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Women physicians as healthcare leaders: a qualitative study

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Abstract

Purpose – The purpose of this paper is to explore the under-representation of women physicians in clinical leadership by examining the issue from their perspective.

Design/methodology/approach – The authors used large group engagement methods to explore the experiences and perceptions of women physicians. In order to capture common themes across this group as a whole, participants were selected using purposeful sampling. Data were analysed using a structured thematic analysis procedure.

Findings – This paper provides empirical insights into the influences affecting women physicians' decision to participate in leadership. The authors found that they often exclude themselves because the costs of leadership outweigh the benefits. Potential barriers unique to healthcare include the undervaluing of leadership by physician peers and perceived lack of support by nursing.

Research limitations/implications – This study provides an in-depth examination of why women physicians are under-represented in clinical leadership from the perspective of those directly involved. Further studies are needed to confirm the generalizability of these findings and potential differences between demographic groups of physicians.

Practical implications – Healthcare organizations seeking to increase the participation of women physicians in leadership should focus on modifying the perceived costs of leadership and highlighting the potential benefits. Large group engagement methods can be an effective approach to engage physicians on specific issues and mobilize grass-roots support for change.

Originality/value – This exploratory study provides insights on the barriers and enablers to leadership specific to women physicians in the clinical setting. It provides a reference for healthcare organizations seeking to develop and diversify their leadership talent.

Keywords Gender, Leadership, Healthcare, Women, Doctors

Paper type Research paper

Introduction

Across occupational sectors, including healthcare, organizations with a higher proportion of women in leadership have been shown to outperform their peers in areas of innovation, accountability, and financial outcomes (Desvaux *et al.*, 2010; Joy *et al.*, 2007). Studies have demonstrated that companies with few or no women in leadership rob themselves of a

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competitive and innovative edge. For example, among 279 companies studied by McKinsey and Co. (Desvaux *et al.*, 2010), those in the top quartile in terms of women in leadership positions outperformed companies without women leaders by 41 per cent on average return on investment and 56 per cent on operating results. Nonetheless, women continue to be under-represented as leaders despite the known advantages of including women in leadership teams (Catalyst, 2011). A similar situation is found in medicine, where women comprise 50 per cent or more of medical school graduates, but only 13-15 per cent of Department Chairs in the USA and Canada and few of the medical directors on the UK's National Health System trust boards (American Association of Medical Colleges, 2014; National Physician Survey, 2007; Department of Health (UK), 2009; Elston, 2009).

The under-representation of women as leaders has been probed from many angles. From a psychosocial perspective, differences in expected roles and behaviours of men and women reinforced through socialization can impact career progression (Eagly, 1987; Eagly and Karau, 2002). For example, women's perceived role in assuming the burden of domestic responsibilities leads to a perceived conflict between work and family responsibilities and makes it less likely that they will be nominated for promotion (Heilman and Okimoto, 2008; Hoobler *et al.*, 2009). With regards to gender and leadership, leadership styles have been dichotomized as masculine (competitive and authoritarian) or feminine (collaborative and relational) (Claes, 1999). Men are often seen as more competent (Heilman, 2001; Wood and Karten, 1986), more likely to be selected for leadership roles (Eagly and Karau, 1991), and more likely to be evaluated favourably for their leadership performance (Ridgeway, 2001; Rees and Garnsey, 2003; Martin, 1994). Men are expected to be more assertive and self-promoting, whereas women who emulate these behaviours may be perceived negatively for failing to conform to social expectations (Rudman, 1998; Bartels *et al.*, 2008; Kolehmainen *et al.*, 2014). Ridgeway asserts that these "constraining expectations" are the principle cause of the so-called glass-ceiling effect (Ridgeway, 2001).

Organizational culture can pose further barriers to the advancement of women. Organizational culture is broadly defined as the values, beliefs and principles held by its members, as shaped by history, norms, symbols, assumptions, language, and practices (Newman, 1995). In some instances, a gendered workplace culture may be visible (e.g. stereotypical roles, a gender hierarchy) (Rees and Garnsey, 2003; Itzin, 1995; Isaac, 2011). In other cases, the cultural influence may be more insidious. Examples include inflexible work practices, failure to value work-life balance, pressure to conform to expectations and norms, biased performance assessment criteria, and recruitment practices that favour selection of "prototypical" leaders (Shamir, 1995; Martin, 1994; Rees and Garnsey, 2003; Whitehead, 2001; Isaac *et al.*, 2014). Finally, workplace cultures that foster competition may find that women who value a collaborative approach exclude themselves (Newman, 1995; Fletcher, 1999).

