CAREER = CAREER?

The effects of gendered individual and organizational characteristics on (women) physicians' career motivation and career investment
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The effects of gendered individual and organizational characteristics on (women) physicians' career motivation and career investment

Een wetenschappelijke proeve op het gebied van de Managementwetenschappen

Proefschrift

ter verkrijging van de graad van doctor
aan de Radboud Universiteit Nijmegen
op gezag van de rector magnificus prof. Mr. S.C.J.J. Kortmann,
volgens besluit van het college van decanen
in het openbaar te verdedigen op vrijdag 23 september 2011
om 13.30 uur precies

door

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geboren op 23 september 1973
te Delft
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Dankwoord

Verdwaasd hing ik op. Moest ik de auto even aan de kant zetten om dit nieuws te verteren? Het was begin zomer 2004, ergens op de A50 tussen Apeldoorn en Arnhem. Ik was amper een half jaar daarvoor bevallen van Cara en wilde zo graag nu eindelijk dat proefschrift schrijven. Ik had een paar weken daarvoor gesolliciteerd op de vacature junior onderzoeker bij de faculteit Managementwetenschappen aan de Radboud Universiteit. De vacature beschreef een onderzoek met als thema werkprivé balans. Kolfje naar de hand van deze jonge werkende moeder, dacht ik. Maar ik was “een goede tweede”, zo bleek na dit desastreuze telefoontje. Ik begreep er niets van. En zo begon het.

Tussen 2004 en begin 2007 was ik buitenpromovenda, de pleister op de wond van de afwijzing. Intussen had ik een leuke en drukke baan bij het KLPD. Die promotie, dat leek soms meer op zo’n hobby die je op je CV noemt, maar waarvan je weet dat je er nauwelijks aan toe komt. Er moest regelmatig in de auto op weg naar de universiteit een soul/R&B-sister aan te pas komen met de tekst “Tell me no, and I’ll show you I can” (miss Whitney Houston - uit volle borst) om de moed erin te houden. Eind 2006 was er eindelijk een klein plekje vrij bij Managementwetenschappen. Ik kon – om te beginnen voor twee jaar – een aanstelling krijgen. Met een vreselijke dikke buik van Tessel zoende ik mijn collega’s bij de politie vaarwel en na mijn verlof startte ik dan eindelijk in februari 2007 aan mijn promotieonderzoek, fulltime en betaald. Voor velen is het promotietraject behalve inspirerend en leuk ook zwaar, frustrerend, een worsteling met deadlines, fnuikend commentaar, dieptepuntjes en soms met tijdelijk verlies van (zelf)vertrouwen. Ik had dit alles voor mijn gevoel al gehad in de aanloop naar een aanstelling. Daarmee vergeleken voelde mijn promotietraject zelf als een ‘educated sabbatical’. Lege agenda en lekker schrijven. Die enkele keer dat het wel zwaar was, had ik een heel arsenal aan mensen die voor me klaar stonden. Aan hen nu dit woord van dank (waarvan de lengte recht evenredig is aan de omvang van het proefschrift).

