions were used where possible. There were limitations with respect to time spent with each participant due to the nature of their work and availability. Individual member checking with study participants was limited due to location and availability constraints as well. However, my advisor and other workshop classmates served as peer debriefers to test out and discuss my tentative analysis, introspections, ideas, and findings. Study limitations are reviewed in the next section, following this review of quality criteria of authenticity.

Ontological Authenticity

Ontological authentication requires that the researcher and each participant are able to reflect on the constructions of the participant's lived experience in a sophisticated and meaningful way to enrich their understandings of the co-constructions. The intent of ontological authentication is to improve the level of understanding of the individual constructions "from the tacit to the propositional level" (Lincoln & Guba, 2013, p. 70).

This study utilized the following methods to ensure ontological authenticity, from Lincoln and Guba (2013). As the inquirer, I conducted dialectical conversations with each participant in each interview with openness to and awareness of my own preunderstandings. The interviews developed trusting and caring relationships with each of the participants, with limited comparison processes of individual and co-constructions where possible, as well as final

introspective statements of mutual growth. The introspection statements of growth for the participant were embedded in each interview's closing questions (see Appendix A), and I found myself, as the researcher, engaged and empathetic in the experiences of each participant. Both the participants and I, as the researcher, experienced an openness and increased understanding and awareness of their individual lived experiences through the course of the interviews and immediately afterward. I received participant comments that they had never before reflected on the kinds of questions asked in the interviews, and that they were genuinely appreciative of my interest in researching their experiences.

Educative Authenticity

Educative authenticity as a quality criterion results when participants develop a greater understanding, appreciation for, and tolerance of the constructions of others (Lincoln & Guba, 2013). Methodologically, the use of dialectical conversations (in the form of interviews), peer debriefing (with classmates and my advisor), and limited comparison of participants' and researcher's constructions occurred throughout the interviews and subsequent analyses. The study advisor conducted an audit trail of the constructions.

Catalytic Authenticity

Catalytic authentication, as described by Lincoln and Guba (2013), stimulates and facilitates action for change. In my role as researcher, the study resulted in numerous dialogues with health care colleagues including women physicians, hospital administrators, and clinical leaders regarding policies, systems, and perspectives of gendered organizational culture. These numerous conversations served as a catalyst for policy discussions and the need for greater awareness of the unique needs of women physicians.

This study continues to inspire interest and has left an impression on me to recognize, continually, the unique challenges of women physicians in my current and prior health care roles and institutions. As a senior leader and scholar-practitioner in health care, discussions of this study topic with women physicians, peer administrators, and clinical leaders have generated significant interest and dialogue in understanding the lived experience of women physicians. In loyalty to my participants as their voice, I have advocated for actions, policy changes, and programmatic development. For example, I have successfully championed for building a new child development center to support the needs of working families, including physicians. The experience of studying the lived experience of women physicians in academic pediatrics has changed the way in which I approach and support employees in my employment role.

Tactical Authenticity

As highlighted in Chapter 3, empowering individuals to take the action this inquiry implies or recommends is the critical component of tactical authenticity (Guba & Lincoln, 1989). Study participants, my advisor, my cohort classmates, and other stakeholders (e.g., the IRB) had input into the research process as well as a role in its emergence. The methods of data collection, interpretation, and reporting, dialectic conversations, member checking, and any dialogues about power (particularly as a human resource leader and practitioner) were discussed and negotiated. The limited discussions with study participants were intended to decrease any potential barrier to taking action related to the themes identified. In the case of this study, little intervention was required, as in my work I am an influencer and advocate in support of the study findings.

Study Limitations

Limitations of a study were described by Price and Murnan (2004) as “the systematic bias that the researcher did not or could not control and which could inappropriately affect the

results” (p. 66). C. M. Roberts (2010) added that “limitations are areas over which [the researcher] ha[s] no control” (p. 162) and include methodological concerns such as sample size, response rates, and data collection and location constraints.

A major limitation of this study is the positionality of the researcher as a White male studying and writing about women physicians in academic pediatrics. Although conscious of this positionality and sensitive to potential bias, “every act of inquiry is simultaneously a political act, in the sense of the exercise of power” (Lincoln & Guba, 2013, p. 77). As this study’s researcher, I made every attempt to acknowledge bias, recognize the privilege of serving as the human instrument of the research and voice for the study participants, and “take a posture of advocacy and activism with respect to all stakeholder groups” (p. 78). It is up to the reader to determine if I succeeded.

Another limitation to this study concerns the sampling approach. Hermeneutic phenomenology “does not generalize from an empirical sample to a certain population” (Van Manen, 2014, p. 249). The sample size depends on the context of the phenomenon being studied. As Van Manen (2014) explained, “Depending on the phenomenological question, the general aim should be to gather enough experientially rich accounts that make possible the figuration of powerful experiential examples or anecdotes that help to make contact with life as it is lived” (p. 353). Purposeful, snowball sampling was the method used in this study to identify and attract participants. This study’s interpreted data and developed constructions involved 16 participants. Whether or not the number of participants was the right number is open for debate, as further sampling to include more, or a different set of, participants may have resulted in different interpretations and constructions. However, as Bartholomew et al. (2021) contended, “Samples must be sufficient to answer a research question . . . researchers should be certain they are able to

answer their research questions with the data they have, first and foremost” (p. 12). This study provided a human instrument for the participants in answering this study’s research questions. The reader must determine if the themes are relevant and transferable to their understanding of the lived experience of women physicians in academic pediatrics.

In addition, utilizing a hermeneutic phenomenological methodology requires interactions between the researcher and the study participants, “focusing on their [participants’] initial constructions and aimed at developing reconstructions by a process in which all share equally” (Lincoln & Guba, 2013, p. 65). These constructions were derived through consensus, and “paradoxically, dependent on the existence of a minimal level of resistance and conflict that must be resolved to achieve a common construction” (p. 69). Although the participants were engaged in the outcomes of their respective interviews, the physical distance between the researcher and study participants made the process of consensus difficult. The resulting constructions may have been different and/or more sophisticated interpretations with time and closer physical proximity with the participants.

Aging of the data is another limitation of this study, as the data were collected in 2016 and analyzed for theme constructions over a 2-year period. The length of time it took to conduct this study was due primarily to my full-time work commitment as a health care system executive. Over the span of time utilized for data collection, analysis, and write-up, a number of social issues came to light which may have influenced the study participants’ responses. Thus, the data must be viewed in the context of the time in which the data were collected and readers must determine applicability and transferability in light of this context. The recognition of these social changes and their potential impacts on the study are discussed in the Epilogue following this Chapter 5.

My Lived Experience as the Human Instrument of the Research

Guba and Lincoln (1981) described the role and characteristics of the researcher as the human instrument of the research. The researcher as human instrument recognizes the multiple and concurrent roles as study administrator, data collector, data analyst, and data interpreter, serving as “both an independent variable and an interaction effect” (p. 128). In other words, the researcher is not a distant, unbiased, nor impartial judge of the data. As such, “findings produced by qualitative inquiry are always relative and context-bound” (D. L. Stewart, 2010, p. 293). This perspective aligns with constructivism’s presumptive ontology of relativism and epistemology of transactional subjectivism. The researcher is oneself a variable, recognizing the influences that have shaped one’s own lived experience and perceptions of people and environments. As Lincoln and Guba (2013) stated,

The “realities” taken to exist depend on the transaction between the knower and the “to-be-known” in the particular context in which the encounter between them takes place. The transaction is necessarily highly subjective, mediated by the knower’s prior experience and knowledge, by political and social status, by gender, by race, class, sexual orientation, nationality, by personal and cultural values, and by the knower’s interpretation (construction) of the contextual surround. (p. 40)

The challenge, then, for the research as the human instrument of the research is learning to recognize one’s existing perceptions while suspending them to construct new understandings from the data and voices of the participants. The researcher as human instrument in the constructivist paradigm is dynamic and creative, seeking understanding that is “unique, atypical, different, idiographic individualistic” (Guba & Lincoln, 1981, p. 129). This allows the researcher fluidity in identifying, understanding, and constructing the phenomena under consideration.

Serving Guba and Lincoln’s (1981) Seven Characteristics of the Human Instrument

Guba and Lincoln (1981) described seven characteristics of the human instrument of research. Table 6 summarizes each characteristic and how each was applied in this study.

Table 6. *Guba & Lincoln's (1981) Seven Characteristics of the Human Instrument as Applied in This Study*

Characteristic	Description	Application in this study
Responsiveness	Exercises contextual interaction with the dimensions of the context and with the participants, making the dimensions explicit.	Used open-ended, semistructured questions to begin and allow the participant drive the direction of the questions and follow ups. As inquirer, answered questions from my own perspective.
Adaptability	Utilizes multiple modes of data collection through perceptivity and instinct, adjusting style, method, and approach as needed.	Adjusted approach based on meeting place, pace of interview, body language, and areas of interest.
Holistic emphasis	Sees the world as a continuous context within which study participants view themselves and their lives as real, true, and meaningful.	Recognized the connection between organizational and personal contexts in the use of yin-yang framework, and developed two thematic categories and eight themes from the data.
Knowledge-base expansion	Builds understanding through conscious and unconscious levels of awareness along with tacit and propositional realms of knowing.	Conscious understanding experienced through descriptions of participant lived experience and later through interpretive constructions exploring data individually and as shared experiences.
Processual immediacy	Processes data immediately upon acquisition, reordering, changing the direction of the inquiry based upon it, generating hypotheses, and testing them as they are created.	While semistructured interviews provided outline for data collection, follow-up questions and points were raised spontaneously with no two interviews exactly the same. Thoughts were shared and directions changed based upon participant responses.
Opportunity for clarification and summarization	Uses the data collection process to probe, delve, scrutinize, or cross-examine to ensure statement clarity; uses summarization as a credibility check, a participant record, and an opportunity to catch missed information or points.	Provided probing of responses, active listening and summarization, follow up questions and closing question for additional information and clarification.
Opportunity to explore atypical or idiosyncratic responses	Explores responses from experts, or those with unique roles, and those who may provide atypical or idiosyncratic responses.	The participants were specific types of physicians that and the inquirer was familiar enough with the environment to follow up on atypical responses that influenced category and thematic constructions.

Note. Adapted with permission from “Major characteristics of the instrument,” in Chapter 6, *The evaluator as instrument*,” by E. G. Guba & Y. S. Lincoln, 1981, in *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches* (pp. 128-138). Copyright 1981 by Jossey-Bass (now owned by Wiley); permission from Wiley conveyed through Copyright Clearance Center, Inc.

Serving Guba and Lincoln's (1981) Five Desirable Qualities of the Human Instrument

In addition to the seven characteristics of the researcher as the human instrument of the research, Guba and Lincoln (1981) described the desirable qualities of the inquirer as the human instrument. Table 7 describes those desirable qualities and their application in this study. Overall, my experience as the human instrument tightly aligned with the desirable qualities Guba and Lincoln described.

Table 7. *Guba & Lincoln's (1981) Desirable Qualities of the Human Instrument as Applied in This Study*

Quality	Application in this study
Empathic	Found myself empathizing with participants during the interview and upon reflection afterward. The thematic categories and themes reflect the empathetic stance of the inquirer—as the constructions recognize the institutional and personal challenges faced by women physicians in academic pediatrics.
Dealing with psychological stressors	This study involved few psychological stressors except with one participant who felt that her career suffered due to a bad relationship with her boss. In that instance, I expressed understanding and allowed her to process aloud.
Good listener	Was self-aware with active listening but often felt mechanical with follow-up questions and could have probed more effectively after reading transcripts.
Attentive to others' social & behavioral signals	Took social and behavioral cues from participants related to gender issues and ethnic dynamics that helped in construction of thematic categories and themes.
Finding people truly interesting	As a human resources executive, this study provided me with the opportunity to understand people with whom I seldom interface. Genuinely found my participants interesting!

Note. Adapted with permission from “What are desirable qualities for ‘human instrument,’” in Chapter 6, The evaluator as instrument, by E. G. Guba & Y. S. Lincoln, 1981, in *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches* (pp. 138-150), Copyright 1981 by Jossey-Bass (now owned by Wiley); permission from Wiley conveyed through Copyright Clearance Center, Inc.

Other Learning as the Human Instrument of the Research

I found crafting phenomenology utilizing Vagle's (2014a, 2014b) less structured approach was freeing. Vagle's introduction to the books began with a quote from Van Manen:

Phenomenology aims at gaining a deeper understanding of the nature or meaning of our everyday experiences. . . . [It] does not offer us the possibility of effective theory with

which we can now explain and/or control the world, but rather it offers us the possibility of plausible insights that bring us in more direct contact with the world. (Van Manen, 1990, p. 9)

This perspective of utilizing phenomenology to study people's lived experience rejects the notions of methodological perfectionism [overly-mechanistic procedural focus], as well as theorizing as the goal of a study. Rather, it is one's understanding of or learning from interpretive insights that the reader may transfer to an application of their choosing. Methodological perfectionism is incompatible with phenomenology in the constructivist paradigm, as it contradicts presumptions pertaining to ontology and epistemology. It is also incompatible with the constructivist hermeneutic methodology "whereby the constructions are successively disclosed and plumbed for meaning" (Lincoln & Guba, 2013, p. 40).

As the human instrument of the research, the process of constructing meanings from participants' lived experience is, as Vagle (2014a, 2014b) described it, "more of a craft than a method" (p. 104). Vagle's insights radically changed my perspective and gave me confidence and freedom of exploration and joy in my topic. "As phenomenologists, we are actively engaged in crafting something, and as we engage in craftwork, we need to resist the urge to follow a recipe, and instead embrace the open searching, tinkering, and reshaping that this important work requires" (p. 104). Developing a craft is freeing for the researcher, as each discussion, note, and construction hones one's craftwork in search of greater understanding of the lived, everyday human experience. I can take the learnings from my researcher craftwork and reaffirm the constructions by provoking action in my role as a human resources administrator and policymaker to improve the workplace and create a vision of equality and fairness more akin to Lorber's (1984) vision.

Drawing Conclusions

The findings of this phenomenological study of the shared experience of women physician in academic pediatrics were constructed with institutional and personal categories and corresponding themes presented in the yin-yang framework. The yin-yang framework provided a philosophical and visual way of presenting the complementary, mutually interdependent, and reciprocal themes. For the women physicians in this study, institutional barriers still exist as vestiges of gendered traditional hierarchical structures and culture. The reality for the women physicians in this study was that they still have a disproportionate responsibility for home-life and childrearing. They still had to be more intentional in working through the cultural norms that men take for granted in terms of role expectations, leadership ambition, and systemic symbols that favor men.

New barriers, disguised as flexible clinical academic roles, could provide desired opportunities to better balance work and life demands, but could also result in new means of segregation for women physicians in the academic medical structure. However, as women physicians' prevalence increases, along with greater self-awareness of their collective power, in national professional groups, and through mentoring, there is hope for these women physicians in academic pediatrics to influence the change of values that shape academic medical culture.

It is important for women physicians to voice their unique needs and expectations, challenge organizations' cultural norms, address the self-defeating beliefs underlying the imposter phenomenon, and seek more organizational power and influence. At the same time, organizational leaders in academic pediatric medicine need to recognize the barriers women physicians face and work to eliminate them through thoughtful change and inclusive policy and practice.

The participants in this study were smart, interesting, and committed to their profession of physicians in academic pediatrics. Overwhelmingly, they selected a profession that aligned with their values and proudly proclaimed their caring for the most vulnerable in their identity in “physician-ness.” They struggled with personal challenges. They should be celebrated and supported as the change agents that they are. And although women physicians have yet to achieve Lorber’s (1984) vision, there is hope.