Empirical studies have identified additional challenges for female physicians in academia. The coincident timing of the biologic clock and tenure clock is a recognized barrier to academic advancement (Schueller-Weidekamm and Kautzky-Willer, 2012; Martin, 1994). Women physicians have been described as less likely than men to value academic accomplishments (Buckley *et al.*, 2000), and to have less self-confidence or leadership ambition (Crolla *et al.*, 2011; Pololi *et al.*, 2013). Gendered organizational cultures and pay inequities have also been described in the academic setting (Foster *et al.*, 2000; Bickel *et al.*, 2002; Westring *et al.*, 2012; Yedidia and Bickel, 2001).

However, there is scant research examining the lack of women physicians in clinical leadership (Elston, 2009; Schueller-Weidekamm and Kautzky-Willer, 2012). This is

becoming increasingly relevant as healthcare organizations strive to optimize healthcare delivery in the face of resource constraints. Physician leadership is critical to success as physicians have a unique understanding of the delivery of quality clinical care, and are generally seen as credible and influential (Martin and Waring, 2012). Furthermore, physicians drive a significant proportion of resource utilization within most healthcare systems with increasing demands for accountability (Forbes *et al.*, 2004). In this context, physician leadership is defined broadly to encompass both formal and informal leadership roles. Physicians may assume a formal leadership or management role within a hierarchical structure with direct responsibility over people and/or resources. They may also assume informal leadership roles with varying degrees of influence over decision making, resource utilization, and accountability for the quality of healthcare delivery. As informal leaders, physicians lead by influence rather than authority (Martin and Waring, 2012).

Studies to date examining the sparse representation of women physicians in leadership have relied largely on mail-in or on-line surveys, expert opinion or interviews of current leaders, and have not been corroborated by an in-depth examination of the issue from the perspective of women physicians themselves. The advantage of qualitative research over surveys and interviews is the ability to capture nuances and subtleties that are deeply personal and subjective. The opportunity to probe and capture the rich detail of the internal experiences of a select group of women physicians will provide a more comprehensive understanding of what enhances and what undermines the development and expression of leadership potential from their perspective.

Our objective was to understand what prevents women physicians from taking on leadership roles in our healthcare organization by examining the salient elements in their understanding and experience of leadership.

Methodology

Setting

This study was conducted at a large, tertiary care, multi-site Canadian healthcare organization. Healthcare delivery is the joint responsibility of physician and administrative co-leads at the programme, departmental, and executive levels through a dyad management model (Zismer and Brueggemann, 2010). Physicians are independent practitioners with appointments at the hospital, and are reimbursed by the provincial healthcare system for clinical activities through a fee-for-service model. Stipends are provided for formal leadership positions, but compensation is not always equivalent to potential clinical earnings.

Of the 844 physicians with a primary hospital appointment, 30 per cent are women. At the time of this study, only seven of 54 (13 per cent) Department and Division Heads were women. Executive leaders requested an exploratory study into why women physicians were under-represented in clinical leadership and to understand how their participation could be increased.

Study design

We used a discovery-oriented approach to probe for data from the ground up, rather than a theory-driven approach which is used to confirm or expand on existing theories (Yeh and Inman, 2007). As the objective of this study was to explore the subjective leadership experiences and perceptions of women physicians, an inductive approach was better suited to answer the study's research question. We used the large group engagement methods described by Brown and Isaacs (Brown *et al.*, 2005).

This form of focus group discussion allows a large and diverse group of participants to learn from each other, develop a shared vision, propose common solutions (Axelrod, 2010; Holman and Devane, 1999).

Recruitment

We used the purposive, maximum variation sampling strategy described by Patton (2002), in order to capture the common leadership experiences of women physicians across our organization. In purposive sampling, individuals who can inform the phenomenon of central interest to the study are invited to participate. The strategy of maximum variation entails the selection of participants that vary along predetermined characteristics in order to ensure the data represent different perspectives on the problem, process, or event. In the current study, participants were recruited to represent key attributes of the population as a whole with respect to clinical specialty, age group, years of hospital affiliation, and leadership experience. The sample size was based on large group engagement methods whereby 10 per cent of the population of eligible participants is selected (Dannemiller Tyson Associates, 2000). The final number of participants was based on the capacity of the venue, ensuring the minimum sample size was achieved.

All women physicians with a primary appointment to our hospital were eligible to participate. Participants were recruited in three steps. First, a list of possible participants was selected, ensuring all clinical specialties, age groups, years of hospital affiliation, and leadership experience were represented. After confirming how many of these participants were able to attend, additional physicians were invited following the same process. Finally, the remaining five seats were offered to all eligible participants on a first-come, first-served basis to give all eligible physicians an opportunity to contribute.