Allereerst mijn promotoren. Ik heb altijd moeten uitleggen waarom ik er vier heb. Ik grap altijd dat ik ze spaar, voor elk geslaagd jaar één. In werkelijkheid was dit multidisciplinaire team een essentiële voorwaarde voor dit geslaagde onderzoek. Het was een uitdaging – tenminste voor mij – de verschillende stijlen en formats uit ieders discipline te leren begrijpen en gerijmd te krijgen. Onze discussies waren behalve scherp en nuttig ook leuk.
Als de kritiek me na een tijdje echt te pittig werd, dan zagen jullie meestal op tijd aan de kleur van mijn wangen dat wat luchtigheid geboden was. Hans, dank voor het vertrouwen dat je in me had vanaf het allereerste begin en de moeite die je hebt gedaan om me binnenboord te halen. Ik heb vreselijk veel van je geleerd, zelfs om een beetje geduldiger te zijn. En ja, "the reviewer is always right". Het helpt, dat is wel gebleken. Lieve Pascale, ook jij was er zowat vanaf het eerste uur. Samen kwamen we op de wildste ideeëns, om die een paar maanden later bij te stellen als de fruitautomaat de juiste cijfers maar niet wilde oppesten. Pas & Peters/Peters & Pas, ooit zijn we een begrip! Rob, dank voor je frisse, nuchtere blik, je humor, je kwartjes en je hulp. Voor mijn gevoel hoefde ik maar een kick te geven en je was er. Ik heb vaak gelachen om je commentaren bij mijn drafts, ook al was je niet altijd even dol op mijn beeldsprakig betoog. Bij 'men in skirts' sloeg de rode pen echt op tilt (FIND, I did not REPLACE)! Enfin, eindelijk: ze is doc. Lieve Toine, jij moest je invechten tot aan de rector magnificus toe, maar gelukkig kreeg je je zin. Je hoorde er gewoon bij, al was het maar vanwege de wonderlijke wijze waarop onze eerste ontmoeting verliep bij jou thuis. Je was een fijne aanvulling op het team en kon mij veel leren over de medische wereld en professionele cultuur. Je opende deuren en zorgde dat ik beslagen ten ijs kwam met mijn vragenlijsten en focusgroepen. Ik koester nog warme herinneringen aan ons tripje naar Istanbul en ons kopje koffie op het terras van het Hilton. Ook wil ik bij deze mijn manuscriptcommissie, Beate van der Heijden, Paul Boselie en Anneke Van Doorne-Huiskes bedanken voor het lezen en positief beoordelen van het manuscript.

Lieve paranimfen, lieve Marieke en Samula. Mariek, we zijn af en aan roomies geweest, maar doorlopend dikke maatjes. We kunnen uren achter elkaar geconcentreerd werken, maar daarna giebelen als schoolmeisjes van zeven. Even de oksels ruiken en de panty’s ophijsen, liefst met het gevoel dat we publiek hebben. Ik vrees dat vanaf nu de zonwering naar beneden moet. Lieve Samul, je was mijn sparringpartner door dik en dun. Jij was (en bent!) die “beste eerste”, zo ontdekten we later. Goddank, want ik had het geen enkel ander persoon gegund. Dank voor de tijd die je altijd voor me had als ik weer eens van me af moest praten, voor je hulp bij het in hoge snelheid door discourse methodes fietsen, je google werk (SAMSEARCH als startpagina), voor je integriteit en support. Ik weet niet wat de toekomst ons heeft gebracht tegen de tijd dat je dit leest, maar ik weet vreselijk zeker dat het goed gaat komen. Linksom of rechtsom.

Veel dank ook aan mijn andere ‘roommate’, Ine. Dank voor je hulp, zowel met sparren als met de hulp bij het voorbereiden van het onderwijs, toen dat ongelukkig ging samenvallen met de afronding van het proefschrift. Dank
Dankwoord

ook aan de rest van de ‘gender in organizations’ groep: Yvonne Benschop, Laura Berger, Inge Bleijenbergh, Caroline Essers en Claudia Groß. Veel dank ook aan de OD&D groep, met wie ik hoop in de toekomst veel mooi onderzoek te gaan doen: Jan Achterbergh, Jac Christis, Liesbeth Gulpers, Paul Hendriks, Wil Martens, Kristina Lauche, Hans Losscher, Max Visser, Simone van Zolingen en in het bijzonder (;-)) Dirk Vriens. En hoewel ik hier nu wel heel veel mensen op de grote hoop gooi, dank aan de SHRM-groep, net als de Strategie en Methoden groepen. Hoewel ik als niet-medicus de odd-one-out was, ben ik met veel plezier onderdeel geweest van de vakgroep Vrouwenstudies Medische Wetenschappen aan het UMC st Radboud. Het was leuk met jullie op te trekken tijdens het ‘zendingswerk’ in het land en bij de WONCA congressen. Ik dank ook het Institute for Genderstudies, waar ik met een teentje ook toe heb mogen behoren. Dank aan mijn stud-ass’en, c.q. studenten, bij Regressie, Joris en Elma, voor al hun monnikenwerk. Jan-Willem, je hulp en creativiteit bij het maken en onderhouden van de web-survey waren geweldig. Dankzij jou hadden de respondenten nauwelijks door dat de vragenlijst zeker 50 minuten in beslag nam om in te vullen. And last but not least, thank you Toby for checking my spelling, it was fun and valuable working with you!