Although this study was localized to one pediatric academic medical center in the U.S., the rigor of this study’s process and its findings suggest a high level of potential transferability and transportability (Lincoln & Lynham, 2011) to like institutions. This study satisfied the phenomenological methodology and constructivist paradigm by serving as a catalyst for change and improved human flourishing.

Given the period over which the study was conducted, the Epilogue which follows considers the study within the current environment and the context of events which have occurred since the data collection and analysis. Perhaps Lorber’s (1984) vision is even more relevant and informative in today’s increasingly social, technological, political, and economic climate.

EPILOGUE

Attention to gender issues in organizations was reignited with Sandberg's (2013) book, *Lean-In: Women, Work, and the Will to Lead*, in which Sandberg directly confronted the bias women face in the workplace, and subsequently started a movement of support groups (West, 2018). Anecdotally, from my position as a human resources executive, there seemed to be something stirring about the gender in the workplace, and this interest coincided with my doctoral coursework which ultimately led to this dissertation study. This study's data were collected in 2016–2017. Subsequently, several major developments occurred relevant to the study's purposes. The #MeToo movement (Burke, 2021; Hillstrom, 2019; Rodino-Colocino, 2018), a significant social movement founded by Burke (2021; Boyd & McEwan, 2022) in 2006, focused on supporting survivors of sexual violence and rose to prominence in 2017, following exposure of sexual abuse by Harvey Weinstein in the entertainment industry (Hillstrom, 2019; Nikolova, 2021; Wahyudiputra, et al., 2021). The movement targeted, in particular, abuse by men in positions of power who used their roles to take advantage of vulnerable women, especially in the workplace (Berraf, 2022; Farrow, 2019; Miazad, 2020). Widespread media coverage led by notable Hollywood actresses exposed a number of male entertainment-industry leaders, celebrities, and politicians.

George Floyd's horrific death in 2020 at the hands of the Minneapolis police (Hill et al., 2020; Parks, 2020) spotlighted institutional racism, and led to mass protests and civil unrest (Altman, 2020; Campo-Flores et al., 2020; Deliso, 2021; Silverstein, 2021). *Institutionalized racism* points to the manner in which the construct of race is embedded in societal operating structures such as education, government, health care, and the corporate arena (Tyson, 2006). The subsequent Black Lives Matter (2024) movement (Dunivin et al., 2022; Nummi et al.,

Feagon, 2019; Weddington, 2021) and a number of articles and books—notably including Eddo-Lodge’s (2017) *Why I’m No Longer Talking to White People About Race*, DiAngelo’s (2018) *White Fragility*, Kendi’s (2019) *How to Be an Antiracist*, and Wilkerson’s (2020) *Caste: The Origins of Our Discontents*—challenged structural racism and White supremacy, bringing these issues to the forefront of societal consciousness and forcing dialogues into institutions ranging from universities, government, corporations, and the entertainment and media industries. New diversity, equity, and inclusion efforts (Colvin, 2022; McKinsey, 2022; U.S. Chamber of Commerce, 2021; N. White, 2022) in corporations and government recognized the intersectionality of gender, race, ethnicity, and class, exploring social justice concepts such as implicit (also referred to as *unconscious*) bias, microaggressions, antiracism, and White supremacy. The idea of a reframing of the social strata came into public consciousness, as well as through corporate and governmental initiatives (Berry-James et al., 2021; Deloitte, 2021; Jude, 2020; Wallace, 2020; Zheng, 2020). For example, The World Bank (2022) described the need for social inclusion, which it defined as “the process of improving the terms on which individuals and groups take part in society—improving the ability, opportunity, and dignity of those disadvantaged on the basis of their identity” (Social Inclusion section).

As consciousness of race and racism came to the forefront, sexual identity issues related to the lesbian, gay, bisexual, transgender, queer, intersexed, asexual, and other related (LGBTQIA+) communities also intensified in challenging societal norms. The Supreme Court of the United States’ 2015 legalization of same-sex marriage, changed traditional dynamics and further highlighted discrimination, marginalization, and microaggressions within the larger social strata (Nadal, 2019; Obergefell v. Hodges, 2015). Relatedly, transgenderism took on an increasingly visible role in the media due to high profile cases in entertainment, politics, and

sports (Taylor et al., 2018), and the issue of transgender health care has gained greater interest and support (Coleman et al., 2022). Although this current study focused on women physicians in academic pediatrics, further research on intersectionality, and specifically greater inclusion of LGBTQIA+ experiences in the patterns of formal and informal organization of the workplace would enhance the literature beyond this study's contributions to understanding of shared experience.

These significant social movements exposed abuses of power in the traditional and patriarchal hierarchies and structures and demanded the end to prejudicial and discriminatory treatment of women, people of color, and other marginalized groups. How did all of this rising social consciousness impact the women physicians in academic pediatrics in this study, and their interview responses? I was not able to reach back out to them, but I do believe that they may have responded with greater self-awareness of their positions in the academic culture and gendered hierarchy, and demanded greater influence in their organizations and an accelerated end to the double standards and gendered cultural positioning. They may also have been emboldened to seek higher levels of leadership in academe as prior generations retire. Conversely, it is also possible that the social movements actually reflected what had already been stirred in academic pediatrics, albeit with less media coverage. The increasing prevalence of women, together with their increasing self-awareness, activism, and influence, has changed the face of academic pediatrics. These social movements could provide the tailwinds needed to finally reach Lorber's (1984) vision.

As these social movements have had substantial impact on societal injustices toward women in general, and including professional women, another major event occurred that specifically impacted women physicians: the COVID-19 pandemic. Again, unfortunately, I did

not have the opportunity to reach out to this study's participants during and after the pandemic. However, similar to the significant pending social changes, an obvious question emerged: How might the pandemic have shaped interpretations of this study of women physicians in academic pediatrics? It seemed clear that the pandemic magnified at least a few of the personal themes, including Pulling Double Duty, and Physician Identity and the Calling of Care, constructed from the participants' lived experience in this study. Women physicians in their role as mothers were impacted specifically related to child care and the fact that many schools were shut down and later required online learning. This placed more responsibility on women physicians in their disproportionate role as domestic care providers.

In addition, during the pandemic, networking and professional development opportunities went exclusively online, limiting opportunities for deeper discussions and relationship building. There seem to be mixed responses to online events, but suffice to say that women physicians in academic pediatrics probably suffered more than men in established positions of power.

Brubaker (2020) specifically noted that the pandemic "highlighted systemic assumptions about women physicians that may cause unintentional disadvantage" (p. 835), including the reduction of work hours, and "modifying career progress" (p. 835) to accommodate and balance the demands of the work-life with personal responsibilities. The increases in patient volumes brought about by the pandemic required adjustments to physicians' professional lives with "many of these adjustments . . . made disproportionately by women physicians" (p. 836).

Brubaker called for both women and men to "reject the expectation of unhealthy personal sacrifice" (p. 836), and further stated,

Working toward a more appropriate life-work balance for all physicians will improve opportunities for physicians to reach their full potential in the[ir] personal roles while growing professionally to care for patients and each other. Women and men physicians

should be able to share the joy and the work of their lives equally. The COVID-19 pandemic may just be the catalyst needed to achieve that goal. (p. 836)

Perhaps the concurrent social awakening combined with the realities of the COVID-19 pandemic accelerated the pathway to Lorber's (1984) vision, and thus the impact on women physicians in academic pediatrics. Although this study's meaning and implications were never intended to extend beyond its participant group, consistent with the constructivist paradigm, its findings in the context of past and current informing literature, combined with my practitioner experience, suggest a degree of transferability and transportability (Lincoln & Lynham, 2011). In my own setting, for example, although I am no longer in an academic institution, I was inspired to develop and implement a leadership development program for the needs of women physicians. Without this study and the shared experiences of the participants, the understanding required to develop and implement that program would not have occurred. Just as Lorber's book and vision transferred to and inspired this study, so too am I encouraged that this study may do the same for related future research and researchers.

REFERENCES

- Aaltio, I., & Mills, A. J. (2002). Organizational culture and gendered identities in context. In I. Aaltio, & A. J. Mills (Eds.), *Gender, identity and the culture of organizations* (pp. 3-18). Routledge.
- Abma, T. A., & Widdershoven, G. A. M. (2011). Evaluation as a relationally responsible practice. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 669-680). Sage.
- Abrishami, D. (2018). The need for cultural competency in health care. *Radiologic Technology*, 89(5), 441-448. <http://www.radiologictechnology.org/content/89/5/441.short>
- Acker, J. (1988). Class, gender, and the relations of distribution. *Signs: Journal of Women in Culture and Society*, 13(3), 473-497. <https://doi.org/10.1086/494429>
- Acker, J. (1990). Hierarchies, jobs, and bodies: A theory of gendered organizations. *Gender and Society*, 4(2), 139-158. <https://doi.org/10.1177/089124390004002002>
- Acker, J. (1992). From sex roles to gendered institutions. *Contemporary Sociology*, 21(5), 565-569. <https://doi.org/10.2307/2075528>
- Acker, J. (2006). Inequality regimes: Gender, class and race in organizations. *Gender & Society*, 20(4), 441-464. <https://doi.org/10.1177/0891243206289499>
- Acker, J. (2012). Gendered organizations and intersectionality: Problems and possibilities. *Equality, Diversity and Inclusion*, 31(3), 214-224. <https://doi.org/10.1108/02610151211209072>
- Ahmed, F., Burt, J., & Roland, M. (2014). Measuring patient experience: concepts and methods. *The Patient–Patient-Centered Outcomes Research*, 7, 235-241. <https://doi.org/10.1007/s40271-014-0060-5>
- Allison, R., & Banerjee, P. (2014). Intersectionality and social location in organization studies, 1990-2009. *Race, Gender & Class*, 67-87. <https://www.jstor.org/stable/43496985>
- Altman, A. (2020, June 4). *Why the killing of George Floyd sparked an American uprising*. *Time*. <https://time.com/5847967/george-floyd-protests-trump>
- Alvesson, M. (2013). *Understanding organizational culture* (2nd ed.). Sage.
- Alvesson, M., & Billing, Y. D. (2002). Beyond body counting: A discussion of the social construction of gender at work. In I. Aaltio & A. J. Mills (Eds.), *Gender, identity and the culture of organizations* (pp.72-91). Routledge.
- Alvesson, M., & Billing, Y. D. (2009). *Understanding gender and organizations* (2nd ed.). Sage.

- American Academy of Pediatrics. (2019, December 22). *Executive committee*. Author. <https://www.aap.org/en-us/about-the-aap/aap-leadership/Pages/Executive-Committee.aspx>
- American Association for Women in Radiology. (2022). Author. <https://www.aawr.org>
- American Association of University Professors. (2019, September 23). *Tenure*. Author. <https://www.aaup.org/issues/tenure>
- American Association of University Women. (n.d.). Author. <https://www.aauw.org>
- American Medical Women's Association. (2024). Author. <https://www.amwa-doc.org>
- American Psychological Association. (2020). *Publication manual of the American Psychological Association* (7th ed.). Author. <https://doi.org/10.1037/0000165-000>
- Andersson, T. (2015). The medical leadership challenge in healthcare is an identity challenge. *Leadership in Health Services*, 28(2), 83-99. <https://doi.org/10.1108/lhs-04-2014-0032>
- Andrade, M. S., Westover, J. H., & Peterson, J. (2019). Job satisfaction and gender. *Journal of Business Diversity*, 19(3). <https://articlearchives.co/index.php/JBD/article/view/1789>
- Aragão, C. (2023, March 1). *Gender pay gap hasn't changed much in two decades*. Pew Research Center. <https://www.pewresearch.org/short-reads/2023/03/01/gender-pay-gap-facts>
- Arifeen, S. R., & Gatrell, C. (2013). A blind spot in organization studies: Gender with ethnicity, nationality and religion. *Gender in Management*, 28(3), 151–170. <https://doi.org/10.1108/gm-01-2013-0008>
- Association of American Medical Colleges. (2018a). Figure 16, Percentage of full-time U.S. medical school faculty by sex and race/ethnicity, 2018. *Diversity in medicine: Facts and figures 2019*. <https://www.aamc.org/data-reports/workforce/data/figure-16-percentage-full-time-us-medical-school-faculty-sex-and-race/ethnicity-2018>
- Association of American Medical Colleges. (2018b). Figure 20, Percentage of physicians by sex and race/ethnicity, 2018. *Diversity in medicine: Facts and figures 2019*. <https://www.aamc.org/data-reports/workforce/data/figure-20-percentage-physicians-sex-and-race/ethnicity-2018>
- Association of American Medical Colleges. (2021). Table 2.2. Number and percentage of ACGME residents and fellows by sex and specialty, 2021. *ACGME residents and fellows by sex and specialty, 2021*. National GME Census in GME Track® (Aug. 27, 2022). <https://www.aamc.org/data-reports/workforce/data/acgme-residents-fellows-sex-and-specialty-2021>
- Association of American Medical Colleges. (2022a). *Faculty roster: U.S. medical school faculty*. 2022 U.S. medical school faculty distribution of full-time U.S. medical school faculty.

Table 9: U.S. medical school faculty by gender and rank, 2022.