Focus group structure

Participants were assigned to one of six concurrent focus groups; each group was comprised of five or six participants. Each focus group was designed as a maximum mixture of all participants, so that each person represented one of the demographic groups within the system as characterized in Table I (Dannemiller Tyson Associates, 2000), as well as diversity in leadership experience including formal (compensated)

	Women physicians[a] *n* (% of all physicians)	Focus group participants *n* (% of women physicians)
Overall	252 (29.6)	35 (13.9)
Clinical specialty		
Internal medicine	84 (30.0)	12 (14.3)
Family medicine	34 (43.6)	2 (5.9)
Obstetrics/Gynecology	40 (52.6)	3 (8.3)
Anaesthesia/Critical care	30 (29.1)	2 (7.7)
Surgery	15 (9.9)	5 (33.3)
Mental health	16 (44.4)	4 (25.0)
Radiological sciences	18 (24.7)	4 (22.2)
Laboratory medicine	12 (35.3)	1 (8.3)
Emergency medicine	6 (20.0)	1 (16.7)
	Median (Range)	
Age (Years)	46.8 (30-71)	44.9 (35-58)
Length of hospital affiliation (Years)	12 (0-38)	10 (0-26)

Note: [a]Includes only physicians with full-time hospital appointments

Table I. Demographic characteristics of women physicians and focus group participants

leadership roles, informal/voluntary (uncompensated) leadership roles, and no leadership experience. This allows participants within each group to learn from each other, develop a shared understanding of the issues, and identify experiences that are common to women physicians as a whole (Axelrod, 2010; Eggers *et al.*, 2002).

Each focus group was led by a facilitator with the support of a scribe. Facilitators were university-appointed professional counsellors and psychologists. Scribes were Masters and PhD students in psychology, trained in qualitative data capture and analysis. Facilitators and scribes received training on this research protocol and data collection procedures.

To facilitate small group discussion, we developed a preliminary set of open-ended interview questions around topics identified by the literature as important aspects of women in leadership (the Appendix). However, facilitators were instructed to encourage the participants to explore issues that they felt affected their leadership choices and not be constrained by the interview questions. Facilitators and scribes were paired and assigned to guide group exploration through one of four topics (the Appendix). Groups were provided one hour blocks to discuss each topic. After the hour exploration, the facilitator-scribe pairs rotated to another group until each group of participants was exposed to each of the four topics throughout the day.

Pilot study

A pilot study was conducted to obtain feedback on the semi-structured interview protocol. Four eligible participants who were unable to attend the event were selected for the pilot study. They represented different clinical specialties, age groups, and leadership experience. They were asked to provide feedback on the clarity of the questions, whether the questions inspired them to talk about leadership and their experiences, and whether anything was missed. Their feedback was used to better prepare the facilitators for the event and to make minor changes to the interview protocol.

Data collection procedures

Because audio-recordings were not practical in a setting of multiple simultaneous group discussions occurring in the same room (i.e. noise), scribes were assigned to keep a written record of the exchanges and disclosures occurring within the groups. As the scribes were trained in qualitative analysis, they were able to capture and transcribe the salient elements of the discussion, and interpret the data in vivo using the participants' own language. While verbatim recording was at the scribes' discretion, there was ongoing communication among the participants and the scribes to ensure the recorded data accurately represented the views of the participants. As such there was an immediate and ongoing member check: the scribes used flip-charts to capture the data so that participants could see, and correct or clarify as needed, the data as they were being captured. Each focus group ended with a short period of feedback and presentation of a summary where participants were invited to clarify and correct the data that were recorded.

Data analysis procedures

A systematic and structured thematic analysis was conducted according to the procedures described by Braun and Clarke (2006, 2012). This data driven analysis (as opposed to theory-driven analysis) method identifies patterns and themes across the dataset using a step-by-step inductive approach.

Step 1 – familiarizing oneself with the data: the primary author familiarized herself with the data by transcribing verbal data and immersing herself in the data to the point where she was familiar with the depth and breadth of the content.

Step 2 – generating initial codes: the primary author identified the most basic elemental codes (words or phrases that represent the most basic elements of the raw data) which are at a higher level of abstraction than the raw data and involve some interpretative and inductive work. The codes organize the data into groups. An example of this coding process is represented in Table II. The second author audited these initial codes and provided feedback; the final decision to adjust codes was made by the primary author.

Step 3 – searching for themes: the primary author grouped the codes together into potential themes (patterns found in the data) and subthemes using an inductive ("bottom up") approach whereby analysis is driven by the data (Braun and Clarke, 2006, 2012).

Step 4 – reviewing themes: these potential themes were then reviewed and refined to the point where each theme was internally coherent and there were identifiable distinctions between themes. The themes were then organized into an initial thematic table which was verified by the second author.

Step 5 – defining and naming themes: themes were named by the primary author and distinct definitions for each theme were created. Each theme was analysed separately and within the context of the overall thematic structure.