Van de dankwoorden richting het ‘publieke’ domein, dan nu het ‘privé’ domein. Een hele kluit lieve vriendinnen. Lieve Amsterdamse ladies, Caroline, Diana, Djoekie, Karen, Marjolein, Lilian, Daphne, Roos, en andere minder frequente aanschuivers: hoewel soms een mijl op zeven om op vrijdagavond nog vanuit Nijmegen naar centrum Amsterdam af te reizen, onze etentjes zijn het meer dan waar. Bij elk avondje voel ik me bevoorrecht en trots met deze wereldmeiden aan tafel te zitten en lief en leed te delen. Lieve Ellen, L. Wie had dat gedacht, 20 jaar geleden op de bank video kijkend, dat ik ooit een proefschrift zou schrijven? Nou ja, jij waarschijnlijk wel maar ik zeker niet. Dank voor je aanmoediging en steun, al had dat vaak niets met promoveren te maken. En dan nu even in sneltreinvaart een rondje langs zomaar wat namen. Lieve buurtjes, links en rechts, van nr. 20 tot en met nr. 1, dank voor alle keren dat de meisjes bij jullie terecht konden, dank Loor dat het grote meisje zelfs midden in de nacht terecht kon voor de nodige peptalk, dank aan weer een paar huizen verder voor medisch advies buiten kantooruren/privé Prednison-voorraden (dank Martijn), heel veel dank aan allen voor al die ‘slootjes’ en borrels die de nodige ontspanning gaven. En dan toch in het bijzonder Daan, dank voor je creatieve input en tijd bij het ontwerpen van de voorkant. Beter een goede Buuf dan een verre vormgever! Joost, Maarten (en aanhang), grote neven van me, dank voor de nodige
ontspanning en reflectie op wat nu eenmaal genetisch zo is bepaald en waar we ons dus alleen maar aan over kunnen geven (de bar is open). Lieve Gilbert & Ivanka, Rindern hebben we weten te vinden en gelukkig dat onze vriendschap dat heeft overleefd. Lieve wijze vrouw, Hetty, mijn digitale pen-pal. Dank voor al je wijze woorden en zelfs de noodtelefoontjes als je tussen de regels door las dat ze het echt even dreigde te verliezen. Je begrijpt toch wel dat je je agenda mag leeg vegen in de dagen voor de verdediging hè?
Want EmWave ain't enough then girl!
Mieke (maar eigenlijk ook een beetje Gertie, Deborah en Melvin), jij bent het ware geheim achter het succesvol combineren van een jong gezin en twee veeleisende carrières. Ik heb het thema vier jaar bestudeerd, maar het eigenlijke antwoord op de vraag in de titel “Care + een veeleisende werkomgeving = “: MIEKIE. Helaas voor de rest van de tweeoverdieners ben je gelukkig bij ons. Met gezond verstand, luisterende oren, een bemoedigend en soms corrigerend woordje (ja maar Hans begon!), de bakjes fruit die je me boven komt brengen, hou je mij (ons) al zeker 5 jaar op de been. Letterlijk en figuurlijk, want je bent ook m’n allerfijnste loopteugel. Ik hoop echt dat we onze blessures overwinnen en weer aan die 22 km per week komen dit jaar. Miek, je bent mijn controle-variabele met de hoogste, significante bèta; mijn roze/paarse Langejan, mijn teruggevonden setje sleutels, mijn dierbare vriendin.