<https://www.aamc.org/data-reports/faculty-institutions/data/2022-us-medical-school-faculty>

Association of American Medical Colleges. (2022b, September). *Table B-3. Number of active residents, by type of medical school, GME specialty, and gender.*

<https://www.aamc.org/data-reports/students-residents/data/report-residents/2022/table-b3-number-active-residents-type-medical-school-gme-specialty-and-gender>

Association of American Medical Colleges. (2022c, December). *2023 U.S. physician workforce data dashboard: Total physicians in all specialties.* Retrieved March 29, 2024

<https://www.aamc.org/data-reports/data/2023-us-physician-workforce-data-dashboard>

Association of American Medical Colleges. (2023a). *Faculty roster: U.S. medical school faculty.* U.S. medical school deans by dean type and gender. <https://www.aamc.org/data-reports/faculty-institutions/data/us-medical-school-deans-trends-type-and-gender>

Association of American Medical Colleges. (2023b). Report on residents: *Table B3. Number of active residents, by type of medical school, GME specialty, and gender, 2022-2023 active residents.* Retrieved March 29, 2024 from <https://www.aamc.org/data-reports/students-residents/data/report-residents/2023/table-b3-number-active-residents-type-medical-school-gme-specialty-and-gender>

Association of American Medical Colleges. (2023c). U.S. medical school faculty. *Table 13: U.S. medical school faculty by gender, rank, and department, 2023.* Retrieved March 29, 2024 from <https://www.aamc.org/data-reports/faculty-institutions/report/faculty-roster-us-medical-school-faculty>

Association of American Medical Colleges. (2023d, July). 2023 FACTS: Enrollment, graduates, and MD-PhD data by gender and race/ethnicity, *Table B-4: Total U.S. MD-granting medical school graduates.* Retrieved March 30, 2024 from <https://www.aamc.org/data-reports/students-residents/data/2023-facts-enrollment-graduates-and-md-phd-data>

Association of American Medical Colleges. (2023e, September). Report on residents. Table C8. Full-time faculty-appointment status at U.S. medical schools for residents who completed residencies, by specialty and rank. *Residents who completed training, 2013-22.* Retrieved from <https://www.aamc.org/data-reports/students-residents/data/report-residents/2023/table-c8-full-time-faculty-appointment-status-us-medical-schools-residents>

Association of American Medical Colleges. (2023f, October 27). *2023 FACTS: Applicants and matriculants data, by legal residence and gender.* Table A-7.2: Applicants, first-time applicants, acceptees, and matriculants to U.S. MD-granting medical schools by gender, 2014-2015 through 2023-2024. Retrieved from <https://www.aamc.org/data-reports/students-residents/data/2023-facts-applicants-and-matriculants-data>

Association of American Medical Colleges. (2023g, November). 2023 FACTS: Enrollment, graduates, and MD-PhD data by institution, *Table B-1.2: Total Enrollment by U.S. MD-*

granting medical school and gender. Retrieved March 30, 2024 from <https://www.aamc.org/data-reports/students-residents/data/2023-facts-enrollment-graduates-and-md-phd-data>

Association of American Medical Colleges (2023h, December). *U.S. medical school faculty, Table 8: U.S. medical school faculty by gender and race/ethnicity, 2023*. Retrieved March 29, 2024 from <https://www.aamc.org/data-reports/faculty-institutions/report/faculty-roster-us-medical-school-faculty>

Association of American Medical Colleges. (2023i, December). *U.S. medical school faculty, Table 9: U.S. medical school faculty by gender and rank, 2023*. Retrieved March 29, 2024 <https://www.aamc.org/data-reports/faculty-institutions/report/faculty-roster-us-medical-school-faculty>

Association of American Medical Colleges. (2023j December 31). *U.S. medical school faculty, 2023. Table C: Department chairs by department, gender, and race/ethnicity*. Retrieved March 29, 2024. <https://www.aamc.org/data-reports/faculty-institutions/report/faculty-roster-us-medical-school-faculty>

Association of American Medical Colleges. (2024a). 2023 U.S. physician workforce data dashboard. *Total physicians in all specialties: Physicians by race/ethnicity*. <https://www.aamc.org/data-reports/data/2023-us-physician-workforce-data-dashboard>

Association of American Medical Colleges. (2024b). *U.S. physician workforce data dashboard: 2023 key findings and definitions*. Retrieved from <https://www.aamc.org/data-reports/data/2023-key-findings-and-definitions>

Association of Women Surgeons. (2023). Author. <https://www.womensurgeons.org>

Atewologun, D. (2018). Intersectionality theory and practice. In *Oxford research encyclopedia of business and management*. <https://doi.org/10.1093/acrefore/9780190224851.013.48>

Au, M. (2011). *This won't hurt a bit (and other white lies): My education in medicine and motherhood*. Grand Central.

Babbitt, L. G. (2013). An intersectional approach to Black/White interracial interactions: The roles of gender and sexual orientation. *Sex Roles*, 68, 791-802. <https://doi.org/10.1007/s11199-011-0104-4>

Bajaj, S. S., Tu, L., & Stanford, F. C. (2021). Superhuman, but never enough: Black women in medicine. *Lancet*, 398(10309), 1398–1399. [https://doi.org/10.1016/S0140-6736\(21\)02217-0](https://doi.org/10.1016/S0140-6736(21)02217-0)

Barab, S. A., MaKinster, J. G., & Scheckler, R. (2003). Designing system dualities: Characterizing a web-supported professional development community. *The Information Society*, 19(3), 237-256. <https://doi.org/10.1080/01972240390210064>

- Bartholomew, T. T., Joy, E. E., Kang, E., & Brown, J. (2021). A choir or cacophony? Sample sizes and quality of conveying participants' voices in phenomenological research. *Methodological Innovations*, 14(2), 20597991211040063. <https://doi.org/10.1177/20597991211040063>
- Baumgardner, J. (2011). "Is there a fourth wave? Does it matter?" In J. Baumgardner (Ed.), *F'em! Goo goo, gaga and dome thoughts on balls* (pp. 1–3). Seal Press. <http://www.feminist.com/resources/artspeech/genwom/baumgardner2011.html>
- Berraf, H. L. D. (2022). The representation of women in post #MeToo Hollywood: Three case studies—*Bombshell*, *The Assistant*, and *Once Upon a Time . . . In Hollywood*. *AMERICANA: E-Journal of American Studies in Hungary*, 18(1). <https://www.americanaejournal.hu/index.php/americanaejournal/article/view/45478>
- Berry-James, R. M., Blessett, B., Emas, R., McCandless, S., Nickels, A. E., Norman-Major, K., & Vinzant, P. (2021). Stepping up to the plate: Making social equity a priority in public administration's troubled times. *Journal of Public Affairs Education*, 27(1), 5-15. <https://doi.org/10.1080/15236803.2020.1820289>
- Beshiri, P. H. (1969). *The woman doctor*. Cowles.
- Bierema, L. L. (2002). A feminist approach to HRD research. *Human Resource Development Review*, 1(2), 244-268. <https://doi.org/10.1177/1534484302012006>
- Billick, M., Rassos, J., & Ginsburg, S. (2022). Dressing the part: gender differences in residents' experiences of feedback in internal medicine. *Academic Medicine*, 97(3), 406-413. <https://doi.org/10.1097/acm.0000000000004487>
- Black Lives Matter*. (2024, March 7). About. <https://blacklivesmatter.com/about>
- Blackwell, T., Cassel, C., Duffy, F. D., Holmboe, E., Humphrey, H., Reuben, D., Rodgers, G., Saag, M., Wachter, R., Wesson, D., Wexler, L., & Langdon, L. (2006, March). *Final report of the Committee on Recognizing New and Emerging Disciplines in Internal Medicine (NEDIM) - 2*. American Board of Internal Medicine. <https://www.abim.org/Media/tp1kirzg/nedim-2-report.pdf>
- Blau, F. D., & Kahn, L.M. (2017). The gender wage gap: Extent, trends, and explanations. *Journal of Economic Literature*, 55(3), 789-865. <https://doi.org/10.1257/jel.20160995>
- Bleich, S. N., Özaltın, E., & Murray, C. J. (2009). How does satisfaction with the health-care system relate to patient experience? *Bulletin of the World Health Organization*, 87(4), 271-278. <https://doi.org/10.2471/blt.07.050401>
- Blevins, K. (2018). bell hooks and consciousness-raising: Argument for a fourth wave of feminism. In J. R. Vickery & T. Everbach (Eds.), *Mediating misogyny: Gender, technology, and harassment* (pp. 91-108). Palgrave MacMillan. https://doi.org/10.1007/978-3-319-72917-6_5

- Bluestone, N. R. (1978). The future impact of women physicians on American medicine. *American Journal of Public Health*, 68(8), 760–763. <https://doi.org/10.2105/ajph.68.8.760>
- Blumhagen D. W. (1979). The doctor's white coat: The image of the physician in modern America. *Annals of Internal Medicine* 91(1), 111–116. <https://doi.org/10.7326/0003-4819-91-1-111>
- Boamah, S. A., Hamadi, H. Y., Havaei, F., Smith, H., & Webb, F. (2022). Striking a balance between work and play: The effects of work–life interference and burnout on faculty turnover intentions and career satisfaction. *International Journal of Environmental Research and Public Health*, 19(2), 809. <https://doi.org/10.3390/ijerph19020809>
- Borges, N. J., Navarro, A. M., Grover, A., & Hoban, J. D. (2010). How, when, and why do physicians choose careers in academic medicine? A literature review. *Academic Medicine*, 85(4), 680-686. <https://doi.org/10.1097/acm.0b013e3181d29cb9>
- Borges, N. J., Navarro, A. M., & Grover, A. C. (2012). Women physicians: Choosing a career in medicine. *Academic Medicine*, 87(1), 105-114. <https://doi.org/10.1097/acm.0b013e31823ab4a8>
- Boston Women's Health Book Collective. (1973). *Our bodies, ourselves*. Simon & Schuster.
- Boston Women's Health Collective. (1970). *Women and their bodies: A course*. New England Free Press. <https://www.ourbodiesourselves.org/wp-content/uploads/Women-and-Their-Bodies-1970.pdf>
- Boulis, A. K., & Jacobs, J. A. (2008). *The changing face of medicine: Women doctors and the evolution of health care in America*. Cornell University Press.
- Bowman, M. A. (2002). Women in medical schools and academia. In M. Bowman, E. Frank, & D. Allen (Eds.), *Women in medicine* (3rd ed., pp. 110-120). Springer.
- Bowman, M. A., & Allen, D. I. (1990). *Stress and women physicians* (2nd ed.). Springer-Verlag.
- Bowman, M. A., Frank, E., & Allen, D. I. (2002). *Women in medicine: Career and life management* (3rd ed.). Springer.
- Boyd, A., & McEwan, B. (2024). Viral paradox: The intersection of “me too” and #MeToo. *New Media & Society*, 26(6), 3454-3471. <https://doi.org/10.1177/14614448221099187>
- Britton, D. M. (2000). The epistemology of the gendered organization. *Gender & Society*, 14(3), 418-434. <https://doi.org/10.1177/089124300014003004>
- Britton, D. M., & Logan, L. (2008). Gendered organizations: Progress and prospects. *Sociology Compass*, 2(1), 107-121. Portico. <https://doi.org/10.1111/j.1751-9020.2007.00071.x>

- Brodsky v. Kaleida Health et al. [U.S. District Court, Western District of New York, Case No. 1:01-cv-00676], Volume F. Supp. (2007).
https://textbookdiscrimination.com/Files/USNYWD/07000196_C_20070327_080022.pdf
- Bronner, S. E. (2011). *Critical theory: A very short introduction*. Oxford University Press.
- Brottman, M. R., Char, D. M., Hattori, R. A., Heeb, R., & Taff, S. D. (2020). Toward cultural competency in health care: A scoping review of the diversity and inclusion education literature. *Academic Medicine*, 95(5), 803-813. <https://doi.org/10.1097/acm.0000000000002995>
- Brown, A. J., Swinyard, W., & Ogle, J. (2003). Women in academic medicine: A report of focus groups and questionnaires, with conjoint analysis. *Journal of Women's Health*, 12, 999-1008. <https://doi.org/10.1089/154099903322643929>
- Brown-Berchtold, L., Yu, K., Hunagund, S., & Tsai, N. (2024). Rates of burnout and utilization of employee assistance program among attending physicians at San Joaquin General Hospital and County Clinics. *Journal of Workplace Behavioral Health*, 1-8. <https://doi.org/10.1080/15555240.2024.2313093>
- Brubaker, L. (2020). Women physicians and the COVID-19 pandemic. *JAMA*, 324(9), 835-836. <https://jamanetwork.com/journals/jama/fullarticle/2769140>
- Bull, C., Byrnes, J., Hettiarachchi, R., & Downes, M. (2019). A systematic review of the validity and reliability of patient-reported experience measures. *Health Services Research*, 54(5), 1023-1035. <https://doi.org/10.1111/1475-6773.13187>
- Bunton, S. A. & Henderson, M. K. (2013). *Handbook of academic medicine: How medical schools and teaching hospitals work*. Association of American Medical Colleges. <https://store.aamc.org/handbook-of-academic-medicine-how-medical-schools-and-teaching-hospitals-work-print.html>
- Burgess, D. J., Joseph, A., van Ryn, M., & Carnes, M. (2012). Does stereotype threat affect women in academic medicine? *Academic Medicine*, 87(4), 506-512. <https://doi.org/10.1097/acm.0b013e318248f718>
- Burke, T. (2021). *Unbound: My story of liberation and the birth of the Me Too movement*. Flatiron Books: An Oprah Book.
- Butkus, R., Serchen, J., Moyer, D. V., Bornstein, S. S., Hingle, S. T., & Health and Public Policy Committee of the American College of Physicians. (2018). Achieving gender equity in physician compensation and career advancement: A position paper of the American College of Physicians. *Annals of Internal Medicine*, 168(10), 721-723. <https://doi.org/10.7326/m17-3438>
- Butter, I., Carpenter, E., Kay, B., & Simmons, R. (1985). *Sex and status: Hierarchies in the health workforce*. American Health Association.

- Calás, M. B., & Smircich, L. (2006). From the “woman’s point of view” 10 years later: Towards a feminist organization studies. In S. R. Clegg, C. Hardy, T. B. Lawrence, & W. R. Nord (Eds.), *The Sage handbook of organization studies* (2nd ed., pp. 284-346). Sage.
https://sk.sagepub.com/reference/hdbk_orgstudies2ed/n9.xml
- Callahan, J. L. (2007). Gazing into the crystal ball: Critical HRD as a future of research in the field. *Human Resource Development International*, 10(1), 77-82.
<https://doi.org/10.1080/13678860601170344>
- Cameron, K. S., & Quinn, R. E. (2011). *Diagnosing and changing organizational culture* (3rd ed). Jossey-Bass.
- Campo-Flores, A., Ansari, T., Ailworth, R., & Bauerlein, V. (2020, June 1). Anger and unrest sweep across US. *Wall Street Journal*. <https://www.wsj.com/articles/george-floyd-protests-minneapolis-11590844180>
- Cannella, G. S., & Lincoln, Y. S. (2011). Ethics, research regulations, and critical social science. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp.81-89). Sage.
- Carnes, M., Morrissey, C., & Geller, S. E. (2008). Women’s health and women’s leadership in academic medicine: Hitting the same glass ceiling? *Journal of Women’s Health*, 17, 1453–1462. <https://doi.org/10.1089/jwh.2007.0688>
- Carr, P. L., Ash, A. S., Friedman, R. H., Szalacha, L., Barnett, R. C., Palepu, A., & Moskowitz, M. M. (2000). Faculty perceptions of gender discrimination and sexual harassment in academic medicine. *Annals of Internal Medicine*, 132(11), 889-896.
<https://doi.org/10.7326/0003-4819-132-11-200006060-00007>
- Carr, P. L., Szalacha, L., Barnett, R., Caswell, C., & Inui, T. (2003). A “ton of feathers”: Gender discrimination in academic medical careers and how to manage it. *Journal of Women’s Health*, 12(10), 1009-1018. <https://doi.org/10.1089/154099903322643938>
- Carvajal, M. J., Popovici, I., & Hardigan, P. C. (2018). Gender differences in the measurement of pharmacists’ job satisfaction. *Human Resources for Health*, 16, 1-8.
<https://doi.org/10.1186/s12960-018-0297-5>
- Cassel, C. K., & Reuben, D. B. (2011). Specialization, subspecialization, and subspecialization in internal medicine. *New England Journal of Medicine*, 364(12), 1169-1173. <https://doi.org/10.1056/nejmsb1012647>
- Cassell, J. (1998). *The woman in the surgeon’s body*. Harvard University Press.
- Catenaccio, E., Rochlin, J. M., & Simon, H. K. (2022). Addressing gender-based disparities in earning potential in academic medicine. *JAMA Network Open*, 5(2), e220067-e220067.
<https://doi.org/10.1001/jamanetworkopen.2022.0067>

Centers for Medicare and Medicaid Services. (2024, March 7). *HCAHPS: Patients' perspectives of care survey*. <https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey>

Chan, A. S., & Fisher, D. (Eds.). (2009). *The exchange university: Corporatization of academic culture*. UBC Press.

Chapman, E. N., Kaatz, A., & Carnes, M. (2013). Physicians and implicit bias: How doctors may unwittingly perpetuate health care disparities. *Journal of General Internal Medicine*, 28(11), 1504–1510. <https://doi.org/10.1007/s11606-013-2441-1>

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127-154). Left Coast Press.