Step 6 – producing the report: in this final stage of the analysis, the primary author adjusted the thematic structure as necessary to provide a clear and coherent representation of the data and prepared a report outlining the conceptual ordering (themes and subthemes) along with examples.

Trustworthiness

The following strategies were used to improve the trustworthiness of data interpretation.

Member checking. As our objective was to understand the perspective of women physicians, we used member checking to gain feedback on how well the data collection and interpretation reflected this perspective. Member checking occurred in three steps: first, during data collection as participants corrected or clarified the data being captured on flip-charts; second, at the end of each focus group as facilitators and scribes reflected back a summary of the discussion for participant feedback; and third, following data analysis when we solicited participant feedback on our interpretation of the data to ensure that the resulting thematic structure and report reflected the thoughts, feelings, opinions, and intentions disclosed by the focus group members.

We invited participants to review the draft report with the following questions in mind: do the findings capture and accurately represent my position/opinion? If so, how?

Verbatim example	Initial code	Subtheme	Theme
Often it appears that individuals in leadership positions have been handpicked, or the result of "who knows who" It sometimes seems the decision was made even before there were any meetings	Selection process lacks transparency	Recruitment and selection of leaders	Organizational factors Definition: participants' perceptions of the impact of the organizational culture on their willingness to assume leadership roles

Table II. Example of themes, subthemes, and coding of verbatim data

If not, why not? Feedback was collected by e-mail. Overall, participants agreed that the results of the data analysis accurately represented their views. Five participants proposed a clarification or increased emphasis of a specific concept; these comments were incorporated into the final conceptual scheme.

Auditing. The data analysis conducted by the primary author was audited by the second author at two points: after generation of the initial codes; and after development of the initial thematic structure. The intent of the auditing was to promote consistency in the analytic process and identify potential bias of a single investigator.

Ethics approval and informed consent

This study was approved by the institution's research ethics board. Informed consent was obtained in written form prior to the focus groups. The data were collected without identifying information so that specific data could not be paired with individual respondents. The data and informed consent forms were kept under lock and key in the researchers' office.

Results

Of the 252 eligible women physicians, 35 (14 per cent) participated. All clinical specialties and leadership experience were represented (Table I). The median age of participants was 45 (range 35-58) years, with an average length of appointment of ten (range 0-26) years. Participants had diverse leadership experience: 15 (43 per cent) had formal leadership roles, nine (26 per cent) had informal leadership roles, and 11 (31 per cent) had no leadership experience.

Thematic analysis

The analysis yielded three themes and multiple subthemes, representing a common understanding of the barriers and opportunities for leadership in the participants' context. The themes are: (I) individual factors influencing female physician leadership; (II) organizational factors influencing female physician leadership; and (III) leadership support, development, and systemic correctives. These themes were interrelated. However, for ease of presentation they are presented as discrete elements. The themes and subthemes are briefly described below with a brief exploration of the categories that gave rise to each theme, along with select verbatim and paraphrased examples. The findings are summarized in Figure 1.

Theme I: individual factors that influence women in medical leadership

This theme reflects how participants perceive and define leadership, whether they see themselves as leaders, and their leadership aspirations and challenges. There were three subthemes: (A) definition of a leader; (B) self as a leader; and (C) challenges to women assuming leadership roles.

Subtheme A: definition of a leader. Participants expressed how they would define a leader, and the qualities and roles of a leader. They were neither compelled nor constrained by conventional notions of leadership. One participant observed: "The title does not make the leader: someone may have a leadership position but not really be a leader, and some assume leadership positions without the official title". They identified leadership roles in different contexts within their personal and professional lives and recognized that they were leaders by virtue of being physicians. They enumerated the qualities of a good leader as being competent, having integrity, being visionary not reactionary, and being connected to others. Critical functions of leadership were