Lieve pap en mam, dank voor al het voorwerk. Pap, mijn doorzettingsvermogen is absoluut genetisch bepaald. Weet je dat ik nog dagelijks als ik met Viv achter ‘het Rhedens’ loop denk aan hoe we daar zaten bij de rector die me niet wilde toelaten tot het VWO? Dank dat je meteen daarna bent doorgereden naar het KGL. Uit studies is gebleken dat vrouwen wiens moeder vroeger werkte, later zelf ook meer uren werken dan vrouwen wiens moeder thuis bleef. Onzin, hè mam? Vrouwen die destijds veel meer hadden gekund als de samenleving daar ruimte voor had geboden, brengen hun dochters bij hoe belangrijk het is een goede opleiding te genieten en economisch zelfstandig te zijn. En daar je me ook geleerd hebt hoe te ‘luchten’ om te ontsnappen aan dagelijkse huishoudelijke beslommeringen, leek het me verstandig die opleiding maar zo hoog mogelijk te maken. Nu dat salaris nog. Dank ook voor alle keren opaasssen, vooral ook tijdens die eerste moeilijke jaren op de boerderie in afgelegen Harfsen. Maar ook later, voor alle keren dat de meisjes bij jullie konden logeren als hun ouders even een lang weekendje of midweekje nodig hadden om bij te komen of congressen te bezoeken. Dank ook Hille, Kobbe, Gill, en Carolien.

Lieve schone ouders, want die heeft deze promovenda ook. Lieve Geke, aan jou had ik mijn persoonlijke archivaris, elk krantenknipsel over vrouwen naar de top werd uitgeknipt en opgestuurd door jou. Ik hoop altijd dat het
mijn naam is op de antieke (?) bruine KLM cabine-personeel envelop! Ook dank voor alle keren dat je voor me duimde en je steun uitte. Het toppunt was wel toen je halsoverkop huis, haard en (jouw) Hans verliet om bij ons thuis de boel over te pakken omdat we naar Rome moesten. Lieve Hans, dank dus ook voor alle keren dat je je vrouw naar Velp liet afreizen. Onze gesprekken over jouw vroegere werkveld en liefde voor filosofie hoop ik nog lang met je te kunnen voeren, liefst met een ijskoud biertje, des cacahuètes, op het terras in Canadel. You better beat the odds! Femke, Sjoerd, ‘mannen van Amstelveen’ en Nicolette, dank voor jullie support!

Lieve Caat, Giechel, klein kopietje van me. Hoe symbolisch het is dat jij eindelijk 7 meter onder water en door het gat zwom voor diploma B terwijl ik mijn manuscript inleverde, zullen alleen jij (later) en ik begrijpen. Ik denk nog vaak aan wat je me ooit ‘s avonds zei toen ik je uitlegde dat ik een beetje verdrietig was omdat ik dacht dat het boek eindelijk goed was en er toen toch weer van alles anders moest. Je was 6 jaar, haalde je duim uit je mond en zei “ik ken geen één kindje uit mijn klas van wie de moeder een boek heeft geschreven, dus wat maakt het nou uit dat je het nog een beetje anders moet maken”. Als ik jou hoor lachen (als een startende oude 2CV) vloeit alle spanning van me af. Ik kan niet wachten tot jij je eerste boek schrijft, al is het alleen maar omdat ik dan niet meer je dictaten hoef uit te werken. Met jouw inlevingsvermogen, scherpe analyses, gevoel voor taal, humor en tomeloze fantasie moet dat een smashing debuut worden!

Lieve Tess, Goochem, onze wijsneus. We moeten het eerste levende wezen die jij niet genadeloos om je vingertje windt nog tegenkomen. Je vertedert – zelf bij een driftbuitje –, je verleidt, je verbindt, je staat je mannetje, je bent zelfverzekerd, zorgeloos en prachtig in balans, daar ben ik vreselijk jaloers op. Jouw scherpe en grappige uitspraken maken dat, eenmaal thuis, piekeren over werk voor mij tot een minimum wordt beperkt. Maar zou je alsjeblieft willen ophouden met scheel kijken als ik je probeer uit te leggen hoe belangrijk het is dat ook meisjes van vier naar school gaan en later hun eigen centjes kunnen verdienen? Kleine smurf, ik ben werkelijk vereerd dat je met mij wilt trouwen en natuurlijk doen we dezelfde roze jurk aan op de bruiloft.