Charmaz, K., & Belgrave, L. L. (2012). Qualitative interviewing and grounded theory analysis. In J. F. Gubrium, J. A. Holstein, A. B. Marvasti, & K. D. McKinney (Eds.), *The Sage handbook of interview research: Complexity of the craft* (pp. 347-367). Sage.

Cheryan, S., & Markus, H. R. (2020). Masculine defaults: Identifying and mitigating hidden cultural biases. *Psychological Review*, 127(6), 1022-1052. <https://doi.org/10.1037/rev000209>

Chesak, S. S., Cutshall, S., Anderson, A., Pulos, B., Moeschler, S., & Bhagra, A. (2020). Burnout among women physicians: A call to action. *Current Cardiology Reports*, 22(7), 1-9. <https://doi.org/10.1007/s11886-020-01300-6>

Chin, E. L. (2002). *This side of doctoring: Reflections from women in medicine*. Sage.

Chow, C. J., Millar, M. M., & López, A. M. (2020). Gender discrimination among academic physicians. *Women's Health Reports*, 1(1), 203-211. <https://doi.org/10.1089/whr.2020.0031>

Churchman, D. (2002). Voices of the academy: Academics' responses to the corporatizing of academia. *Critical Perspectives on Accounting*, 13(5-6), 643-656. <https://doi.org/10.1006/cpac.2002.0564>

Cislaghi, B., & Heise, L. (2019). Gender norms and social norms: Differences, similarities and why they matter in prevention science. *Sociology of Health & Illness*, 42(2), 407-422. <https://doi.org/10.1111/1467-9566.13008>

Clance, P. R., & Imes, S. (1978). The imposter phenomenon in high achieving women: Dynamics and therapeutic intervention. *Psychotherapy Theory, Research and Practice*, 15(3), 241-247. <https://doi.org/10.1037/h0086006>

- Cockerham, W. C. (2005). Health lifestyle theory and the convergence of agency and structure. *Journal of Health and Social Behavior*, 46, 51-67. <https://doi.org/10.1177/002214650504600105>
- Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., De Vries, A. L., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M. Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. M., Motmans, J., Nahata, L., . . . Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people: Version 8. *International Journal of Transgender Health*, 23(Supp 1), S1-S259. <https://doi.org/10.1080/26895269.2022.2100644>
- Collins, T. C., Clark, J. A., Petersen, L. A., & Kressin, N. R. (2002). Racial differences in how patients perceive physician communication regarding cardiac testing. *Medical Care*, 40(Suppl. 1), I27-I34. <https://doi.org/10.1097/00005650-200201001-00004>
- Colvin, C. (2022, July 20). *Once neglected, DEI initiatives now present at all Fortune 100 companies*. <https://www.hrdiver.com/news/2022-fortune-companies-dei/627651>
- Conley, F. K. (1998). *Walking out on the boys*. Farrar, Straus & Giroux.
- Conrad, P., Carr, P., Knight, S., Renfrew, M. R., Dunn, M. B., & Pololi, L. (2010). Hierarchy as a barrier to the advancement of women in academic medicine. *Journal of Women's Health*, 19(4), 799-805. <https://doi.org/10.1089/jwh.2009.1591>
- Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine*, 139(11), 907–915. <https://doi.org/10.7326/0003-4819-139-11-200312020-00009>
- Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Hong Thi Vu, Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *JAMA*, 282(6), 583-589. <https://doi.org/10.1001/jama.282.6.583>
- Corbin, J., & Strauss, A. (1990). Grounded theory method: Procedures, canons, and evaluation procedures. *Qualitative Sociology*, 13(1), 3-21. <https://doi.org/10.1007/bf00988593>
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research*. Sage.
- Correll, S. J., Benard, S., & Paik, I. (2007). Getting a job: Is there a motherhood penalty? *American Journal of Sociology*, 112(5), 1297-1338. <https://doi.org/10.1086/511799>
- Craddick, R. A., Thumin, F. J., & Barclay, A. G. (1971). A semantic differential study of the yin-yang symbol. *Journal of Personality Assessment*, 35(4), 338-343. <https://doi.org/10.1080/00223891.1971.10119679>
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine. *University of Chicago Legal Forum*. 1989(1), 139-168. <https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf>

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241-1299.
<https://doi.org/10.2307/1229039>

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Sage.

Cropanzano, R. (2001). Preface. In R. Cropanzano (Ed.), *Justice in the workplace* (pp. xii-xiii). Lawrence Erlbaum Associates.

Crotty, M. (1998). *The foundations of social research*. Sage.

Cruess, R. L., Cruess, S. R., Boudreau, J. D., Snell, L., & Steinert, Y. (2014). Reframing medical education to support professional identity formation. *Academic Medicine*, 89(11), 1446-1451. <https://doi.org/10.1097/ACM.0000000000000427>

Cruess, R. L., Cruess, S. R., & Steinert, Y. (2018). Medicine as a community of practice: Implications for medical education. *Academic Medicine*, 93(2), 185-191.
<https://doi.org/10.1097/ACM.0000000000001826>

Daly, G. (2006). Marxism. In S. Malpas & P. White (Eds.), *The Routledge companion to critical theory* (pp. 28-42). Routledge.

Daniels, S., McLaughlin, J., Gleason, K. A., McDade, S. A., Richman, R., & Morahan, P. S. (2009). Medical school deans' perceptions of organizational climate: Useful indicators for advancement of women faculty and evaluation of a leadership program's impact. *Academic Medicine*, 84(1), 67-79. <https://doi.org/10.1097/acm.0b013e3181906d37>

De Koninck, M., Bergeron, P., & Bourbonnais, R. (1997). Women physicians in Quebec. *Social Science & Medicine*, 44(12), 1825-1832. [https://doi.org/10.1016/s0277-9536\(96\)00292-4](https://doi.org/10.1016/s0277-9536(96)00292-4)

Deliso, M. (2021, April 21). Timeline: The impact of George Floyd's death in Minneapolis and beyond. *ABC News*. <https://abcnews.go.com/US/timeline-impact-george-floyds-death-minneapolis/story?id=70999322>

Deloitte. (2021, July 22). For Millennials and Gen Zs, social issues are top of mind—Here's how organizations can drive meaningful change. *Forbes*.
<https://www.forbes.com/sites/deloitte/2021/07/22/for-millennials-and-gen-zs-social-issues-are-top-of-mind-heres-how-organizations-can-drive-meaningful-change/?sh=401a0165450c>

Denison, D. R. (1990). *Corporate culture and organizational effectiveness*. Wiley & Sons.

Denzin, N. K., & Lincoln, Y. S. (2011). Introduction: the discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., 1-19). Sage.

Dey, I. (1993). *Qualitative data analysis: A user-friendly guide for social scientists*. Routledge. <https://doi.org/10.4324/9780203412497>

DiAngelo, R. (2018). *White fragility: Why it's so hard for White people to talk about racism*. Beacon Press.

Doescher, M. P., Saver, B. G., Franks, P., & Fiscella, K. (2000). Racial and ethnic disparities in perceptions of physician style and trust. *Archives of Family Medicine*, 9(10), 1156-1163. <https://doi.org/10.1001/archfami.9.10.1156>

Dudley, J., McLaughlin, S., & Lee, T. H. (2022, January 19). Why so many women physicians are quitting. *Harvard Business Review*. <https://hbr.org/2022/01/why-so-many-women-physicians-are-quitting>

Dunivin, Z. O., Yan, H. Y., Ince, J., & Rojas, F. (2022). Black Lives Matter protests shift public discourse. *Proceedings of the National Academy of Sciences*, 119(10), e2117320119. <https://doi.org/10.1073/pnas.2117320119>

Dyrbye, L. N., Sotile, W., Boone, S., West, C. P., Tan, L., Satele, D., Sloan, J., Oreskovich, M., & 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. <https://doi.org/10.1007/s11606-013-2581-3>

Dyrbye, L. N., Shanafelt, T. D., Sinsky, C. A., Cipriano, P. F., Bhatt, J., Ommaya, A., West, C. P., & Meyers, D. (2017). Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. *NAM Perspectives*, 7(7). <https://doi.org/10.31478/201707b>

Earvolino-Ramirez, M. (2007). Resilience: A concept analysis. *Nursing Forum*, 42, 73-82. <https://doi.org/10.1111/j.1744-6198.2007.00070.x>

Eddo-Lodge, R. (2017). *Why I'm no longer talking to White people about race*. Bloomsbury.

Edmunds, L. D., Ovseiko, P. V., Shepperd, S., Greenhalgh, T., Frith, P., Roberts, N. W., Pololi, L. H., & Buchan, A. M. (2016). Why do women choose or reject careers in academic medicine? A narrative review of empirical evidence. *The Lancet*, 388(10062), 2948-2958. [https://doi.org/10.1016/s0140-6736\(15\)01091-0](https://doi.org/10.1016/s0140-6736(15)01091-0)

Elta, G. H. (2011). The challenges of being a female gastroenterologist. *Gastroenterology Clinics of North America*, 40(2), 441-447. <https://doi.org/10.1016/j.gtc.2011.03.004>

Ely, R. J., & Meyerson, D. E. (2000). Theories of gender in organizations: A new approach to organizational analysis and change. *Research in Organizational Behavior*, 22, 103-151. [https://doi.org/10.1016/S0191-3085\(00\)22004-2](https://doi.org/10.1016/S0191-3085(00)22004-2)

Ely, R., & Padavic, I. (2007). A feminist analysis of organizational research on sex differences. *Academy of Management Review*, 32(4), 1121-1143. <https://doi.org/10.5465/amr.2007.26585842>

- Epstein, C. F. (1970). *Woman's place: Options and limits in professional careers*. University of California Press.
- Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centered care. *Annals of Family Medicine*, 9(2), 100-103. <https://doi.org/10.1370/afm.1239>
- Erhard, M., Schoenfelder, J., Fügenger, J., & Brunner, J. O. (2018). State of the art physician scheduling. *European Journal of Operational Research*, 265(1), 1-18. <https://doi.org/10.1016/j.ejor.2017.06.037>
- Farrow, R. (2019). *Catch and kill: Lies, spies, and a conspiracy to protect predators*. Hachette UK.
- Feenstra, S., Begeny, C. T., Ryan, M. K., Rink, F. A., Stoker, J. I., & Jordan, J. (2020). Contextualizing the imposter “syndrome.” *Frontiers in Psychology*, 11(5075024). <https://doi.org/10.3389/fpsyg.2020.575024>
- Fenwick, T. J. (2004). Toward a critical HRD in theory and practice. *Adult Education Quarterly*, 54(3), 193-209. <https://doi.org/10.1177/0741713604263051>
- Files, J. A., Mayer, A. P., Ko, M. G., Friedrich, P., Jenkins, M., Bryan, M. J., Vegunta, S., Wittich, C. M., Lyle, M. A., Melikian, R., Duston, T., Chang, Y-H. H., & Hayes, S. N. (2017). Speaker introductions at internal medicine grand rounds: Forms of address reveal gender bias. *Journal of Women's Health*, 26(5), 413-419. <https://doi.org/10.1089/jwh.2016.6044>
- Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *Journal of Pediatrics*, 136(1), 14-23. [https://doi.org/10.1016/s0022-3476\(00\)90043-x](https://doi.org/10.1016/s0022-3476(00)90043-x)
- Folger, R. (1977). Distributive and procedural justice: Combined impact of “voice” and improvement on experienced inequity. *Journal of Personality and Social Psychology*, 35(2), 108-119. <https://doi.org/10.1037//0022-3514.35.2.108>
- Foster, S. W., McMurray, J. E., Linzer, M., Leavitt, J. W., Rosenberg, M., & Carnes, M. (2000). Results of a gender-climate and work-environment survey at a Midwestern academic health center. *Academic Medicine*, 75(6), 653-660. <https://doi.org/10.1097/00001888-200006000-00019>
- Frank, E., Boswell, L., Dickstein, L.J., & Chapman, D.P. (2001). Characteristics of female psychiatrists. *American Journal of Psychiatry*, 158, 205-212. <https://doi.org/10.1176/appi.ajp.158.2.205>
- Frank, E., Brownstein, M., Ephgrave, K., & Neumayer, L. (1998). Characteristics of women surgeons in the United States. *American Journal of Surgery*, 176, 244-250. [https://doi.org/10.1016/s0002-9610\(98\)00152-4](https://doi.org/10.1016/s0002-9610(98)00152-4)

- Frank, E., & Cone, K. (2000). Characteristics of pregnant vs. non-pregnant women physicians: Findings from the women physicians' health study. *International Journal of Gynecology and Obstetrics*, 69, 37-46. [https://doi.org/10.1016/s0020-7292\(99\)00224-6](https://doi.org/10.1016/s0020-7292(99)00224-6)
- Frank, E., Fee, E., Parry, M., & More, E. S. (2009). Opportunities and obstacles for women physicians in the 21st century. In E. S. More, E. Fee, & M. Parry (Eds.), *Women physicians and the cultures of medicine* (pp. 319-341). Johns Hopkins University Press. <https://www.press.jhu.edu/books/title/9686/women-physicians-and-cultures-medicine>
- Franks, A. M., Calamur, N., Dobrian, A., Danielsen, M., Neumann, S. A., Cowan, E., & Weiler, T. (2022). Rank and tenure amongst faculty at academic medical centers: A study of more than 50 years of gender disparities. *Academic Medicine*, 97(7), 1038-1048. <https://doi.org/10.1097/acm.0000000000004706>
- Frei, A. S. (2015). Bow tie or no tie: A rule to reduce healthcare-acquired infections. *Journal of Community Hospital Internal Medicine Perspectives*, 5(5), 28808. <http://dx.doi.org/10.3402/jchimp.v5.28808>
- Gadamer, H.-G. (2008). *Philosophical hermeneutics* (30th anniversary ed.). University of California Press. (Original published in 1978)
- Gamble, V. N. (2000). Subcutaneous scars. *Health Affairs*, 19(1), 164-169. <https://doi.org/10.1377/hlthaff.19.1.164>
- Gardner, R. L., Cooper, E., Haskell, J., Harris, D. A., Poplau, S., Kroth, P. J., & Linzer, M. (2019). Physician stress and burnout: The impact of health information technology. *Journal of the American Medical Informatics Association*, 26(2), 106-114. <https://doi.org/10.1093/jamia/ocy145>
- Gartmeier, M., Baumgartner, M., Burgkart, R., Heiniger, S., & Berberat, P. O. (2019). Why hand hygiene is not sufficient: Modeling hygiene competence of clinical staff as a basis for its development and assessment. *GMS Journal for Medical Education*, 36(4). <https://www.egms.de/static/en/journals/zma/2019-36/zma001247.shtml>
- Garvey, R., Stokes, P., & Megginson, D. (2018). *Coaching and mentoring: Theory and practice* (3rd ed.). Sage.
- Gibbs, G. R. (2007). *Analyzing qualitative data*. Sage.
- Gibson, D. D., & Borges, N. J. (2009). Aligning career expectations with the practice of medicine physician satisfaction. *Journal of Career Development*, 35(4), 331-351. <https://doi.org/10.1177/0894845309335240>
- Ginty, M. (2004, May 4). *Our bodies, ourselves* turns 35 today. *Women's eNews*. <http://womensenews.org/story/health/040504/our-bodies-ourselves-turns-35-today#.UiTOM2Sf4vE>

- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. AldineTransaction.
- Goldenberg, M. J. (2006). On evidence and evidence-based medicine: Lessons from the philosophy of science. *Social Science & Medicine*, 62(11), 2621-2632.
<https://doi.org/10.1016/j.socscimed.2005.11.031>
- Greenberg, J. (1987). A taxonomy of organisational justice theories, *Academy of Management Review*, 12(1), 9-22. <https://doi.org/10.2307/257990>
- Greene, J. C. (1994). Qualitative program evaluation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 530-544). Sage.
- Glesne, C. (2011). *Becoming qualitative researchers: An introduction* (4th ed.). Allyn & Bacon.
- Grigsby, R. K. (2009). Organizational culture and its consequences. In T. Cole, T. Goodrich, & E. Gritz (Eds.), *Faculty health in academic medicine: Physicians, scientists and the pressures of success* (pp. 115-126). Humana Press.
- Group, T. M., & Roberts, J. I. (2001). *Nursing, physician control, and the medical monopoly: Historical perspectives on gendered inequality in roles, rights, and range of practice*. Indiana University Press.
- Grow, H. M., McPhillips, H. A., & Batra, M. (2019). Understanding physician burnout. *Current Problems in Pediatric and Adolescent Health Care*, 49(11), 100656.
<https://doi.org/10.1016/j.cppeds.2019.100656>
- Guba, E. G. (1990). The alternative paradigm dialog. In E. G. Guba (Ed.), *The paradigm dialog* (pp. 17–27). Sage.
- Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. Jossey-Bass.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Sage.
- Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Sage.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 191-215). Sage.
- Gustafson, J. A. (1982). Professions as “callings.” *Social Service Review*, 56(4), 501–515.
<https://doi.org/10.1086/644044>
- Haar, J. M., Russo, M., Suñe, A., & Ollier-Malaterre, A. (2014). Outcomes of work–life balance on job satisfaction, life satisfaction and mental health: A study across seven cultures.