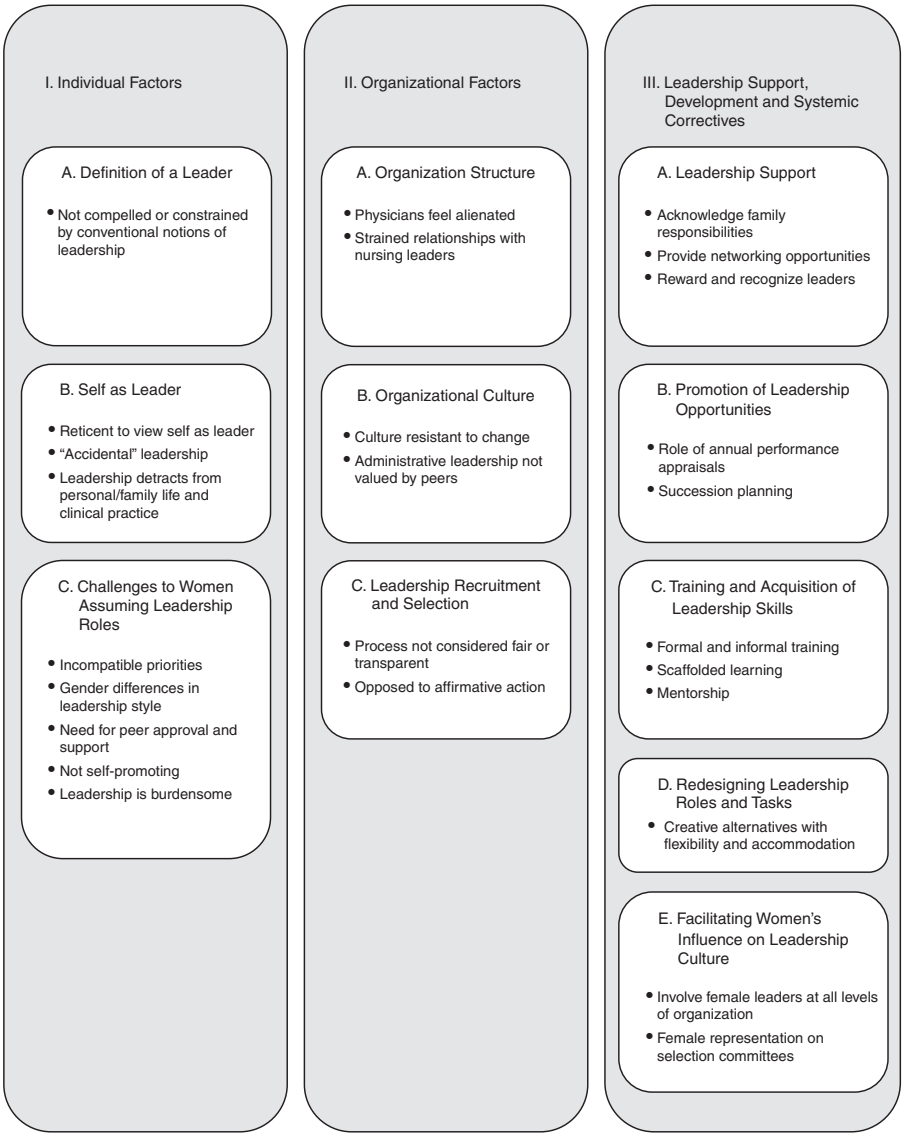

Figure 1.
Women physicians as leaders – summary of key findings

squarely centred on others, including the need to nurture, empower and motivate others and to build consensus.

Subtheme B: self as a leader. This subtheme explores participants' perception of themselves as current or future leaders. When asked if they saw themselves as leaders, one responded: "God no – I see myself as a collaborator, not telling people what to do". Another stated, "I would prefer to have respect or be considered an expert". Those participants involved in leadership activities viewed leadership as positive and motivating, while those not involved in leadership held an uninviting view of leadership as burdensome, lonely, and not worthy of the perceived temporal sacrifices.

Participants that were involved in leadership activities were influenced by accidental or utilitarian factors. For accidental leadership, the description was one of gradually filling needs instead of a deliberate and self-interested pursuit of power. One described her participation in leadership this way: "It just kind of happened". In contrast, the utilitarian leader was driven by a desire to fulfil others' unmet needs or doing the greatest good for others. One saw leadership as "My responsibility to serve the greater good". Among the strongest motivating factors were a sense of purpose and an inherent desire to make a contribution.

While acknowledging its value, most participants perceived leadership as costly. This sentiment received a very strong endorsement. The most important cost identified was time taken away from their personal and family lives. As one participant said: "I value leadership but not at the expense of work-life balance". Another important cost was time away from their clinical practice. One participant observed that "The higher you go, the less you see patients". Another explained her perspective on the clinical costs of leadership this way: "You have to give up clinical time and commit to leaving something behind. We spent years getting these skills so it's a big risk". When they measured what they felt they needed to sacrifice against the gains of assuming leadership roles, they perceived that the cost most often outweighed the benefits.

Subtheme C: challenges to women assuming leadership roles. Several challenges were expressed with regards to women assuming leadership roles. Participants place a premium on their time, family contribution, satisfaction outside of work, and a collaborative working environment. They view these priorities as being incompatible with leadership roles as they are currently structured. One participant observed: "It is a question of different values. Women value collaboration over competition for the most part".

Participants recognized that challenges around the time demands of leadership and the desire for fulfilment in life outside of work are faced by both men and women in the younger generations who refuse to subscribe to what they perceived as the old culture of "my life is my work". They perceived a shift in work-related values where it is not the person that accommodates to the work demands, but the work functions are selected to fit the desired lifestyle.