Tot slot, want je staat altijd onderaan mijn lijstje, maar in dit geval is dat zowaar eens een eer. Mop, mijn derde topprestatie is geleverd en wederom was dat niet gelukt zonder jou. Dank voor alle keren dat je – uiteindelijk toch en onder ingehouden (mwah...) protest van mij - in slaap viel als ik om drie uur ’s nachts nog met je wilde praten over gendered discourses, moeilijke keuzes en conceptuele modellen. Zo was tenminste één van ons de volgende ochtend in staat mij uit bed te trommelen. Ik zal je eeuwig dankbaar zijn voor je onophoudelijke aanmoediging, je geduld met en vertrouwen in mij
en al die andere dingen die dan weer niet in een publiek dankwoord thuishoren. Het waren een bewogen stel jaren. Het maakt niet uit, want als we later samen groot zijn, dan is mijn definitie van ultiem geluk nog steeds dezelfde: Hansepons. Let's go to our corner of the earth.

Velp, 3 juni 2011
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INTRODUCTION

The effects of gendered individual and organizational characteristics on (women) physicians’ career motivation and career investment
1.1. Introduction

The profession of medicine is becoming feminized, as the number of women enrolled in medical school and residency programs has risen dramatically over the past decades (e.g., Levinson & Lurie, 2004). For example, women make up more than 50% of the medical students in the U.S., the Netherlands, and Scandinavian countries (Denmark, Finland, Norway and Sweden), and in Russia 70 percent of physicians have been women ever since the 1930s (e.g., Harden, 2001; Riska, 2001; Van der Velden, Hingstman, Heiligers, & Hansen, 2008). Despite this feminization of the medical profession, women physicians are still overrepresented in lower-paid and lower-prestige specialties, such as primary care, and substantially underrepresented in the higher echelons of medical academia and medical administration – with percentages between 0 and 15 percent (Boulis, 2004; Van der Velden et al., 2008; Van Doorne-Huiskes & Van Beek, 2009). Although this is equally true for other sectors in the Netherlands, it is particularly striking in the health sector. It employs women who are, in the main, as highly educated as their men counterparts, and who work long hours - even when working part-time (SCP, 2008) (The Netherlands Institute for Social Research, from hereon referred to as SCP, 2008). This absence of women physicians in senior medical positions creates the impression that Dutch health care institutions have inequality regimes, which refers to “loosely interrelated practices, processes, actions, and meanings that result in and maintain class, gender and racial inequalities within particular organizations” (Acker, 2006; p. 443).

The general debate and current scientific discussions on gender disparity in senior medical positions have centred on the causes of this disparity. One stream in the debate focuses mainly on women’s individual aspects, such as their alleged lack of career motivation (e.g., Hakim, 2002; Van Vianen & Keizer, 1996) and, consequently, their lack of career investment (Hamel, Ingelfinger, Phimister, & Solomon, 2006).

Several studies have investigated the effect of children on women’s working hours (e.g., Van Wel & Knijn, 2006), job satisfaction (e.g., Scandura & Lankau, 1997) and work-family conflicts (e.g., Saltzstein, Ting, & Saltzstein, 2001). One Dutch study investigated the relationship between career ambition and working hours among parents (Dikkers, Van Engen, & Vinkenburg, 2010) and concluded that parents with higher levels of career ambition work more hours than those with lower levels of career ambition. Although the number of working hours is an important predictor of whether a senior position is attained, it is often explicitly or implicitly assumed that working hours closely reflect career motivation. However, the health care
sector, in which many women physicians work long hours (SCP, 2008), reveals that there is more to career advancement than working long hours alone. Studies on women’s (professional) identities and their willingness to contribute to society also revealed that women’s career motivation involves more than just their decisions on how many hours to work (Duncan, Edwards, Reynolds, & Alldred, 2003; Stone, 2007). The construct of career motivation used in this study is derived from London’s Career Motivation Theory (1983), and distinguishes three dimensions of career motivation: i) the importance or centrality of career in one’s life (‘career centrality’); ii) the degree to which one has formulated clear career goals (‘career insight’); and iii) the degree to which one wants to achieve a senior or higher (hierarchical) position in one’s field (‘career ambition’) (London, 1993, 1997; Lopes, 2006; Noe, Noe, & Bachhuber, 1990; Ouwehand, 2005; SCP, 2008). Career investment is here defined as women physicians’ investment, in terms of time and energy, in their work to enhance their chances of career advancement and/or contributing to society. For example, besides the actual hours worked, other career investment such as having a PhD degree or performing work-related ancillary activities, such as sitting on the committee of a specialists’ association, are important factors for gaining promotion.