Journal of Vocational Behavior, 85(3), 361-373.
<https://doi.org/10.1016/j.jvb.2014.08.010>

Hamel, M. B., Ingelfinger, J. R., Phimister, E., & Solomon, C. G. (2006). Women in academic medicine—Progress and challenges. *New England Journal of Medicine*, 355(3), 310-312.
<https://www.nejm.org/doi/full/10.1056/NEJMe068143>

Hamera, J. (2011). Performance ethnography. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 317-330). Sage.

Han, S., Chae, C., Han, S. J., & Yoon, S. W. (2017). Conceptual organization and identity of HRD: Analyses of evolving definitions, influence, and connections. *Human Resource Development Review*, 16(3), 294-319. <https://doi.org/10.1177/1534484317719822>

Harrison, M. E. (1998). Female physicians in Mexico: Migration and mobility in the lifecourse. *Social Science & Medicine*, 47(4), 455-468. [https://doi.org/10.1016/s0277-9536\(98\)00112-9](https://doi.org/10.1016/s0277-9536(98)00112-9)

Harvey, J. C., & Katz, C. (1985). *If I'm so successful, why do I feel like a fake? The imposter phenomenon*. St. Martin's Press.

Hearn, J. (2014). On men, organizations and intersectionality: Personal, working, political and theoretical reflections (or how organization studies met profeminism). *Equality, Diversity and Inclusion*, 33(5), 414-428. <https://doi.org/10.1108/edi-07-2013-0051>

Hearn, J., & Louvrier, J. (2015). Theories of difference, diversity, and intersectionality. In R. Bendl, I. Bleijenbergh, E. Henttonen, & A. J. Mills (Eds.), *The Oxford handbook of diversity in organizations* (pp. 62-82). Oxford University Press. <https://doi.org/10.1093/oxfordhb/9780199679805.013.28>

Heidegger, M. (2008). *Being and time* (J. Macquarrie & E. Robinson, Trans). HarperPerennial. (Original work published 1962)

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Zewdie, D., Darmstadt, G. L., Greene, M. E., Hawkes, S., Heise, L., Henry, S., Heymann, J., Klugman, J., Levine, R., Raj, A., & Rao Gupta, G. (2019). Gender inequality and restrictive gender norms: Framing the challenges to health. *The Lancet*, 393(10189), 2440–2454.
[https://doi.org/10.1016/s0140-6736\(19\)30652-x](https://doi.org/10.1016/s0140-6736(19)30652-x)

Hekman, S. (2006). Feminism. In S. Malpas & P. Wake (Eds.), *The Routledge companion to critical theory* (pp. 91-101). Routledge.

Heron, J., & Reason, P. (1997). A participatory inquiry paradigm. *Qualitative Inquiry*, 3(3), 274-294. <https://doi.org/10.1177/107780049700300302>

Herzke, C., Bonsall, J., Bertram, A., Yeh, H. C., Apfel, A., & Cofrancesco, J., Jr. (2020). Gender issues in academic hospital medicine: A national survey of hospitalist leaders. *Journal of*

- General Internal Medicine*, 35(6), 1641–1646. <https://doi.org/10.1007/s11606-019-05527-0>
- Hill, E., Tiefenthäler, A., Triebert, C., Jordan, D., Willis, H., & Stein, R. (2020, May 21). How George Floyd was killed in police custody. *The New York Times*.
<https://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html>
- Hillstrom, L. C. (2019). *The #MeToo movement*. Bloomsbury.
- Hoekstra, E., Bell, A. & Peterson, S. R. (2008). Humility in leadership: Abandoning the pursuit of unattainable perfection. In S. A. Quatro & R. R. Sims (Eds.), *Executive ethics: Ethical dilemmas and challenges for the C-suite*. Information Age.
https://digitalcollections.dordt.edu/cgi/viewcontent.cgi?article=1034&context=faculty_work
- Hoff, T., & Lee, D. R. (2021). The gender pay gap in medicine: A systematic review. *Health Care Management Review*, 46(3), E37-E49.
<https://doi.org/10.1097/hmr.0000000000000290>
- Hofstede, G., Hofstede, G. J., & Minkov, M. (2010). *Cultures and organizations: Software for the mind* (3rd ed.). McGraw-Hill.
- Horkheimer, M. (2002). Traditional and critical theory. In M. Horkheimer (Trans., M. J. O’Connell), *Critical theory: Selected essays* (pp. 188-243; Original published 1937). Continuum.
- Hueston, W. J., & Carek, S. M. (2011). Patient preference for physician attire: A survey of patients in family medicine practices. *Family Medicine*, 43(9), 643-647.
<https://pubmed.ncbi.nlm.nih.gov/22002776>
- Husserl, E., & Husserl, E. (1965). *Phenomenology and the crisis of philosophy: Philosophy as a rigorous science, & Philosophy and the crisis of European man/Edmund Husserl; translated with notes and an introduction by Quentin Lauer*. (Q. Lauer, Trans.; including translations of several original works dating from 1910). Harper & Row.
- Iannello, K. (2010). Women’s leadership and third-wave feminism. In K. O’Connor (Ed.). *Gender and women’s leadership: A reference handbook* (pp. 70-77). Sage.
- Ingram, D., & Simon-Ingram, J. (1991). Introduction. In D. Ingram & J. Simon-Ingram (Eds.), *Critical theory: The essential readings* (pp. xix-xxxix). Paragon House.
- Institute for Women’s Policy Research. (2018). *The gender wage gap: 2018: Earnings differences by gender, race and ethnicity*. Author. <http://iwpr.org/publications/annual-gender-wage-gap-2018>
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press. <https://doi.org/10.17226/10027>

- Isaac, C. A., Kaatz, A., & Carnes, M. (2011). Deconstructing the glass ceiling. *Sociology Mind*, 2(1), 80-86. <https://www.scirp.org/journal/paperinformation?paperid=16905>
- Jager, A. J., Tutty, M. A., & Kao, A. C. (2017). Association between physician burnout and identification with medicine as a calling. *Mayo Clinic Proceedings*, 92(3), 415-422. <https://doi.org/10.1016/j.mayocp.2016.11.012>
- Johnson-Bailey, J. (1999). The ties that bind and the shackles that separate: Race, gender, class, and color in a research paper. *Qualitative Studies in Education*, 12(6), 659-670. <https://doi.org/10.1080/095183999235818>
- Jolly, S., Griffith, K. A., DeCastro, R., Stewart, A., Ubel, P., & 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. <https://doi.org/10.7326/m13-0974>
- Jones, K. C., & Whatley, M. W. (2016). Hospitalists: A growing part of the primary care workforce. *AAMC Analysis in Brief*, 16(5). <https://www.aamc.org/data-reports/analysis-brief/report/hospitalists-growing-part-primary-care-workforce>
- Jude, A. (2020, August 27). *How Colin Kaepernick inspired activism, awareness and Seattle athletes to speak out against racial injustice*. *Seattle Times*. <https://www.seattletimes.com/pacific-nw-magazine/aug-30-cover-story>
- Kabbash, I. A., El-Sallamy, R. M., Abdo, S. A., & Atalla, A. O. (2020). Job satisfaction among physicians in secondary and tertiary medical care levels. *Environmental Science & Pollution Research*, 27, 37565–37571. <https://doi.org/10.1007/s11356-020-08506-9>
- Kalet, A., Fletcher, K., Ferdman, D. J., & Bickell, N. A. (2006). Defining, navigating and negotiating success: The experiences of mid-career Robert Wood Johnson clinical scholar women. *Journal of General Internal Medicine*, 21, 920–925. <https://doi.org/10.1007/bf02743138>
- Kane, L. (2020, July 15). Women physicians 2020: The issues they care about. *Medscape*. <https://www.medscape.com/slideshow/2020-women-physicians-6013042#3>
- Kane, L. (2023, April 14). *Medscape physician compensation report 2023: Your income vs. your peers': Average annual compensation by specialty*. *Medscape*. <https://www.medscape.com/slideshow/2023-compensation-overview-6016341#3>
- Kao, A. C., & Jager, A. J. (2018). Medical students' views of medicine as a calling and selection of a primary care-related residency. *Annals of Family Medicine*, 16(1), 59-61. <https://doi.org/10.1370/afm.2149>
- Karnieli-Miller, O., Frankel, R. M., & Inui, T. S. (2013). Cloak of compassion, or evidence of elitism? An empirical analysis of white coat ceremonies. *Medical Education*, 47(1), 97–108. <https://doi.org/10.1111/j.1365-2923.2012.04324.x>

- Kass, D. (2015, October 8). How Dr. Linda Brodsky has pulled us all up. *Feminem: Females Working in Emergency Medicine*. <https://feminem.org/2015/10/08/how-dr-linda-brodsky-has-pulled-us-all-up>
- Keeton, K., Fenner, D. E., Johnson, T. R., & Hayward, R. A. (2007). Predictors of physician career satisfaction, work-life balance, and burnout. *Obstetrics & Gynecology*, 109(4), 949-955. <https://doi.org/10.1097/01.aog.0000258299.45979.37>
- Kendi, I. X. (2019). *How to be an antiracist*. One World.
- Khairat, S., Burke, G., Archambault, H., Schwartz, T., Larson, J., & Ratwani, R. M. (2018). Focus section on health IT usability: Perceived burden of EHRs on physicians at different stages of their career. *Applied Clinical Informatics*, 9(02), 336-347. <https://doi.org/10.1055/s-0038-1648222>
- Khanna, S. K., Cheyney, M., & Engle, M. (2009). Cultural competency in health care: Evaluating the outcomes of a cultural competency training among health care professionals. *Journal of the National Medical Association*, 101(9), 886-892. [https://doi.org/10.1016/s0027-9684\(15\)31035-x](https://doi.org/10.1016/s0027-9684(15)31035-x)
- Kilminster, S., Downes, J., Gough, B., Murdoch-Eaton, D., & Roberts, T. (2007). Women in medicine—Is there a problem? A literature review of the changing gender composition, structures and occupational cultures on medicine. *Medical Education*, 41, 39-49. <https://doi.org/10.1111/j.1365-2929.2006.02645.x>
- Kincheloe, J. L., McLaren, P., & Steinberg, S. R. (2011). Critical pedagogy and qualitative research: Moving to the bricolage. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 163-177). Sage.
- King, J. E., & Cooley, E. L. (1995). Achievement orientation and the imposter phenomenon among college students. *Contemporary Educational Psychology*, 20, 304-312. <http://doi.org/10.1006/ceps.1995.1019>
- Krolokke, C., & Sorensen, A.S. (2006). *Gender communication theories and analyses: From silence to performance*. Sage.
- Krupat, E., Rosenkranz, S. L., Yeager, C. M., Barnard, K., Putnam, S. M., & Inui, T. S. (2000). The practice orientations of physicians and patients: The effect of doctor-patient congruence on satisfaction. *Patient Education & Counseling*, 39(1), 49-59. [https://doi.org/10.1016/s0738-3991\(99\)00090-7](https://doi.org/10.1016/s0738-3991(99)00090-7)
- Ku, M. C. (2011). When does gender matter? Gender differences in specialty choice among physicians. *Work and Occupations*, 38(2), 221-262. <https://doi.org/10.1177/0730888410392319>
- Kuchinke, K. P. (2010). Human development as a central goal for human resource development. *Human Resource Development International*, 13(5), 575-585. <https://doi.org/10.1080/13678868.2010.520482>

- Kumar, S., & Jagacinski, C. M. (2006). Imposters have goals too: The imposter phenomenon and its relationship to achievement goal theory. *Personality & Individual Differences*, 40, 147-157. <https://doi.org/10.1016/j.paid.2005.05.014>
- Langford, J., & Clance, P. R. (1993). The imposter phenomenon: Recent research findings regarding dynamics, personality and family patterns and their implications for treatment. *Psychotherapy: Theory, Research, Practice, Training*, 30(3), 495-501. <https://doi.org/10.1037/0033-3204.30.3.495>
- Larson, E., Sharma, J., Bohren, M. A., & Tunçalp, Ö. (2019). When the patient is the expert: Measuring patient experience and satisfaction with care. *Bulletin of the World Health Organization*, 97(8), 563-569. <https://doi.org/10.2471/blt.18.225201>
- Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge: Cambridge University Press.
- Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3), 21-35. <https://doi.org/10.1177/160940690300200303>
- Leadley, J., & Sloane, R. A. (2011). *Women in U.S. academic medicine and science: Statistics and benchmarking report 2009-2010*. Association of American Medical Colleges. <https://www.apcprods.org/assets/docs/ldd/womeninu.s.academicmedicinestatisticsandbenchmarkingreport2009.pdf>
- Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., & Healy, G. B. (2012a). A culture of respect, part 2: Creating a culture of respect. *Academic Medicine*, 87(7), 853-858. <https://doi.org/10.1097/acm.0b013e3182583536>
- Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., & Healy, G. B. (2012b). Perspective: A culture of respect, part 1: The nature and causes of disrespectful behavior by physicians. *Academic Medicine*, 87(7), 845-852. <https://doi.org/10.1097/acm.0b013e318258338d>
- Lee, M. (2001). A refusal to define HRD. *Human Resource Development International*, 4(3), 327-341. <https://doi.org/10.1080/13678860126442>
- Lee, S. E., Lee, M. H., Peters, A. B., & Gwon, S. H. (2020). Assessment of patient safety and cultural competencies among senior baccalaureate nursing students. *International Journal of Environmental Research and Public Health*, 17(12), 4225. <https://doi.org/10.3390/ijerph17124225>
- Levine, R. B., Lin, F., Kern, D. E., Wright, S. M., & Carrese, J. (2011). Stories from early-career women physicians who have left academic medicine: A qualitative study from a single institution. *Academic Medicine*, 86(6), 752-758. <https://doi.org/10.1097/acm.0b013e318217e83b>

