



# BMJ Open 'I felt forced to find an alternative': a qualitative analysis of women medical educators' narratives of career transitions

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## ABSTRACT

**Objectives** While institutional and systemic attempts to increase women's participation in medical education have enabled increasing numbers to enter the field and achieve more senior positions, little is known about lived experiences of female clinical educators. Women clinicians are more likely to change careers and work less than full time. This study focuses on women medical educators' narratives of career change, with the aim of exploring the interplay between factors affecting career decision-making, career trajectory and professional development.

**Methods** We employed narrative enquiry approaches to two data sources (55 written accounts of turning points; 9 semistructured interviews reflecting on periods of career transition). Through analysing themes within each dataset before comparing and contrasting datasets simultaneously, we identified three areas of inconsistency and tension.

**Results** Participants reported feeling both drawn and pushed into medical education. Some respondents reported that they were compelled by circumstances to enter medical education. Participants' narratives were ambiguous regarding personal and professional identities. Additionally, participants asserted their position as autonomous agents while acknowledging their powerlessness when encountering organisational, social and cultural expectations limiting the ability to make independent choices. Even where primary decisions to pursue medical education were positive and motivated by interest, subsequent disappointments and challenges led some participants to doubt their choices.

**Conclusions** Career advancement in medical education may involve women taking significant personal or career sacrifices, partly due to the continued existence of a medical culture allowing men to dominate senior ranks. Women medical educators achieving satisfying senior roles in the field may harbour lingering regret and resentment at the personal and career costs.

## INTRODUCTION

Over 20 years ago, Wear's ground-breaking study of the experiences of women physicians in the American Medical Academy revealed a challenging climate characterised by sexual harassment, inequality and systematic organisational barriers including difficulties with maternity leave and childcare.<sup>1</sup> Since then,

## STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The use of a mixed methods qualitative approach in this study allowed us to draw significant conclusions from the key differences and similarities between our two datasets and explore the complexities surrounding decision-making and professional identity.
- ⇒ As an all-female team of researchers, we were aware of the risk of bias, both in our interpretation of the data and potentially in the choices participants made around revealing information.
- ⇒ Employment of methodological rigour mitigated risk through use of reflective research notes, regular discussions concerning our personal perspectives and careful attention to dual coding and analysis.

the number of women in medicine has grown sharply, thanks to an increase in women medical students and physicians. Female medical students now outnumber males in the UK and the USA.<sup>2</sup> Several significant initiatives within government and higher education, changes in the law and more flexible training routes have also led to changes in the working environment.<sup>3</sup> Yet at the same time, concern is growing that there is a shortage of clinically qualified educators within the medical education workforce<sup>4 5</sup> and that a gender pay gap among clinically qualified academics persists, exacerbated by medical school promotion systems.<sup>6 7</sup> While women are increasingly visible in medical education, particularly among the middle ranks of educational leadership,<sup>3</sup> their career pathways and the decisions that have influenced these are often complex.<sup>8 9</sup>

Gender biases in society influence women in favour of more 'socially desirable' behaviours and choices.<sup>9 10</sup> Three reviews highlight the impact of female stereotyping on women's career choices in academic medicine.<sup>9-11</sup> Women experience more gender discrimination than their male counterparts, but confronting sexism carries a social

and personal cost.<sup>12</sup> Furthermore, implicit and explicit gender bias affects women's opportunities in academic medicine.<sup>11 13</sup>

Women face additional barriers to career progression,<sup>13</sup> including the challenge of balancing professional responsibilities with family life,<sup>9 14</sup> adapting to workplace culture<sup>15</sup> and a lack of female role models.<sup>9 11–13 16</sup> Women physicians are more likely to change careers, quit roles and to work less than full time. Moreover, women physicians are less likely to identify professional role models compared with their male colleagues, an issue worsened by a lack of women in senior leadership positions.<sup>16</sup> Multiple studies have found that lack of effective mentorship inhibits women's career development.<sup>9 17</sup> Women physicians are more likely to change careers, quit roles and to work less than full time.<sup>7 12 16</sup>