As this study will reveal, women physicians are also confronted with norms concerning the ‘ideal’ worker (i.e., physician), who is always available and unencumbered with caretaking responsibilities (e.g., Acker, 1992). Being an ‘ideal’ physician is, by definition, incompatible with that of the Dutch motherhood ideology in which the ‘ideal’ mother only works three days outside the house (SCP, 2008). Based on the Framing Theory of Lindenberg and Frey (1993), this study introduces four frames based on the degree to which women physicians internalize these gendered and conflicting role prescriptions, namely: career frame, care frame, switching frames and non-traditional frames.

The other side of the debate, meanwhile, focuses more on contextual, in particular, organizational aspects of the institutions in which women work, such as companies’ family-friendly human resource (HR) arrangements and supportive work-home cultures. In this study, family-friendly HR arrangements refer to both the provision of and use of HR arrangements (i.e., policies, programmes) intended to help those with young children (particularly women) to balance their work and family responsibilities (Allen, 2001). A supportive work-home culture refers to the extent to which the culture of the organization supports and values the integration of employees’ work and family lives (Thompson, Beauvais, & Lyness, 1999). In the present study, three dimensions of the (perceived) supportiveness of the work-home culture are
distinguished, namely i) career support, which refers to the attention and support from supervisors and/or colleagues for one's career goals; ii) work-life balance support, which refers to supervisors and/or colleagues' sympathy for obtaining or retaining work-life balance; and iii) the absence of career hindrance, which refers to the perceived support for upward mobility, even though one adapts one's work to suit family matters such as working part-time (e.g., expectations concerning how much time employees must spend visibly at work).

One may ask which aspect, the individual or the organizational, accounts for the lack of women in senior medical positions the best. Are women physicians not motivated enough to strive for senior positions, and if not, why not? Are they too distracted by motherhood, or have they internalized a traditional societal motherhood ideology to obtain social approval from their environment? Or can most explanations be found in the still male-dominated health care institutions (HCIs) in which these women physicians work, with demanding professional standards, perhaps rather rigid work structures, and an unsupportive work-home culture which still favours the 'ideal' physician who is always available? This study does not aim to investigate which aspects provide the best explanations, or to put it differently: who is to blame. All the aspects as mentioned above may play a role in this complex and multifaceted issue and a multidisciplinary approach is required (Khapova & Arthur, 2010). One could say that individual aspects are affected by their social context, such as organizational work-home cultures and vice versa, and together and in interaction they affect (women) physicians' career motivation and investment. Stemming from a critical (realistic) perspective, I use both qualitative and quantitative research methods in this study. In doing so, I reveal two aspects of interaction. First, based on quantitative techniques, I show that work-home cultures are able to affect the relationship between women physicians' frames and their career motivation. Second, with qualitative research techniques, I reveal how individual internalizations of how to behave appropriately as a physician (or as a mother) are subtly reflected in academic specialists' talk on the dominant norm of the 'ideal' physician. Not only do individuals in interaction with each other construct these normalizing discourses, they also resist and counter-resist (resisting resistance), thereby strengthening the dominant norm on the 'ideal' specialist or 'ideal' mother. Especially the investigation of these gendered discourses reveal how individuals inextricably interact with social contexts in organizations, and vice versa.
This study was designed to contribute to the societal and scientific debates on the causes of the gendered inequality in senior medical positions. How can having caretaking responsibilities at home (Care) together with (+) a demanding profession and working environment (for example, the Emergency Room) result in prosperous careers for women physicians?

The first aim of this study is to gain a better understanding of the effects of both the individual and organizational aspects of the career motivation and career investment of women physicians in particular. From an individual perspective, I am interested in whether having children and personal views regarding the ‘ideal’ mother and the ‘ideal’ physician affect women physicians’ career motivation and investment. From an organizational perspective, I am interested in whether the development and implementation of family-friendly HR arrangements and family-friendly work-home cultures affect women physicians’ career motivation and investment. This approach will enable me to combine the scientific insights previously acquired in other disciplines, such as psychology, gender studies and human resource management (HRM) studies.