Participants maintained that the challenges of incompatible priorities were more generational than gender related. Nonetheless, they acknowledged that women often take a greater proportion of family responsibilities than their male counterparts and that these responsibilities compete with career aspirations for their time. They also perceived some innate differences in leadership styles between genders, suggesting that women are more reflective, perfectionistic, collaborative, and protective of their time, but less likely to delegate, define boundaries around their responsibilities, promote themselves, or ask for help.

Participants were highly sensitive to their peers' perception of them pursuing leadership opportunities and whether they might be seen as depriving others of the opportunity. One participant observed that "Women will self-sacrifice because they don't want to take training opportunities away from others". Women may be reluctant to assume leadership roles that others want because they "don't want to step on any toes". They acknowledged that colleagues may have to cover their absences for leadership responsibilities or training. The notion that pursuing their own leadership aspirations could adversely affect their colleagues was a deterrent.

There was fear of rejection among those who self-identify for a leadership position. If rejected, they are less likely to consider future leadership opportunities. As aptly

stated by one participant: "We need support from others because some will not self-identify for a position and for those who do and get rejected at the first try, they might not want to nominate themselves for subsequent positions".

On the whole, participants perceived that to be a leader in their current work context would be burdensome and unrewarding. They felt leaders are alienated, lack control over their time, are expected to be available 24/7 without reprieve, and are under-recognized. As stated by one participant: "There aren't a lot of venues to identify and reward good leaders; it's not recognized at all". Generally, the qualifiers used to describe their understanding of leadership were unfavourable. One participant asked: "Why on earth would you want that position?"

Theme II: organizational factors that influence women in leadership

This theme reflects participants' perceptions of the impact of the organizational structure, culture, and practices on their willingness to assume leadership roles. The main subthemes were: (A) organizational structure; (B) organizational culture; and (C) leadership recruitment and selection.

Subtheme A: organizational structure. On the whole, participants appeared to have little knowledge of organizational leadership within their context and expressed a sense of alienation. One participant commented that she "can't understand the structure or what people do. Don't feel like we have part in the corporate structure. It is very top down". They expressed a desire to be viewed as stakeholders in decision making and to engage in bi-directional communication with hospital administrators. As suggested by one participant: "Allow us to give upwards feedback instead of just being told what is happening".

The fact that most women in hospital leadership are nurses seemed to create tension. One participant observed that "There is a lot of head butting between nurses and physicians. We don't feel a commonality of goals and values. This is critical because nurses are in leadership roles. There is an imbalance between physicians and nurses". Participants felt that many nurse leaders do not understand their needs, respect their time, or facilitate physician participation. Nonetheless, they observed that nurses seem to have a model that works in promoting female leadership, and that physicians could learn from the nursing model.

Subtheme B: organizational culture. Participants perceived an organizational culture that is resistant to change. One participant felt that "the structure wants to continue with its autocratic style because of the fear of change". They perceived a lack of both gender and cultural diversity and felt that more intentional inclusion of different types of leaders would result in a healthier organization. One participant suggested that "the organization needs to recognize the value of gender diversity and the different leadership styles".

They believed that most physicians see little value in hospital administrative leadership as illustrated by the following verbatim comments: "Administrative positions are generally not honourable or prestigious positions, and thus there is little appeal. They are seen as being obligated to the hospital administration and not to the medical staff". "They are seen as individuals who have lost touch".

Subtheme C: leadership recruitment and selection. Participants expressed a desire for a transparent, formal selection strategy, and clear advertisement of leadership opportunities. Many described the selection process for leadership positions as subversive and politicized, selecting for those who are most visible rather than those

most qualified. Verbatim comments expressing this sentiment include the following: "The current process selects for the one who puts the time in – visible time spent". "It's the result of who knows who" or "being in the right place at the right time".

They generally lacked knowledge of how to express their leadership interests. They would welcome a concerted effort to make them more aware of opportunities. They perceived that women physicians are less likely to step up naturally to assume or pursue leadership positions, though many would consider such roles if asked. While they welcomed proactive measures to support women physicians, they absolutely decried any affirmative action measures. They wanted to be nominated for leadership because they are seen a capable candidates, not because they are women. This sentiment was strongly expressed in terms of not using gender as a "trump card" or being subjected to "tokenism".

Theme III: leadership support, development, and systemic correctives

While Theme II describes organizational structure, culture, and practices that adversely impacted participants' involvement in leadership, Theme III captures their recommendations to address these factors. These were themed as: (A) leadership support; (B) promotion of leadership opportunities; (C) training and the acquisition of leadership skills; (D) redesigning leadership roles and tasks; and (E) facilitating women's influence on leadership culture.