- Levinson, W., & Lurie, N. (2004). When most doctors are women: What lies ahead? *Annals of Internal Medicine*, 141, 471-474. <https://doi.org/10.7326/0003-4819-141-6-200409210-00013>
- Levinson, W., Tolle, S. W., & Lewis, C. (1989). Women in academic medicine: Combining career and family. *New England Journal of Medicine*, 321, 1511-1517. <https://doi.org/10.1056/nejm198911303212205>
- Li, B., Jacob-Brassard, J., Dossa, F., Salata, K., Kishibe, T., Greco, E., Baxter, N. N., & Al-Omran, M. (2021). Gender differences in faculty rank among academic physicians: A systematic review and meta-analysis. *BMJ Open*, 11(11), e050322.
- Li, P. P. (2008). Toward a geocentric framework of trust: An application to organizational trust. *Management and Organization Review*, 4(3), 413-439. <https://doi.org/10.1111/j.1740-8784.2008.00120.x>
- Lichtenstein, R. (1984). Measuring the job satisfaction of physicians in organized settings. *Medical Care*, 22(1), 56-68. <https://doi.org/10.1097/00005650-198401000-00005>
- Lieberwitz, R. L. (2005). The corporatization of academic research: Whose interests are served. *Akron Law Review*, 38, 759. <https://ideaexchange.uakron.edu/akronlawreview/vol38/iss4/5>
- Lin, J. C., Bowser, K. E., Drudi, L. M., DiLosa, K. L., & Yi, J. (2021). Equal pay for equal work: Disparities in compensation in vascular surgery. *Journal of Vascular Surgery*, 74(2), 21S-28S. <https://doi.org/10.1016/j.jvs.2021.03.052>
- Lincoln, Y. S. (2011). “A well-regulated faculty . . .”: The coerciveness of accountability and other measures that abridge faculties’ right to teach and research. *Cultural Studies↔ Critical Methodologies*, 11(4), 369-372. <https://doi.org/10.1177/1532708611414668>
- Lincoln, Y. S. (2012). The political economy of publication: Marketing, commodification, and qualitative scholarly work. *Qualitative Health Research*, 22(11), 1451-1459. <https://doi.org/10.1177/1049732312457713>
- Lincoln, Y. S. (2018a). A dangerous accountability: Neoliberalism’s veer toward accountancy in higher education. In M. Spooner & J. McNinch (Eds.), *Dissident knowledge in higher education* (pp. 3-20). University of Regina Press.
- Lincoln, Y. S. (2018b). Fracking the faculty: The privatization of public knowledge, the erosion of faculty worklife quality, the diminution of the liberal arts. In N. K. Denzin & M. D. Giardina [Eds.], *Qualitative inquiry in the public sphere* (pp. 25-32). Routledge. <https://doi.org/10.4324/9781315143385>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

- Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. In D. D. Williams (Ed.), *New directions for program evaluation* (Vol. 30, pp. 73–84). Jossey-Bass.
- Lincoln, Y. S., & Guba, E. G. (2013). *The constructivist credo*. Left Coast Press.
- Lincoln, Y. S., & Lynham, S. A. (2011). Criteria for assessing theory in human resource development from an interpretive perspective. *Human Resource Development International*, 14(1), 3–22. <https://doi.org/10.1080/13678868.2011.542895>
- Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 97-128). Sage.
- Lincoln, Y. S., & Stanley, C. A. (2021). The faces of institutionalized discrimination and systemic oppression in higher education: Uncovering the lived experience of bias and procedural inequity. *Qualitative Inquiry*, 27(10), 1233-1245. <https://doi.org/10.1177/107780042111026892>
- Linzer, M., & Harwood, E. (2018). Gendered expectations: Do they contribute to high burnout among female physicians? *Journal of General Internal Medicine*, 33(6), 963-965. <https://doi.org/10.1007/s11606-018-4330-0>
- Linzer, M., Smith, C. D., Hingle, S., Poplau, S., Miranda, R., Freese, R., & Palamara, K. (2020). Evaluation of work satisfaction, stress, and burnout among U.S. internal medicine physicians and trainees. *JAMA Network Open*, 3(10), e2018758-e2018758. <https://doi.org/10.1001/jamanetworkopen.2020.18758>
- Lo Sasso, A. T., Armstrong, D., Forte, G., & Gerber, S. E. (2020). Differences in starting pay For male and female physicians persist; Explanations for the gender gap remain elusive. *Health Affairs*, 39(2), 256–263. <https://doi.org/10.1377/hlthaff.2019.00664>
- Long, T., & Cooke, F. L. (2023). Advancing the field of employee assistance programs research and practice: A systematic review of quantitative studies and future research agenda. *Human Resource Management Review*, 33(2), 100941. <https://doi.org/10.1016/j.hrmr.2022.100941>
- Longo, P., & Straehley, C. J. (2008). Whack! I've hit the glass ceiling! Women's efforts to gain status in surgery. *Gender Medicine*, 5(1), 88-100. [https://doi.org/10.1016/s1550-8579\(08\)80011-3](https://doi.org/10.1016/s1550-8579(08)80011-3)
- Lopate, C. (1968). *Women in medicine*. Johns Hopkins Press.
- Lorber, J. (1984). *Women physicians: Careers, status, and power*. Tavistock.
- Lorber, J. (1993). Why women physicians will never be true equals in the American medical profession. In E. Riska & K. Wegar (Eds.), *Gender, work and medicine: Women and the medical division of labour* (pp.62-76). Sage.

- Lorber, J. (1994). *Paradoxes of gender*. Yale University Press.
- Lorde, A. (1984). *Sister outsider: Essays and speeches*. Crossing Press.
- Lowenstein, S. R., Fernandez, G., & Crane, L. A. (2007). Medical school faculty discontent: Prevalence and predictors of intent to leave academic careers. *BMC Medical Education*, 7(37), 1-8. <https://doi.org/10.1186/1472-6920-7-37>
- Lu, D. W., Lall, M. D., Mitzman, J., Heron, S., Pierce, A., Hartman, N. D., McCarthy, D. M., Jarregui, J., & Strout, T. D. (2020). # MeToo in EM: A multicenter survey of academic emergency medicine faculty on their experiences with gender discrimination and sexual harassment. *Western Journal of Emergency Medicine*, 21(2), 252-260. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7081862>
- Lumumba-Kasongo, M. (2007). My Black skin makes my white coat vanish. In P. Rothenberg (Ed.), *Race, class, and gender in the United States: An integrated study* (7th ed., pp. 294-295). Worth. [https://books.google.com/books?hl=en&lr=&id=N2pyIc8VoWcC&oi=fnd&pg=PA294&dq=Lumumba-Kasongo,+M.+\(2006,+April+3\).+My+Black+skin+makes+my+white+coat+vanish.+New+sweek,+V\(I\),+p.+20&ots=J7_GN-piZW&sig=JzI8jtd96Pe_INySeZsrSl-gS4#v=onepage&q&f=false](https://books.google.com/books?hl=en&lr=&id=N2pyIc8VoWcC&oi=fnd&pg=PA294&dq=Lumumba-Kasongo,+M.+(2006,+April+3).+My+Black+skin+makes+my+white+coat+vanish.+New+sweek,+V(I),+p.+20&ots=J7_GN-piZW&sig=JzI8jtd96Pe_INySeZsrSl-gS4#v=onepage&q&f=false)
- Luo, Y., & Zheng, Q. (2016). Competing in complex cross-cultural world: Philosophical insights from yin-yang. *Cross Cultural & Strategic Management*, 23(2). <https://doi-org.ezproxy2.library.colostate.edu/10.1108/CCSM-01-2016-0020>
- Lynham, S. A. (2002). The general method of theory-building research in applied disciplines. *Advances in Developing Human Resources*, 4(3), 221-241. <https://doi.org/10.1177/1523422302043002>
- Lyons, N. B., Bernardi, K., Olavarria, O. A., Shah, P., Dhanani, N., Loor, M., Holihan, J. L., & Liang, M. K. (2021). Gender disparity among American medicine and surgery physicians: A systematic review. *American Journal of the Medical Sciences*, 361(2), 151-168. <https://doi.org/10.1016/j.amjms.2020.10.017>
- Malinowska, A. (2020). Waves of feminism. In K. Ross, I. Bachmann, V. Cardo, S. Moorti, & C. M. Scarcelli (Eds.). (2021, 1, pp. 1-7). *International encyclopedia of gender, media, and communication*. John Wiley & Sons. (Original published 2020) https://d1wqtxts1xzle7.cloudfront.net/66702795/waves_of_feminism_2_-libre.pdf?1619558597=&response-content-disposition=inline%3B+filename%3DWAVES_OF_FEMINISM.pdf&Expires=1711230652&Signature=ERCWmsUbbkHQqRiNstq~PnkXtBNGN3ciXOAD-InDpu5WixxfweulUT7EENrv2fI6FOSwy99gDPGgpTxCq~qO-SjGyXOYvAzTc9zvi3oHilkpHAY1TomaOY-LpyvURBbC3f1hLMzfhr6BpZa6zLmSNED0uZykcPoqHCZzLhkJTdpyEFJ~WlkO-NI7Agw2iKB6DqL35IYUE78f4UInIHkaSYoP3Ok8he~Qw9MaNzcR9QItDdY924m2EUnUew54dK1O4XwYZ1kYmFo3ub~NDuof2fqfkY9Vdz54-

- Mallon, W. T., & Vernon, D. J. (2008). *The handbook of academic medicine: How medical schools and teaching hospitals work*. Association of American Medical Colleges.
- Mansini, R., & Zanotti, R. (2019). Optimizing physician scheduling problem in a large hospital ward. *Journal of Scheduling*, 23, 337-361. <https://doi.org/10.1007/s10951-019-00614-w>
- Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed). Sage.
- Martin, P. Y. (2003). “Said and done” versus “saying and doing”: Gendering practices, practicing gender at work. *Gender & Society*, 17(3), 342-366. <https://doi.org/10.1177/0891243203017003002>
- Maslach, C., & Leiter, M. P. (2017). New insights into burnout and health care: Strategies for improving civility and alleviating burnout. *Medical Teacher*, 39(2), 160-163. <https://doi.org/10.1080/0142159x.2016.1248918>
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of psychology*, 52(1), 397-422.
- Mauch, J. E., & Birch, J. W. (1993). *Guide to the successful thesis and dissertation: A handbook for students and faculty*. Marcel Dekker.
- Mayer, A. P., Blair, J. E., Ko, M. G., Hayes, S. N., Chang, Y. H. H., Caubet, S. L., & Files, J. A. (2014). Gender distribution of U.S. medical school faculty by academic track type. *Academic Medicine*, 89(2), 312-317. <https://doi.org/10.1097/ACM.0000000000000089>
- McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society*, 30(3), 1771-1800. <https://doi.org/10.1086/426800>
- McGovern, B., Doyle, E., Fenelon, L. E., & FitzGerald, S. F. (2010). The necktie as a potential vector of infection: are doctors happy to do without? *Journal of Hospital Infection*, 75(2), 138-139. <https://doi.org/10.1016/j.jhin.2009.12.008>
- McKinsey. (2022, August 17). *What is diversity, equity and inclusion?* Author. <https://www.mckinsey.com/featured-insights/mckinsey-explainers/what-is-diversity-equity-and-inclusion>
- McKinsey & LeanIn.org. (2021). *Women in the workplace 2021*. McKinsey. <https://www.mckinsey.com/~media/mckinsey/featured%20insights/diversity%20and%20inclusion/women%20in%20the%20workplace%202021/women-in-the-workplace-2021.pdf?shouldindex=false>
- McLean, G. N., Lynham, S. A., Azevedo, R. E., Lawrence, J. E., & Nafukho, F. M. (2008). A response to Wang and Swanson's article on national HRD and theory

- development. *Human Resource Development Review*, 7(2), 241-258. <https://doi.org/10.1177/1534484308316486>
- McLean, G. N., & McLean, L. (2001). If we can't define HRD in one country, how can we define it in an international context? *Human Resource Development International*, 4(3), 313-326. <https://doi.org/10.1080/13678860110059339>
- McMurray, J. E., Linzer, M., Konrad T. R., Douglas, J., Shugerman, R., & Nelson, K. (2000). The work lives of women physicians: Results from the Physician Work-Life Study. *Journal of General Internal Medicine* (6), 372-380. <https://doi.org/10.1046/j.1525-1497.2000.9908009.x>
- Medical specialty. (2024, February 26). In *Wikipedia*, [https://en.wikipedia.org/wiki/Medical_specialty#:~:text=A%20medical%20specialty%20is%20a,primary%20care%20\(family%20medicine\)](https://en.wikipedia.org/wiki/Medical_specialty#:~:text=A%20medical%20specialty%20is%20a,primary%20care%20(family%20medicine)).
- Merleau-Ponty, M. (2013). *Phenomenology of perception* (D. Landes, Trans). Routledge. (Original work published 1962)
- Merriam-Webster. (n.d.-a). Axiology. In Merriam-Webster.com dictionary. Retrieved December 9, 2023, from <http://www.merriam-webster.com/dictionary/axiology>
- Merriam-Webster. (n.d.-b). Epistemology. In Merriam-Webster.com dictionary. Retrieved December 9, 2023, from <http://www.merriam-webster.com/dictionary/epistemology>
- Merton, R. K. (1957). Some preliminaries to a sociology of medical education. In R. Merton, G. Reader, & P. Kendall (Eds.), *The student-physician: Introductory studies in the sociology of medical education* (pp. 3-80). Harvard University Press. <https://doi.org/10.4159/harvard.9780674366831.c2>
- Merton, R. K. (1972). Insiders and outsiders: A chapter in the sociology of knowledge. *American Journal of Sociology*, 76(1), 9-47. <https://doi.org/10.1086/225294>
- Miazad, A. (2020). Sex, power, and corporate governance. *UC Davis Law Review*, 54, 1913-1998. https://lawreview.law.ucdavis.edu/sites/g/files/dgvnsk15026/files/media/documents/54-4_Miazad.pdf
- Mills, A. J. (1988). Organization, gender and culture. *Organization Studies*, 9(3), 351-369. <https://doi.org/10.1177/017084068800900304>
- Milot, M. (2019). EAP treatment stigma as a barrier to employee help-seeking: Predictors and validation of a brief scale for its measurement. *EASNA Research Notes*, 8(2). <https://archive.hshsl.umaryland.edu/handle/10713/11454>
- Mink, R., Norwood, V., Degnon, L., Harris, C. E., Kennedy, C., Spicer, R., Coury, D., & Bale, J. F. (2012). Council of Pediatric Subspecialties (CoPS): The first five years. *Pediatrics*, 130(2), 335-341. <https://doi.org/10.1542/peds.2011-2979>