The second aim of this study is to shed more light on whether – and if so how – individual and organizational aspects interact when affecting women physicians’ career motivation, their career investment and, ultimately, their career advancement. For example, women physicians may have certain personal views on good mothering that may affect their career motivation. But the family-friendly HR arrangements and work-home cultures of health organizations may serve to reinforce or diminish the effects of personally held views about motherhood on career motivation. I also want to reveal how societal discourses on certain notions - such as having children, motherhood ideology, but also the normalizing discourse on the ideal physician, which makes itself heard the loudest within organizational cultures - can indirectly have an influence on the career motivation, career investment and, consequently, the career progression of women academic specialists.

The remainder of this chapter will elaborate on how the individual and the (perceived) organizational aspects and their interaction affect the career motivation and investment of women physicians. It will also present the main research questions of this dissertation.
1.2. Theoretical framework and research questions

Before going into the relationships between the individual and organizational aspects and the career motivation and investment of women physicians, I believe it is important to provide more insight into the specific context in which women physicians in this study find themselves. Physicians are important assets to society, and many studies have been done in order to investigate matters such as the preferences of physicians (and women physicians) for particular specialties, the average number of years spent as a resident, the (preferred) number of working hours, and the differences between actual and contracted working hours (De Jong, Heiligers, Groenewegen, & Hingstman, 2006; Heiligers & Hingstman, 2000; Heiligers & Hingstman, 2002; Van der Velden et al., 2008). A few studies have specifically addressed the career preferences of women physicians (Keizer, 1997; Kruijthof, 2005). Other career characteristics such as their terms of employment, whether they hold a PhD degree or are involved in work-related ancillary activities, and physicians' personal views of the 'ideal' physician, have been studied less frequently. Regarding the often cited explanatory factors for the lack of career progression among women physicians, such as the characteristics of the household in which they live (i.e., their partner's profession, partner's working hours, the presence of children, the average age of their youngest child and the childcare facilities they use), but also the characteristics of the organization in which they work (i.e., the number and type of family-friendly arrangements offered and used, perceptions regarding supportive work-home cultures), have not been described yet. The first research question is therefore:

Q1: What are the characteristics of the households women physicians live in (e.g., partners work, children, views on motherhood); how do they perceive the family-friendliness of the organizations in which they work (e.g., the family-friendly arrangements offered, the use of these arrangements, supportive work-home cultures) and what are (women) physicians' career characteristics in terms of their career motivation (career centrality, career insight and career ambition) and career investment (e.g., working hours, PhD degree and work-related ancillary activities)?

1.2.1 Individual aspects

Individual aspects that are often assumed to affect women's career motivation and investment are their child-related caretaking responsibilities (e.g., Taylor, Lambert, & Goldacre, 2009), and the influence of the traditional Dutch motherhood ideology (Van Engen, Dikkers, Vinkenburg, &
De Rooy, 2009; Van Wel & Knijn, 2006). One particular circumstance in a woman physician’s life which is often cited as a potential source of variation in career motivation is the presence of (young) children. The associated caretaking responsibilities are closely tied to the traditional motherhood ideology, which means that women – to a greater extent than men – face a significant contradiction between (societal) expectations at home and at work (e.g., Bassin, Honey, & Kaplan, 1994). According to the dominant Dutch motherhood ideology, an ‘ideal’ mother should work no more than three days a week outside the home (SCP, 2008). As a societal motherhood ideology, motherhood is rooted in issues concerning care-giving and time allocation (Arendell, 2000), as well as issues such as aspiring to be a role model in terms of work and family life (Marshall, Godfrey, & Renfrew, 2007). Marks and Houston (2002) state that there is evidence from international research that an individual may experience conflicting ideological and personal views regarding their work and family roles. For instance, a mother may disagree with prevailing attitudes on motherhood in principle, but actually accept or (subconsciously) internalize this dominant ideology at a personal level. In line with previous qualitative research (Arendell, 2000; Johnston & Swanson, 2006, 2007; Marshall et al., 2007), I therefore distinguish two dimensions within the construct of the traditional view of the ‘ideal’ mother, which refer to personal, internalized ideals regarding good mothering. The first dimension is time allocation, which refers to a woman physician’s personal view on how she should divide her time between her family/children and other aspects of her life such as work. The second dimension is that of the role model, which refers to whether a woman physician believes it is important to set an example to her children as a mother who works outside the home and the importance which she attaches to her own career relative to that of her husband.