Subtheme A: leadership support. Participants expressed a desire for a supportive structure to ease the pressures of leadership. This could be improved considerably by a culture that encourages both men and women to make their families a priority. In the words of one participant: "In order for me to value being a leader there needs to be a change in culture to acknowledge family responsibilities as a part of my life". Practical recommendations included parental leave policies, providing access to day care, more administrative support and on-site office space. Participants indicated that departmental support is crucial to providing the clinical coverage that would allow them to attend leadership training and become more involved in leadership activities. While protected time is often allocated for research activities, leadership development was not perceived as a priority in many departments.

Participants valued networking opportunities "so that you don't feel alone and learn what works for others". Although they were not primarily motivated by financial considerations, they requested making compensation more equitable for those who give up clinical time to shoulder leadership responsibilities. Finally, they recommended formal recognition as a demonstration of support.

Subtheme B: promotion of leadership opportunities. Participants requested more transparency around the roles, qualifications, expectations, and evaluation criteria of formal leadership positions. An annual performance appraisal with their own leader was recommended as a way to identify leadership strengths and opportunities for development. They would welcome an opportunity to learn more about various leadership roles to assess whether they would be a good fit. They identified succession planning as a responsibility of current leaders.

Subtheme C: training and the acquisition of leadership skills. While participants identified that some leadership qualities are inherent, they acknowledged that many key leadership skills are acquired through training and experience. Participants endorsed the importance of both formal training as well as being "immersed in the role" to gain skills through practical experience. They recommended identifying entry level

roles with a clear developmental plan for working towards middle and top level leadership positions. Finally, they expressed a need for male and female mentors.

Subtheme D: redesigning leadership roles and tasks. Participants identified flexibility in the way leadership roles are defined and executed as a key factor in their ability to participate. Alternatives proposed included shared leadership positions, more flexibility for participation (e.g. teleconferencing rather than travelling between sites), and more optimal meeting times. Participants appealed for the option to delay leadership roles and pursue non-traditional career trajectories. They perceive that their absence for maternity leave or childcare responsibilities gives the impression that they are not fully engaged and that declining opportunities excludes them from future opportunities. As one participant explained: "There's a mentality of 'if you don't show up, it's because you're not interested'. So in fact, even being away on maternity leave makes you miss out on many opportunities and then it's more difficult to return. Family is seen as an interruption to a career, not as part of the journey". Another said: "I would like to change the culture where you can say 'no now, yes later, keep asking' ". Participants requested acknowledgement of the fact that they have competing priorities and cannot always participate, but that this does not signal disinterest.

Subtheme E: facilitating women's influence on leadership culture. Although participants perceived some resistance to change, they acknowledged that the culture of leadership in their context is evolving from an "autocratic" to a more collaborative approach and departments with more women leaders are at the forefront of this change. To allow further change, participants felt that females need to be placed at every level in order to influence the cultural shift. They expressed the need for more women physicians as role models at various levels of the organization "to show that it is possible" and to inspire others. Finally, they recommended that leader selection committees have female representation.

Discussion

A participatory approach to exploring female physician leadership allowed us to glean the perspective of those directly affected, develop a shared understanding of the issues, and engage them in identifying opportunities for change. Participants welcomed the opportunity to discuss the topic, to network, and to learn from others. We uncovered several interesting perspectives on the influences affecting women's decision to participate in leadership. A salient finding was participants' lack of willingness to assume leadership roles because they perceived the sacrifices to be too great (costs outweigh the benefits). Participants felt this was largely a generational issue rather than a gender issue. In contrast to some studies, participants did not perceive that they are excluded from leadership simply because they are women.

There are some apparent contradictions in our findings that merit further exploration. The women in this study strongly endorsed the concept that barriers to leadership (e.g. time demands) are generational rather than gender related, and did not recognize gender as a direct impediment. At the same time, they readily identified important differences in social norms related to both domestic responsibilities and leadership behaviours. A similar phenomenon was described by Isaac and Griffin (2015) whereby women chairs in academic medicine dismissed gender as a "non-issue" while recognizing differences in social expectations. Social role theory suggests that the impact of such social norms on women's behavioural and role choices often goes unrecognized (Eagly, 1987).

Another paradox was the expressed desire for more role models and for women to be "placed" at every level of the organization, contradicted by strong opposition to affirmative action. Affirmative action and gender quotas in hiring and promoting women have been advocated as a means to increase the number of women leaders (Kumar and Johnston, 1999; Desvaux *et al.*, 2010). However, the effectiveness of these measures is debated, particularly in the absence of other strategies to promote diversity (Thomas, 1990; Crosby *et al.*, 2006). There is evidence to suggest that female leaders selected through affirmative action programmes are perceived to be less qualified, and that the women affected devalued their own leadership contribution and viewed leadership positions as less desirable (Islam and Zilenovsky, 2011; Heilman *et al.*, 1987, 1992). Our participants expressed similar sentiments; they felt empowered when approached and encouraged to take on leadership roles on the basis of their qualifications and abilities rather than their gender. Furthermore, their heightened sensitivity to peer opinion serves as a strong motivator to avoid situations where they could be perceived as depriving others of leadership opportunities.