Much literature on gender and professional experiences focuses on careers in academic medicine and research, but literature specific to careers in student and physician education is limited. Additionally, studies tend to focus on systemic and organisational limitations and barriers to women's careers,<sup>7 13 15</sup> but few studies have focused on the personal experiences of women regarding how they navigate these limitations and barriers. Such insights are needed to more fully understand the reach and impact of such factors. Krueger *et al* argue 'stress, burnout, and perceptions about the workplace are associated with job satisfaction and job turnover among academic physicians' (p. 179) and also that job dissatisfaction may negatively affect faculty performance in teaching and mentoring.<sup>17</sup> Identifying the sources of satisfaction and dissatisfaction among women medical educators may help understand the factors that contribute to faculty retention, career commitment and teaching performance. The purpose of this study was to focus on the lived experiences of clinical women in medical education in order to explore the interplay between the factors that affect their career decision-making and ultimately, their career trajectory and professional development.

We aimed to collate women medical educators' narrative accounts of their experience of career change or career crossroads within their working lives and the lasting influence of the choices they made.

We sought detailed data regarding:

1. Factors that trigger women medical educators to consider career change.
2. Factors that may influence the outcomes of women medical educators' career decision-making.
3. The presence or absence of supportive factors following a career change.

## METHODS

### Study design

This study, conducted during 2018–2019, was qualitative in nature given the broad exploratory focus of the study aims. Our epistemological stance was situated within a constructivist paradigm which recognises that

knowledge is co-constructed through individuals' socially mediated interactions with others. Since the exchange of stories is both a fundamental educational process within social learning theory<sup>18</sup> and an important indicator of how individuals assign meaning to their experiences, it was particularly appropriate as an approach to our aim of understanding the experiences of women clinical teachers.<sup>19</sup> Our focus was on moments of career decision-making, a way of stimulating participants' memories and enhancing their recall in order to produce a potentially rich source of personal reflections, anecdotes and reminiscences. Our interpretive approach was underpinned by feminist theory, which although has many definitions and understandings, is fundamentally concerned with the critique of systems that perpetuate patriarchy, sexism and male privilege.<sup>20</sup>

Our decision to take a narrative analysis approach to analysing the data was informed by an earlier focus group study which suggested that medical educators discussing their working lives were doing more than simply supplying information; they were 'performing' their identity as medical educators through narratives about their experiences.<sup>21</sup> Narrative analysis, because of its focus on attempting to understand how stories reflect the way in which people make sense of their lives<sup>18</sup> is therefore appropriate.

### Patient and public involvement

There were no patients involved in this study.

### Participant recruitment and data collection

We recruited participants through the professional networks of the UK Academy of Medical Educators (AoME) via email and Twitter. Eligible participants were women medical educators, clinical or non-clinical, who had experience of teaching or having taught medical students or doctors. Participation was voluntary. We invited participants to answer a short online survey requesting information regarding participant demographics and role in education. We provided participants with information on participation, informed consent, data storage and protection.

To address the study aims while allowing for wider participation, we collected personal narratives through a combination of free-text open comments, where participants provided short anonymous written accounts of a turning point during their medical education career, and interviews, where participants had the opportunity of opting-in to take part in one-to-one semistructured interviews to discuss the topic further. The two methods were as follows:

1. Free-text comments providing personal short written accounts (105 characters maximum) of turning points that led to career change (study aim 1), as style and genre (which are areas of interest in narrative analysis) may be more apparent in written accounts, particularly where the role of researchers as the 'consumers' of the story is less immediate to the process of creation.<sup>19</sup>

**Table 1** Description of Labov's narrative components

Component of narrative	Description
1. Abstract	An initial clause in a narrative that provides an introduction to the events of the narrative and summary of what is to come.
2. Orientation	Orientation clauses provide information on the setting and context of the events of a narrative, such as time, place and characters involved.
3. Complicating action	The complicating action is the obligatory part of a narrative and describes the main events of the story through a sequence of temporally oriented clauses.
4. Evaluation	Evaluative clauses convey the point of a narrative and the personal relation and interest to the narrator.
5. Resolution	The resolution concludes the events of story/complicating action.
6. Coda	The final clauses which signify the end of the narrative and return it to the present moment of telling.