- Mobilos, S., Chan, M., & Brown, J. B. (2008). Women in medicine: The challenge of finding balance. *Canadian Family Physician*, 54(9), 1285-1286.
<https://www.cfp.ca/content/54/9/1285.short>
- Mohajan, H. (2022). Four waves of feminism: A blessing for global humanity. *Studies in Social Science & Humanities*, 1(2).1-8. <https://doi.org/10.56397/sssh.2022.09.01>
- Morantz, R. M. (1978). Women in the medical profession: Why were there so few? [Review of the book "*Doctors Wanted—No Women Need Apply*": *Sexual Barriers in the Medical Profession, 1835-1975*, by M. R. Walsh (1977), Yale University Press]. *Reviews in American History*, 6(2), 163–170. <http://doi.org/10.2307/2701292>
- Morantz-Sanchez, R. M. (1985). *Sympathy and science: Women physicians in American medicine*. Oxford University Press.
- More, E. S., Fee, E., & Parry, M. (Eds.). (2009). *Women physicians and the cultures of medicine*. Johns Hopkins University Press. <https://www.press.jhu.edu/books/title/9686/women-physicians-and-cultures-medicine>
- Morganson, V. J., Litano, M. L., & O'Neill, S. K. (2014). Promoting work-family balance through positive psychology: A practical review of the literature. *Psychologist-Manager Journal*, 17(4), 221-244. <https://doi.org/10.1037/mgr0000023>
- Morgen, S. (2009). Women physicians and the 20th-century women's health movement in the United States. In E. S. More, E. Fee, & M. Parry (Eds.), *Women physicians and the cultures of medicine* (pp. 160-183). Johns Hopkins Press.
<https://www.press.jhu.edu/books/title/9686/women-physicians-and-cultures-medicine>
- Muro, E. (2013). *Feminism: A fourth wave?* Political Studies Association.
<https://www.psa.ac.uk/psa/news/feminism-fourth-wave>
- Nadal, K. L. (2019). A decade of microaggression research and LGBTQ communities: An introduction to the special issue. *Journal of Homosexuality*, 66(10), 1309-1316.
<https://www.tandfonline.com/doi/full/10.1080/00918369.2018.1539582>
- Nikolova, E. (2021, September). "The balance of power is Me: 0, Harvey Weinstein: 10": A critical discourse analysis of the press representation of Hollywood's biggest sexual harassment scandal. In *Women's Studies International Forum*, 88, 102515.
<https://doi.org/10.1016/j.wsif.2021.102515>
- Nomura, K., & Gohchi, K. (2012). Impact of gender-based career obstacles on the working status of women physicians in Japan. *Social Science & Medicine*, 75(9), 1612-1616.
<https://pubmed.ncbi.nlm.nih.gov/22867864>
- Nonnemaker, L. (2000). Women physicians in academic medicine: New insights from cohort studies. *New England Journal of Medicine*, 342, 399-405.
<https://doi.org/10.1056/nejm200002103420606>

- Nummi, J., Jennings, C., & Feagin, J. (2019, December). #BlackLivesMatter: Innovative Black resistance. *Sociological Forum*, *34*, 1042-1064. <https://doi.org/10.1111/socf.12540>
- Nye, R. A. (2009). The legacy of masculine codes of honor and the admission of women to the medical profession in the 19th century. In E. S. More, E. Fee, & M. Parry (Eds.), *Women physicians and the cultures of medicine* (pp. 141-159). Johns Hopkins Press. <https://www.press.jhu.edu/books/title/9686/women-physicians-and-cultures-medicine>
- Obergefell v. Hodges, 576 U.S. 644 (2015). <https://www.justice.gov/sites/default/files/crt/legacy/2015/06/26/obergefellhodgesopinion.pdf>
- Olson, K., Marchalik, D., Farley, H., Dean, S. M., Lawrence, E. C., Hamidi, M. S., Rowe, S., McCool, J. M., O'Donovan, C. A., Micek, M.A., & Stewart, M. T. (2019). Organizational strategies to reduce physician burnout and improve professional fulfillment. *Current Problems in Pediatric and Adolescent Health Care*, *49*(12), 100664. <https://doi.org/10.1016/j.cppeds.2019.100664>
- Olympia, R. P. (2021). Choosing a career in academic medicine. In P. Garrett & K. Yoon-Flannery (Eds.), *A pediatrician's path: What to expect after a pediatrics residency* (pp. 105-113). Springer. https://doi.org/10.1007/978-3-030-75370-2_16
- Ovseiko, P. V., Pololi, L. H., Edmunds, L. D., Civian, J. T., Daly, M., & Buchan, A. M. (2019). Creating a more supportive and inclusive university culture: A mixed-methods interdisciplinary comparative analysis of medical and social sciences at the University of Oxford. *Interdisciplinary Science Reviews*, *44*(2), 166-191. <https://doi.org/10.1080/03080188.2019.1603880>
- Oxford Learner's Dictionary (n.d.). Epistemology. In *Oxford learner's dictionary*. Retrieved December 9, 2023, from <https://www.oxfordlearnersdictionaries.com/us/definition/english/epistemology>
- Özbilgin, M. F., Beauregard, T. A., Tatli, A., & Bell, M. P. (2011). Work-life, diversity and intersectionality: A critical review and research agenda. *International Journal of Management Reviews*, *13*(2), 177-198. <https://doi.org/10.1111/j.1468-2370.2010.00291.x>
- Palepu, A., & Herbert, C. P. (2002). Medical women in academia: The silences we keep. *Canadian Medical Association Journal*, *167*(8), 877-879. <https://www.cmaj.ca/content/167/8/877>
- Park, Y. S., Konge, L., & Artino Jr., A. R. (2020). The positivism paradigm of research. *Academic Medicine*, *95*(5), 690-694. <https://doi.org/10.1097/acm.0000000000003093>
- Parks, B. (2020, June 24). *George Floyd's death was 'murder' and the accused officer 'knew what he was doing,' Minneapolis police chief says*. CNN. <https://www.cnn.com/2020/06/24/us/minneapolis-police-chief-comment-george-floyd-trnd/index.html>

- Patton, M. Q. (1980). *Qualitative evaluation methods*. Sage.
- Patton, M. Q. (2008). *Utilization-focused evaluation*. Sage.
- Pelley, E., & Carnes, M. (2020). When a specialty becomes “women’s work”: Trends in and implications of specialty gender segregation in medicine. *Academic Medicine*, 95(10), 1499-1506. <https://doi.org/10.1097/acm.0000000000003555>
- Pololi, L. H. (2010). *Changing the culture of academic medicine: Perspectives of academic medicine*. Dartmouth College Press.
- Pololi, L. H., Civian, J. T., Brennan, R. T., Dottolo, A. L., & Krupat, E. (2013). Experiencing the culture of academic medicine: Gender matters, A national study. *Journal of General Internal Medicine*, 28(2), 201–207. <https://doi.org/10.1007/s11606-012-2207-1>
- Pololi, L. H., Conrad, P., Knight, S., & Carr, P. (2009). A study of the relational aspects of the culture of academic medicine. *Academic Medicine*, 84(1), 106-114. <https://doi.org/10.1097/acm.0b013e3181900efc>
- Pololi, L. H., & Jones, S. J. (2010). Women faculty: An analysis of their experiences in academic medicine and their coping strategies. *Gender Medicine*, 7(5), 438-450. <https://doi.org/10.1016/j.genm.2010.09.006>
- Pololi, L. H., Krupat, E., Civian, J. T., Ash, A. S., & Brennan, R. T. (2012). Why are a quarter of faculty considering leaving academic medicine? A study of their perceptions of institutional culture and intentions to leave at 26 representative U.S. medical schools. *Academic Medicine*, 87(7), 859-869. <https://doi.org/10.1097/ACM.0b013e3182582b18>
- Powell, G. N., & Butterfield, D. A. (2015). The glass ceiling: What have we learned 20 years on? *Journal of Organizational Effectiveness: People and Performance*, 2(4), 306-326. <https://doi.org/10.1108/joep-09-2015-0032>
- Prasad, A., & Prasad, P. (2002). Otherness at large: Identity difference in the new globalized organizational landscape. In I. Aaltio, & A. J. Mills (Eds.), *Gender, identity and the culture of organizations* (pp. 57-71). Routledge.
- Pratt, J. H. (1987). Adams v. Bennett and Women’s Equity Action League v. Bennett. *Equity & Excellence in Education*, 23(3), 67–74. <https://doi.org/10.1080/1066568870230306>
- Precious, T. & Watson, S. (2004, December 25). Big cost seen in ruling on UB medical faculty pay. *Buffalo News*. https://buffalonews.com/news/big-cost-seen-in-ruling-on-ub-medical-faculty-pay/article_ce8587db-9c39-5bff-90c5-ac7e0fa130aa.html
- Price, J. H., & Murnan, J. (2004). Research limitations and the necessity of reporting them [Editorial]. *American Journal of Health Education*, 35(2), 66-67. <https://doi.org/10.1080/19325037.2004.10603611>

- Ragins, B. R., & Cotton, J. L. (1993). Gender and willingness to mentor in organizations, *Journal of Management*, 19(1), 97-111. <https://doi.org/10.1177/014920639301900107>
- Ramakrishnan, A., Sambuco, D., & Jagsi, R. (2014). Women's participation in the medical profession: Insights from experiences in Japan, Scandinavia, Russia, and Eastern Europe. *Journal of Women's Health (15409996)*, 23(11), 927-934. <https://doi.org/10.1089/jwh.2014.4736>
- Rasmussen, J. M., Najarian, M. M., Ties, J. S., Borgert, A. J., Kallies, K. J., & Jarman, B. T. (2021). Career satisfaction, gender bias, and work-life balance: A contemporary assessment of general surgeons. *Journal of Surgical Education*, 78(1), 119-125. <https://doi.org/10.1016/j.jsurg.2020.06.012>
- Redmond, P., & McGuinness, S. (2020). Explaining the gender gap in job satisfaction. *Applied Economics Letters*, 27(17), 1415-1418. <https://doi.org/10.1080/13504851.2019.1686111>
- Rennane, S., Acheson-Field, H., Edwards, K. A., Gahlon, G., & Zaber, M. A. (2022). Leak or link? The overrepresentation of women in non-tenure-track academic positions in STEM. *PLOS ONE*, 17(6), e0267561. <https://doi.org/10.1371/journal.pone.0267561>
- Richter, K. P., Clark, L., Wick, J. A., Cruvinel, E., Durham, D., Shaw, P., Shih, G. H., Befort, C., & Simari, R. D. (2020). Women physicians and promotion in academic medicine. *New England Journal of Medicine*, 383(22), 2148-2157. <https://doi.org/10.1056/NEJMsa1916935>
- Risberg, G., Johansson, E. E., & Hamberg, K. (2009). A theoretical model for analyzing gender bias in medicine. *International Journal for Equity in Health*, 8(1), 28. <http://doi.org/10.1186/1475-9276-8-28>
- Riska, E. (1993). Introduction. In E. Riska & K. Wegar (Eds), *Gender, work and medicine* (pp. 1-12). Sage.
- Rivers, N. (2017). *Postfeminism(s) and the arrival of the fourth wave: Turning tides*. Springer.
- Roberts, C. M. (2010). *The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation*. Corwin Press.
- Roberts, L. W. (2020). Women and academic medicine, 2020. *Academic Medicine*, 95(10), 1459-1464. <https://doi.org/10.1097/acm.0000000000003617>
- Rodino-Colocino, M. (2018). Me too, #MeToo: Countering cruelty with empathy. *Communication and Critical/Cultural Studies*, 15(1), 96-100. <https://doi.org/10.1080/14791420.2018.1435083>
- Roemer, J. E. (1996). *Theories of distributive justice*. Harvard University Press.
- Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. Constable.

- Rogers, N. (2009). Feminists fight the culture of exclusion in medical education. In E. S. More, E. Fee, & M. Perry (Eds.), *Women physicians and the cultures of medicine* (pp. 205-241). Johns Hopkins University Press. <https://www.press.jhu.edu/books/title/9686/women-physicians-and-cultures-medicine>
- Rohrmann, S., Bechtoldt, M. N., & Leonhardt, M. (2016). Validation of the imposter phenomenon among managers. *Frontiers in Psychology*, 7(821). <http://doi:10.3389/fpsyg.201600821>
- Rotbart, H. A., McMillen, D., Taussig, H., & Daniels, S. R. (2012). Assessing gender equity in a large academic department of pediatrics. *Academic Medicine*, 87(1), 98-104. <https://doi.org/10.1097/acm.0b013e31823be028>
- Rotenstein, L. S., Harry, E., Wickner, P., Gupte, A., Neville, B. A., Lipsitz, S., Cullen, E., Rozenblum, R., Sequist, T. D., & Dudley, J. (2021). Contributors to gender differences in burnout and professional fulfillment: a survey of physician faculty. *Joint Commission Journal on Quality and Patient Safety*, 47(11), 723-730. <https://doi.org/10.1016/j.jcjq.2021.08.002>
- Rotenstein, L. S., Torre, M., Ramos, M. A., Rosales, R. C., Guille, C., Sen, S., & Mata, D. A. (2018). Prevalence of burnout among physicians: A systematic review. *JAMA*. 320(11), 1131-1150. <http://doi:10.1001/jama.2018.12777>
- Rouse, L. P., Nagy-Agren, S., Gebhard, R. E., & Bernstein, W. K. (2020). Women physicians: Gender and the medical workplace. *Journal of Women's Health*, 29(3), 297-309. <https://doi.org/10.1089/jwh.2018.7290>
- Rubin, G. (1975). The traffic in women: Notes on the “political economy” of sex. In R. R. Reiter, (Ed.), *Toward an anthropology of women* (pp. 157-210). Monthly Review Press.
- Saboore, S., Naveed, S., Chaudhary, A. M., Jamali, M., Hussain, M., Siddiqi, J., & Khosa, F. (2022). Gender and racial profile of the academic pediatric faculty workforce in the United States. *Cureus*, 14(2), ee22518. <https://doi.org/10.7759/cureus.22518>
- Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality of and use of health care. *Archives of Internal Medicine*, 159(9), 997-1004. <https://doi:10.1001/archinte.159.9.997>
- Saks, A. M. (2022). Caring human resources management and employee engagement. *Human Resource Management Review*, 32(3), 100835. <https://doi.org/10.1016/j.hrmr.2021.100835>
- Saldaña, J. (2009). *The coding manual for qualitative researchers*. Sage.
- Sandberg, S. (with Scovell, N.) (2013). *Lean in: Women, work, and the will to lead*. Alfred A. Knopf.
- Sartre, J. P. (1956). *Being and nothingness*. Philosophical Library.

- Sartre, J. P. (1963). *Search for a method*. Knopf Doubleday.
- Schein, E. H. (1985). *Organizational culture and leadership*. Jossey-Bass.
- Schein, E. H. (2010). *Organizational culture and leadership* (4th ed.). Jossey-Bass.
- Schmittdiel, J., Grumbach, K., Selby, J. V., & Quesenberry, C. P. (2000). Effect of physician and patient gender concordance on patient satisfaction and preventive care practices. *Journal of General Internal Medicine*, 15, 761-769. <https://doi.org/10.1046/j.1525-1497.2000.91156.x>
- Schrecker, E. (2010). *The lost soul of higher education: Corporatization, the assault on academic freedom, and the end of the American university*. New Press.
- Schutz, A. (1970). *On phenomenology and social relations*. University of Chicago Press.
- Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.). Teachers College Press.
- Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. Doubleday/Currency.
- Serwint, J. R., & Stewart, M. T. (2019). Cultivating the joy of medicine: A focus on intrinsic factors and the meaning of our work. *Current Problems in Pediatric and Adolescent Health Care*, 49(12), 100665. <https://doi.org/10.1016/j.cppeds.2019.100665>
- Sewell, W. H. (1992). A theory of structure: Duality, agency, and transformation. *American Journal of Sociology*, 98(1), 1-29. https://edisciplinas.usp.br/pluginfile.php/213064/mod_resource/content/6/texto%201.pdf
- Shabbir, M. N., Ahmed, I., Iqbal, M. A., & Najam, M. S. (2013). Incidence of necktie as a vector in nosocomial infection. *Pakistan Journal of Surgery*, 29(3), 224-225. https://pjs.com.pk/journal_pdfs/jul_sep13/224.pdf
- Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., & West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general U.S. working population between 2011 and 2014. *Mayo Clinic Proceedings*, 90(12), 1600-1613. <https://doi.org/10.1016/j.mayocp.2015.08.023>
- Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles*, 59, 301-311. <https://doi.org/10.1007/s11199-008-9501-8>
- Silverstein, J. (2021, June 4). The global impact of George Floyd: How Black Lives Matter protests shaped movements around the world. *CBS News*. <https://www.cbsnews.com/news/george-floyd-black-lives-matter-impact>
- Smart, D. R. (2012). *Physician characteristics and distribution in the U.S.* [2012 ed.]. American Medical Association.