The barriers to clinical leadership identified in our study are reflective of many of the barriers female physicians face in academic leadership (Bickel *et al.*, 2002; Buckley *et al.*, 2000; Foster *et al.*, 2000; Pololi *et al.*, 2013; Westring *et al.*, 2012; Yedidia and Bickel, 2001). These include incompatible priorities, work-life conflicts, lack of mentorship, and the need for more transparent recruitment and selection processes. Our participants confirmed the research by Forbes *et al.* (2004), who found that many physicians are reluctant leaders who assume leadership roles at the expense of their clinical roles, and are concerned about threats to their autonomy as clinicians and loss of respect of their clinical colleagues.

In addition, we elicited some of the more subtle potential barriers for female physicians, including a system that rewards those that are more visible rather than those best qualified (Institute of Leadership and Management, 2011), and reluctance by women to apply for leadership positions if there is a chance they will not be selected (Bickel *et al.*, 2002). Finally, we identified additional potential barriers unique to the healthcare setting. These include the perceived lack of respect for leadership positions by physician peers and perceived lack of support by nursing leaders. The impact of nursing leaders on the female physicians in our study was an unexpected finding. While studies of nursing leadership describe a gender imbalance in the traditional male physician-dominated workplace culture as an impediment to female nurses' autonomy and leadership (Brandi, 2000; Roberts, 1997), the relationship between female nursing leaders and female physicians deserves further exploration.

There are several limitations to this study. We intentionally designed maximally diverse focus groups to ensure diverse views were represented and increase the likelihood that the results are more representative of the population as a whole. This study design strengthens the ability to identify common experiences that are relevant to women physicians at large, but precludes the identification of differences between distinct categories of physicians (e.g. junior vs senior, medicine vs surgery). Second, we cannot determine how unique these leadership barriers are to women as men were excluded from this study. Third, data were not recorded verbatim for practical reasons. The impact of this limitation was minimized by using scribes trained in qualitative analysis to capture the salient features of the discussion and through member checking at the time of data capture, at the close of the day through feedback and discussion, and following data analysis. Finally, this was a single centre study and additional studies are needed to support the explanatory power of our findings.

The field of healthcare has been described as unique in terms of the availability of women qualified for leadership roles (Mcdonagh and Paris, 2012). Our results have practical implications for healthcare organizations looking to include more women physicians in leadership roles. Given the overwhelming endorsement of the cost-benefit considerations, the key point of influence might lie in modifying the costs and perceived costs of leadership so that potential women physician leaders do not opt out, creating a natural yet unfortunate gender inequality in leadership that is based on self-exclusion. On the other hand, reinforcing the positive aspects of leadership and providing a utilitarian perspective could serve as powerful motivators. These messages may be most effective if delivered by women physicians already in leadership roles. Finally, this exploratory study demonstrates the feasibility and value of a participatory approach in engaging physicians around a particular issue.

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Appendix. Concurrent focus groups semi-structured interview guide

A-Topic 1: individual factors

What does leadership mean to you? How do you define leadership? Do you see yourself as a leader? Why? Why not?

Is leadership one of your career goals? Do you see value in being a leader?

What are some of the challenges in the lives of women physician leaders or those who wish to assume leadership positions? Can you give specific examples from your experience?

In your opinion, what could be done to overcome these challenges?

B-Topic 2: organizational culture

What is your opinion of the process used to select, support, and reward or recognize physician leaders?

Is the organizational culture conducive to women physicians in leadership? Why? Why not? Can you give some specific examples from your experience?

In your opinion, what would be some concrete steps administration could take to support women physicians in leadership? Your leadership?

C-Topic 3: departmental/divisional culture

With regards to your department or division, what is your opinion of the process used to select, support, and reward or recognize physician leaders?

Is the culture within your department and division conducive to women physicians in leadership? To the expression of your own leadership qualities? Why? Why not? Can you give some specific examples from your experience?

In your opinion, what would be some concrete steps your department or division could take to support women physicians in leadership? What do you need to express what you consider to be your own leadership skills and aspirations?

D-Topic 4: leadership development

What does it take to develop a good leader?

What leadership development or training opportunities have you had in the past? How have they helped you develop as a leader? What opportunities have been unhelpful?

In your opinion, what steps should be taken to develop or train more women physician leaders?

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