2. Semistructured interviews inviting reflection on periods of decision-making and transition (study aims 2 and 3) of approximately 30 min in duration. We looked to interview those who had made an active career commitment to medical education, so inclusion criteria were UK-based, clinically qualified women who had professional experience as educators, combined with membership of a recognised professional organisation for medical educators such as The Association for the Study of Medical Education or AoME. We recruited UK-based participants for interview as a means of ensuring that health system was excluded as a potential variable factor within our more detailed qualitative exploration. We emailed 18 respondents who met these criteria and had expressed interest in participating. Nine completed consent forms were returned. We conducted nine semistructured interviews within 2 weeks of their completing the survey by telephone or face-to-face (JB, K LW) and generated a topic guide (online supplemental appendix 1) to help direct the interview and ensure consistency between interviewers.<sup>22</sup> All interviews were recorded and transcribed verbatim.

### Data analysis

We analysed the free-text written narratives using Labov's six-part framework, which outlines the elements commonly seen in all types of narratives. These are: abstract, orientation, complicating action, resolution and coda (see table 1).<sup>23</sup>

Labov<sup>23</sup> proposes that all personal narratives follow a particular structure, by which a person introduces an event, giving some background context, followed by a series of complicating actions and a resolution, with evaluation of the experience integrated throughout. Looking into the structure of a narrative and how it is assembled can shed light on how a person makes sense of an event temporally, resulting in an 'event-centred' approach in defining the narrative.<sup>22 24</sup>

We applied an inductive approach to identify emergent themes within the different Labovian elements of the narratives.<sup>22</sup> This was a collaborative approach involving all four authors and we cross-correlated themes to increase

analytical rigour. We used NVivo V.12 (QSR International Pty, 2018) for the management and analyses of data.

We analysed one-to-one semistructured interviews, double-coded them and discussed any variations in interpretation among all researchers to agree on final codes. We developed a framework from initial coding and translated this into NVivo V.12, continuously adapting the framework and adding new codes as we analysed the remaining interviews. This process of double-coding and using an analytical framework ensured rigorous data analysis and minimised the potential for researcher bias.

We then combined the two sets of data into a matrix for further analysis. We identified any inconsistencies of interpretation, discussed these among all researchers and generated a final data table, summarising the interpretations and their evidence.

### RESULTS

We obtained written narrative accounts from 55 participants from various countries including the UK, the USA, Australia, Canada and Europe. We conducted nine one-to-one semistructured interviews with UK-based women educators to discuss their narratives of career crossroads in more detail.

We present our description of women medical educators' career turning points thematically by outlining the push and pull factors, narrative inconsistencies and their positioning of themselves as autonomous agents.

#### Trigger factors—push and pull

Career decision-making for women medical educators involves a complex interplay between a variety of opposing (positive and negative) factors which can be seen to either 'push' women away from clinical medicine into medical education or 'pull' women towards it.

For some participants, key turning points within their careers originated from a specific destabilising experience. One participant describes how medical education provided a lifeline for her following a personal crisis which affected her ability to continue with clinical practice:



I became unwell. I had about 6 months in a wheelchair followed by major surgery, then rehab[...] Education was my only path to stay connected to the profession I love. (Participant 49; narrative)

Another participant described how circumstances led to a shift in perspective and brought about a focus towards improving the practice of future doctors:

I have three children and the eldest has disabilities, and I had to take a bit of time off...I think everything changed for me around that point and I think my perspective...from a medical education point of view, became...I'm very, very focussed on creating a generation of doctors, who can...directly look after my son. (Participant H; interview)