Smith, J. K. (1990). Alternative research paradigms and the problem of criteria. In E. G. Guba (Ed.), *The paradigm dialog* (pp. 167-187). Sage.

Spector, N. D., Asante, P. A., Marcelin, J. R., Poorman, J. A., Larson, A. R., Salles, A., Oxentenko, A.S., & Silver, J. K. (2019). Women in pediatrics: Progress, barriers, and opportunities for equity, diversity, and inclusion. *Pediatrics*, *144*(5), 1-17. <https://doi.org/10.1542/peds.2019-2149>

St. George's University School of Medicine. (2021, January 6). The ultimate list of medical specialties and subspecialties. Author. <https://www.sgu.edu/blog/medical/ultimate-list-of-medical-specialties>

Starmer, A. J., Frintner, M. P., Matos, K., Somberg, C., Freed, G., & Byrne, B. J. (2019). Gender discrepancies related to pediatrician work-life balance and household responsibilities. *Pediatrics*, *144*(4):e20182926. <https://doi.org/10.1542/peds.2018-2926>

Starr, P. (1982). *The social transformation of American medicine*. Basic Books.

Steck, H. (2003). Corporatization of the university: Seeking conceptual clarity. *Annals of the American Academy of Political and Social Science*, *585*(1), 66-83. <https://doi.org/10.1177/0002716202238567>

Stephens, M. (Ed.). (2011). *Pediatrics 101: A resource guide from the American Academy of Pediatrics*. <http://www.aap.org/en-us/professional-resources/Pediatric-Careers/Documents/Peds101book.pdf>

Stewart, D. L. (2010). Researcher as instrument: Understanding "shifting" findings in constructivist research, *Journal of Student Affairs Research and Practice*, *47*(3), 291-306. <https://doi.org/10.2202/1949-6605.6130>

Stewart, M. T., & Serwint, J. R. (2019). Burning without burning out: A call to protect the calling of medicine. *Current Problems in Pediatric and Adolescent Health Care*, *49*(11), 100655. <https://doi.org/10.1016/j.cppeds.2019.100655>

Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology*, *34*(2), 237-245. <https://doi.org/10.1002/jcop.20095>

Swanson, R. A. (2005). The challenge of research in organizations. In R. A. Swanson & E. Holton III (Eds.), *Research in organizations: Foundations and methods of inquiry* (pp. 3-10). Berrett-Koehler.

Swanson, R. A., & Holton, E. F. (2009). *Foundations of human resource development* (2nd ed.). Berrett-Koehler.

Taylor, J. K., Haider-Markel, D. P., & Lewis, D. C. (2018). *The remarkable rise of transgender rights*. University of Michigan Press.

- Tawfik, D. S., Shanafelt, T. D., Dyrbye, L. N., Sinsky, C. A., West, C. P., Davis, A. S., Su, F., Adair, K. C., Trockel, M. T., Profit, J., & Sexton, J. B. (2021). Personal and professional factors associated with work-life integration among U.S. physicians. *JAMA Network Open*, 4(5), e2111575. <https://doi.org/10.1001/jamanetworkopen.2021.11575>
- Templeton, K., Bernstein, C., Sukhera, J., Nora, L. M., Newman, C., Burstin, H., Guille, C., Lynn, L., Schwarze, M. L., Sen, S., & Busis, N. (2019). Gender-based differences in burnout: Issues faced by women physicians. *NAM Perspectives*. <https://doi.org/10.31478/201905a>
- Thunborg, C. (1999). *Lärande av yrkesidentiteter: En studie av läkare, sjuksköterskor och undersköterskor* [Learning occupational identities: A study of physicians, nurses and assistant nurses]. [Doctoral thesis, Linköping University, Sweden]. <https://urn.kb.se/resolve?urn=urn:nbn:se:liu:diva-143154>
- Torrance, H. (2011). Qualitative research, science, and government. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 569-580). Sage.
- Tsouroufli, M., Özbilgin, M., & Smith, M. (2011). Gendered forms of othering in UK hospital medicine. *Equality Diversity and Inclusion*, 30(6), 498-509. <https://doi.org/10.1108/02610151111157710>
- Tulshyan, R., & Burey, J. A. (2021, February 11). Stop telling women they have imposter syndrome. *Harvard Business Review*, 31. <https://hbr.org/2021/02/stop-telling-women-they-have-imposter-syndrome>
- Tyson, L. (2006). *Critical theory today: A user-friendly guide* (2nd ed.). Routledge.
- U.S. Census Bureau (2023). *Quick facts. Black or African American alone, percent*. <https://www.census.gov/quickfacts/fact/table/US/RHI225222>
- U.S. Chamber of Commerce. (2021, November 18). *How businesses can create an effective DEI framework*. <https://www.uschamber.com/on-demand/diversity-and-inclusion/creating-an-effective-diversity-equity-and-inclusion-framework>
- U.S. Government Accountability Office (2023, March 2023). Women continue to struggle for equal pay and representation. Author. <https://www.gao.gov/blog/women-continue-struggle-equal-pay-and-representation>
- Vagle, M. (2014a). *Crafting phenomenological research*. Left Coast Press. <https://doi.org/10.4324/9781315431451>
- Vagle, M. D. (2014b). *Crafting phenomenological research*. Routledge. <https://doi.org/10.4324/9781315431451>
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. SUNY.

- Van Manen, M. (2014). *The phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. Left Coast Press
- Van Straten, S., Stannard, C., Bulabula, J., Boodhia, K., Paul, K., Leong, J., & Klipin, M. J. (2017). A third of patients treated at a tertiary-level surgical service could be treated at a secondary-level facility. *South African Medical Journal*, 107(9), 788- 790. <https://doi.org/10.7196/samj.2017.v107i9.12090>
- Vander Weerdt, C., Stoddard-Dare, P., & DeRigne, L. (2023). Is paid sick leave bad for business? A systematic review. *American Journal of Industrial Medicine*, 66(6), 429-440. <https://doi.org/10.1002/ajim.23469>
- Vanstone, M., & Grierson, L. (2022). Thinking about social power and hierarchy in medical education. *Medical Education*, 56(1), 91-97. <https://doi.org/10.1111/medu.14659>
- Vargas, T. (2018, March 1). She coined the term “glass ceiling.” She fears it will outlive her. *Washington Post*. <https://www.washingtonpost.com/news/retropolis/wp/2018/03/01/she-coined-the-phrase-glass-ceiling-she-didnt-expect-it-to-outlive-her>
- Vineyard Gazette*. (2014, February 19). Dr. Linda Brodsky, 61, internationally recognized surgeon. <https://vineyardgazette.com/obituaries/2014/02/19/dr-linda-brodsky-61-internationally-recognized-surgeon>
- Waddimba, A. C., Mohr, D. C., Beckman, H. B., Mahoney, T. L., & Young, G. J. (2019). Job satisfaction and guideline adherence among physicians: Moderating effects of perceived autonomy support and job control. *Social Science & Medicine*, 233, 208-217. <https://doi.org/10.1016/j.socscimed.2019.04.045>
- Wahyudiputra, A., Amrullah, A. T., & Adrian, D. (2021). The Weinstein effects: Forecasting the genesis of cancel culture in Hollywood industry. *Anaphora: Journal of Language Literary and Cultural Studies*, 4(1), 39-47. <https://doi.org/10.30996/anaphora.v4i1.4710>
- Wallace, J. (2020, June 19). Social justice: ‘A change of consciousness’. *Seattle Times*. <https://www.seattletimes.com/opinion/social-justice-a-change-of-consciousness>
- Walsh, M. R. (1977). *“Doctors wanted: No women need apply” : Sexual barriers in the medical profession, 1835-1975*. Yale University Press.
- Weddington, G. (2021). Racial change and Black movement emergence: A case from the Black Lives Movement. *Mobilization: An International Quarterly*, 26(4), 443-455. <https://doi.org/10.17813/1086-671x-26-4-443>
- Wells, S. (2009). Narrative forms in *Our bodies, ourselves*. In E. S. More, E. Fee, & M. Parry (Eds.), *Women physicians and the culture of medicine* (pp. 184-204). Johns Hopkins Press.
- West, C. (2018). The Lean In collection: Women, work, and the will to represent. *Open Cultural Studies*, 2(1), 430-439. <https://doi.org/10.1515/culture-2018-0039>

- Whaley, C. M., Koo, T., Arora, V. M., Ganguli, I., Gross, N., & Jena, A. B. (2021). Female physicians earn an estimated \$2 million less than male physicians over a simulated 40-year career. *Health Affairs*, 40(12), 1856-1864. <https://doi.org/10.1377/hlthaff.2021.00461>
- White, N. (2022, June 2). Transforming corporate America: The sustaining effects of DEI. *Forbes*. <https://www.forbes.com/sites/forbesbooksauthors/2022/06/02/transforming-corporate-america-the-sustaining-effects-of-dei/?sh=551d0f5757f5>
- White, W. (1972). *North American reference encyclopedia of women's liberation*. North American.
- Wildschut, A., & Gouws, A. (2013). Malevolent medicine: Tensions and contradictions in the gendered re/construction of the medical profession in South Africa. *South African Review of Sociology*, 44(2), 36-53. <https://doi.org/10.1080/21528586.2013.802536>
- Wilkerson, I. (2020). *Caste: The origins of our discontents*. Random House.
- Williams, R. A. (2007). Cultural diversity, health care disparities, and cultural competency in American medicine. *Journal of the American Academy of Orthopaedic Surgeons*, 15, S52-S58. <https://doi.org/10.5435/00124635-200700001-00013>
- Witte, F. M., Stratton, T. D., & Nora, L. M. (2006). Stories from the field: Students' descriptions of gender discrimination and sexual harassment during medical school. *Academic Medicine*, 81(7), 648-654. <https://doi.org/10.1097/01.acm.0000232421.04170.d2>
- WomenMDResources. (2024, February 21). *About us*. Author. <https://womenmdresources.com/about-us>
- Wood, J., Oh, J., Park, J., & Kim, W. (2020). The relationship between work engagement and work-life balance in organizations: A review of the empirical research. *Human Resource Development Review*, 19(3), 240-262. <https://doi.org/10.1177/1534484320917560>
- Woodall, J. (2001). HRDI special issue: Defining HRD. *Human Resource Development International*, 4(3), 287-290. <https://doi.org/10.1080/13678860126437>
- Woods, L. A., Wetle, T. F., & Sharley, K. M. (2018). Why aren't more women in academic medicine reaching the top? *Rhode Island Medical Journal*, 101(3), 19-20. <https://www.proquest.com/openview/f376c6bf19f96813bee3c01027f0f1c4/1?pq-origsite=gscholar&cbl=24126>
- World Bank. (2022, November). *Social inclusion*. Author. <https://www.worldbank.org/en/topic/social-inclusion>
- Wukitsch, M. V. (2012). *The shared experience of women physicians: An exploratory grounded theory study*. [Unpublished manuscript, School of Education, Colorado State University, Ft. Collins.]

- Xierali, I. M., Nivet, M. A., Syed, Z. A., Shakil, A., & Schneider, F. D. (2020). Trends in tenure status in academic family medicine, 1977–2017: Implications for recruitment, retention, and the academic mission. *Academic Medicine*, 95(2), 241-247. <https://doi.org/10.1097/acm.0000000000002890>
- Yeluru, H., Newton, H. L., & Kapoor, R. (2022). Physician burnout through the female lens: A silent crisis. *Frontiers in Public Health*, 10(880061) <https://doi.org/10.3389/fpubh.2022.880061>
- Young, A., Chaudhry, H. J., Pei, X., Halbesleben, K., Polk, D. H., & Dugan, M. (2015). A census of actively licensed physicians in the United States, 2014. *Journal of Medical Regulation*, 101(2), 7-22. <https://doi.org/10.30770/2572-1852-101.2.7>
- Zaidi, Z., & Larsen, D. (2018). Commentary: Paradigms, axiology, and praxeology in medical education research. *Academic Medicine*, 93(11S), S1-S7. <https://doi.org/10.1097/acm.0000000000002384>
- Zheng, L. (2020, June 15). We're entering the age of corporate social justice. *Harvard Business Review*. <https://hbr.org/2020/06/were-entering-the-age-of-corporate-social-justice>
- Zimmer, B. (2015, April 30). The phrase “glass ceiling” stretches back decades. *Wall Street Journal*. <https://www.wsj.com/articles/the-phrase-glass-ceiling-stretches-back-decades-1428089010>
- Zuger, A. (2004). Dissatisfaction with medical practice. *New England Journal of Medicine*, 350(1), 69-75. <https://doi.org/10.1056/nejmsr031703>

APPENDIX A: INTERVIEW QUESTIONS

A Hermeneutic Phenomenological Study of Women Physicians' Shared Experience at an Academic Pediatric Hospital

Study Interview Questions

5-22-15

Demographic Questions

Age

Medical school graduation date

Education level

Race/Ethnicity

Sexual Orientation (if willing to share)

Initial Open-ended Questions

1. How did you come to choose medicine as a career?
2. What other areas of study or professions did you consider before deciding on medicine?
3. Who, if anyone, influenced your decision to go to medical school? Tell me about how she/he influenced you.
4. How would you describe your experience in medical school? What was going on in your life then? How, if at all, has your view of your medical school experience changed?
5. How would you describe the person you were then?

Intermediate Questions

1. Could you describe a typical day when you are interacting with other physicians? Nurses?
2. In order to be successful in your environment, what did you need to learn and how did you learn that?
3. Tell me about your thoughts or feelings in working with women physicians versus male physicians? What experiences have you had that have shaped your perspective about these working relationships?
4. How would you describe the relationship you have with nurses? What factors most influence that relationship from your perspective?
5. What helps you manage these relationships? What problems have you encountered? Tell me the sources of these problems?
6. Who has been helpful to you when you have relationship problems at work? How has she/he been helpful?

7. What are the most important lessons you learned through working with other women in the health care setting?
8. Tell me how you would describe the person you are now. What most contributed to this change [or continuity]?

Ending Questions

1. What are the most important ways for women to manage relationships with each other in health care?
2. How have you grown as a person since medical school? Tell me about the strengths that you've discovered in the course of your career as a physician? [If appropriate] What do you most value about yourself now? What do others most value in you?
3. If you could use a metaphor to describe your experience or learning process as a woman physician at a pediatric teaching hospital...what would it be? Why that choice?
4. Based on your experiences, what advice would you give to women physicians just getting out of medical school?
5. If you were to have residents in their first week and give them five gifts of knowledge (or nuggets of wisdom)...what would those be? Why?
6. Is there anything that you might not have thought about before that occurred to you during this interview?
7. Is there anything else you think I should know to understand relationships between women at [Name of institution]?
8. Could you provide the name of a woman physician colleague who will give me a different perspective?
9. Is there anything you would like to ask me?