For some participants, negative experiences in previous clinical roles, described as 'toxic' by more than one, appeared to be a driving force behind change, with many having experienced situations of conflict or hostile environments in their previous work:

the conditions were biased, the staff were biased, the environment was toxic. I quit after about 6 months... I learned that some people just aren't cut out for day-to-day patient care. I learned I was one of them. (Participant 35; narrative)

One participant, who was working in a busy clinical job, described feeling 'forced' into an alternative path due to pressure to work full time. Medical education offered a ready alternative:

The department had a toxic chauvinistic culture, and it was made clear to me that I could only progress my career if I was full time. I did not want to work full-time so I felt forced to find an alternative. (Participant 21; narrative)

In contrast, for some women, positive experiences and encounters had affected their attitudes and, ultimately, choices around pursuing careers in medical education. The impact of mentorship and role models on women's career experiences was frequently highlighted:

Being mentored (unofficially) by 2 brilliant medical educators - encouraged me to pursue this as part of my career. (Participant 23; narrative)

I was inspired by a really brilliant woman, who was the [...] director of medical education at the time in the Trust, and did half research jobs, half clinical jobs. And I thought, oh, I want to be like you really. (Participant D; interview)

Many women stressed the importance of meaningful networks, discussing connections, networks and support as springboards for their careers. These connections gave participants support to achieve positions and seek out career opportunities:

So, having good connections, good support, having good people behind you to support you and

challenge you and move you on, that's been very useful. (Participant A; interview)

Participant C (interview) however suggests that for women to generate opportunities they must take a more tactical approach to relationships; something that she found distasteful. Despite this, she feels 'lucky' to have supportive networks:

[you have to] leave your dignity at the door a little bit... I am hugely lucky. I have an amazing network of people who are health professionals and in medical education, both academic and clinically. (Participant C; interview)

Other intrinsic motivators, such as a desire to improve medical education and practice or simply a love for teaching, were frequent influencing factors:

I love being surrounded by [...] the energy and the continuous learning [...] the pull is really that world of medical education [...] I get excited about it. (Participant C; interview)

Participants repeatedly spoke of how medical education had allowed them to express their values in the workplace and appreciated being able to 'make a difference' and the sense of empowerment this brought them:

It provided me with a real sense of purpose. The ability to effect change. To create something from scratch. I had always known I loved teaching; this gave me my first real chance to turn it into something tangible. (Participant 10; narrative)

### Narrative inconsistencies

Despite many participants reflecting positively on their journeys into medical education and speaking of being satisfied with their career decisions, inconsistencies and ambiguities in their narratives suggest that some had lingering reservations.

For example, Participant D (interview) asserts that she is happy with her decision to reduce her work commitments to spend more time with her family:

women make that choice. And it's a choice, and you can make it. (Participant D; interview)

However, she also comments later:

I haven't been able to write the paper because I've been cooking the tea... (Participant D; interview)

This narrative inconsistency reveals the paradoxical nature of women's narratives. She asserts her right to not only choose to work part-time if she wants, echoing narratives of female empowerment, but she also reflects on the loss of agency that has affected her career progress.

Many of the narratives described a conflict between two identities: medical educator and clinician. Participant C (interview) pointed out, for example, that she felt she was 'always straddling this kind of constant tension

between clinicians and academics' and further describes the presence of a 'little bit of imposter syndrome'. There is concomitant concern that one or both identities will be lost in the struggle.

For example, one interviewee implies that she has lost the sense of herself as a 'doctor':

[I try] to remember what it was like to be....to have this "yeah I am a doctor", kind of thing. (Participant A; interview)

However, she subsequently appears to dissociate herself from this position, insisting emphatically:

Medical education is the bulk of what I do now, but I am still a doctor. You can't take that away. I will always be a doctor... (Participant A; interview)

There was an overall positivity within written narrative accounts from the online survey. Many respondents reflected on challenging situations, describing a time of difficulty but still concluding with a positive message:

It was not a great experience and the lack of administrative support, looking back now, was brutal...I wouldn't make a transition like this again unless I was guaranteed better guidance, support and resources up-front but ultimately I feel fortunate to have had the opportunity. (Participant 38; narrative)

In contrast, many interviewees' reflections lacked positivity. Some were even regretful:

I do have some very strong views on how we should educate our junior doctors [...] And the environment that I work in is not... what I would need to change is not going to happen. (Participant I; interview)

### 'Settling' for/within medical education

Most participants asserted that they were content with their career trajectory. However, they also admitted sacrificing some career ambitions in order to balance their time with other 'push factors'.

The need to adjust careers to achieve work-life balance appeared to be a significant catalyst for transitioning into a career in medical education. Several participants spoke of conflicting personal and professional roles. These often appeared to be determining factors in their career decisions:

I was looking initially for a flexible role alongside my practice work that would fit around child-care and started teaching medical students. (Participant 40; narrative)

was going down a scientific clinical academic route but realised that this was not my passion nor conducive to a family life and a clinical career. (Participant 7; narrative)

Furthermore, once in a medical education role, it seemed that participants still compromised further by accepting less competitive roles within the field.

Participant D (interview) suggested that she had previously wanted to pursue management and academic enterprise but opted for medical education instead. She justifies her decision:

it's because actually for the last 16 years I've been looking after my children [...] It's not very interesting and...and exciting. You get to the point where you just think, you know what, I'm comfy now. (Participant D; interview)

This participant acknowledges that she has sacrificed progressing in her career to care for her family. She has reached a point of comfort but has sacrificed 'interest' and 'excitement' to achieve this.

Participant I (interview) likens her first pregnancy to a 'medical emergency', highlighting the urgency and importance of the decision-making process that led her to opt for a less demanding role:

sometimes events overtake, and just like with any new... well, if you are presenting with any kind of medical emergency, you pause, you take stock, you re-evaluate, and then you change your path, you know, and adapt to the new normal. (Participant I; interview)

## DISCUSSION

Our results reveal the complex interplay between a variety of opposing (positive and negative) push and pull factors which influence the decisions of women entering medical education. Studies exploring the motivations of clinical teachers frequently note 'pull' factors, such as passion for teaching and influential role models and mentors.<sup>4</sup> While this study also reports these factors, it suggests that for many female clinical educators their journey into education was often equally the result of a 'push', a change in personal circumstance or the need to escape previously stressful work situations, such as those of clinical practice. Research to date has tended primarily to address systemic barriers to a career in medical education for women,<sup>13 15 17</sup> with an associated assumption that a career in medical education is welcomed or desired. There has, however, been less awareness of the position of some women who may have felt forced or 'pushed' by circumstances into choosing and pursuing an educator career. The extent to which gender has an implication on such career decisions is of particular significance. While the positive 'pull' factors reported by participants are likely to be universally experienced (between men and women) due to their nature, when it comes to the negative 'push' factors, gender appears to have a greater implication.

Many women discussed how their career trajectory was restricted by the system within which they found themselves. Participants frequently described reaching a breaking point in their clinical practice, which led to them seeking roles which allowed them to escape from certain stresses of clinical work and ultimately into medical

education. Clinicians are known to experience burnout during their careers, with research indicating that women clinicians have significantly higher rates than males.<sup>25</sup> This was a repeated theme, coupled with the pressure to work full time. Increasingly, female clinicians are seeking less than full-time work<sup>26</sup> and for many participants the hope of achieving greater work–life balance was a key motivating factor, the implication being that medical education accommodates work–life balance better than other areas of medicine. For these participants, there appears to have also been a degree of compromise when making such decisions. Aware of the irreconcilability of the dual family/work pressures on women doctors that are exacerbated by stereotype perception and medical culture, the women in our study vacillated between asserting their right to choose a more family-friendly career path and regret at the disempowerment that had resulted from their exercising those choices. Even where women may be drawn to careers in medical education for reasons other than the need to find a less demanding specialty, the ongoing challenge of balancing personal and professional responsibilities coupled with other barriers may prevent them from pursuing leadership roles. Participants often felt that leadership roles were not open to them because of the associated responsibilities and expectations that would affect other aspects of their lives, such as their role as a mother, with some stating openly that they had sacrificed progressing their careers to care for family. This may result in a group of women who have mentally ‘settled’ for their particular role within medical education and who may consequently be doing it with less satisfaction than they anticipated when they first made the change.

Medical educators’ internal conflicts around their professional identity and the interplay between ‘clinician’ and ‘educator’ have been previously noted.<sup>27</sup> However, an unexpected finding was the ambiguity within participants’ narratives regarding their professional identities. There was further inconsistency in the way in which participants asserted their position as autonomous agents (which is consistent with narratives around female empowerment) while acknowledging their powerlessness when faced with organisational, social and cultural expectations that limited their ability to make independent choices. Most of the written narratives expressed significant pressures on women to commit to medical education careers while simultaneously concluding that it had been ‘worth it’; these assertions may not be taken at face value and require further exploration.

By conducting analysis of both written reports and interviews, our study was able to explore the complex scenarios faced by some women and their mindsets and attitudes surrounding these. There was a powerful contrast between the positive take-home messages of the written narratives and the sometimes negative conclusions of the interviews. While the positive conclusions to the written narratives may genuinely reflect intrinsic attitudes, a more nuanced interpretation (particularly in the light of the significantly less optimistic interview data) may be

that the authors of the written accounts were projecting a traditional ‘heroic’ image of themselves as resilient and able to overcome challenges. Traditional narrative genre conventions (including that most stylised of genres, the ‘written reflection’ with which medical professionals are so familiar) require the author to provide a clear end to the story and a positive take home message involving a lesson learnt.<sup>28</sup> By contrast, when participants undertook interview discussions, it appeared that many had experienced equivocal feelings about their career decision, with some even regretful. For some, the challenges of establishing a medical educator identity, overcoming gender bias, gaining social capital, creating meaningful networks and achieving required qualifications were seen to outweigh the perceived rewards and satisfactions.

We acknowledge limitations to this study. As an all-female team of researchers, we were aware of the risk of bias, both in our own interpretation of the data and potentially in the choices participants made around revealing information. We felt, however, that it was important to offer women a ‘safe space’ in which to discuss their perspectives in line with the feminist approach which informed our research. Furthermore, as the team comprised two practising medical educators and two medical students, we felt that our position as insiders allowed us to gain a more rapid and complete acceptance by participants. Bias was mitigated by our use of reflective research notes, regular discussions concerning our personal perspectives and careful attention to dual coding and analysis. We are also aware that this study was conducted some time ago, notably pre-pandemic. However, interestingly, we feel that experiences of women over the course of the COVID-19 pandemic such as women taking on the majority of the domestic labour or caregiving (ie, childcare, home learning)<sup>29 30</sup> and the impact of this on their careers<sup>31 32</sup> only enhance the relevance of this work in surfacing the pressure and inequity in the broader context that endures.

## CONCLUSIONS

Our study adds to the existing literature on women clinicians’ careers in medical education by exploring their lived experiences using narrative enquiry approaches to interpreting two types of data: personal written accounts of turning points that led to career change and semistructured interviews inviting reflection on periods of decision-making and transition.

We conclude that institutional and systemic attempts to increase women’s participation in medical education have enabled increasing numbers of women to enter the field and achieve more senior positions. However, many decisions associated with career advancement in medical education come with significant personal and career costs to women, who feel they need to navigate their way through the continued existence of a medical education culture that allows men to dominate the higher ranks. Additionally, the costs associated with making career decisions and the continued need to make compromises



(even where a career change was welcomed and has led to senior status) may lead to lingering regret and resentment. While our findings on this are preliminary, further research is needed to explore the long-term outcomes for the career satisfaction and progress of such women. Additionally, the links between educators' career satisfaction and the educational experiences of students and trainees need further exploration.

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