But how valid is the assumption that the career motivation and investment of women physicians are affected by having children and their views of the ‘ideal’ mother? Moreover, does the fact that women physicians have children affect their career motivation alone, or is it both having children and their views of the ‘ideal’ mother? Or does having children affect views on motherhood, which in turn affects career motivation? Additionally, with the changing role of men in caretaking responsibilities (Henwood & Procter, 2003; Kaufman & Uhlenberg, 2000; SCP, 2008), one might also wonder whether having children also affects men physicians’ career motivation. The second set of research questions is therefore:
Q2a: Do women physicians with (young) children hold more traditional views of the ‘ideal’ mother than women physicians without children?

Q2b: Do women physicians with a traditional view of the ‘ideal’ mother have lower levels of career motivation than those who hold a less traditional view of the ‘ideal’ mother?

Q2c: Do women physicians’ views on motherhood mediate the presumed negative relationship between having children and career motivation?

Q2d: Do men and women physicians with children have lower levels of career motivation than those without children?

In behavioural psychology, there are numerous constructs associated with measuring ambition such as ‘career aspiration’ (Rainy & Borders, 1997) and ‘achievement motivation’ (Murphy & Alexander, 2000). However, many existing theoretical constructs are one-dimensional, dealing with only one or a few aspects of a person’s motivation to strive for a career, such as their need for success or power (Mitchell & Daniels, 2003). London (1983), by contrast, perceives career motivation at three different levels, including the influence of the environment and behaviour. The definition of career motivation in this study, as presented in the introduction of this chapter, not only includes issues such as career centrality, but also extends to career-oriented behaviour such as setting goals. Moreover, our conceptualization also includes the dimension of career ambition (SCP, 2008), which provides insight into the aspiration for upward mobility.

In both public and scientific debates it is often assumed, implicitly or explicitly, that women who do not work long hours every week and/or do not do ‘something extra’ to increase their chance of obtaining a higher position, lack career motivation (Hakim, 1993; Van Vianen & Fischer, 2002). In other words, it is often assumed that higher levels of career motivation result in higher career investment (longer hours, extra activities). However, only a few studies have provided empirical evidence for this assumption (Dikkers et al., 2010; Judge, Cable, Boudreau, & Bretz, 1995; Keuzenkamp, 2009). The third set of research question that I will address in this dissertation is therefore:

Q3a: Do women physicians with higher levels of career motivation (career centrality, career insight and career ambition) work more hours than women physicians with lower levels of career motivation?

Q3b: Are women physicians with higher levels of career motivation (career centrality, career insight and career ambition) more likely to hold a PhD degree or be engaged in PhD research?
Q3c: Are women physicians with higher levels of career motivation (career centrality, career insight and career ambition) more likely to be engaged in work-related ancillary activities?

A woman physician with young children – like other working mothers – face an internal conflict and must perform "cognitive aerobatics" when attempting to combine motherhood with a career (Johnston & Swanson, 2007). On the one hand, she does not live up to the societal requirements of the ‘ideal’ mother; yet on the other, she does not fit prescribed ideas of the ‘ideal’ physician.

The view of the ‘ideal’ physician has received very little attention, at least in quantitative research, perhaps due to gendered stereotypical role prescriptions, in which the woman physician’s role as a mother is still presumed to predominate. However, the role of physician is a notoriously demanding one. It routinely involves life-and-death decisions (Van Doorne-Huiskes & Conen, 2007; Peschel & Peschel, 1986), but face hours and overtime also play an important role (Brennan & Zinner, 2003) and a physician is expected to demonstrate almost total dedication. The ideal physician resembles what Acker (1992) calls the ‘ideal worker’, with masculine traits, extreme dedication to work, (e.g., willing to relocate for work), unencumbered by care-taking responsibilities at home, flexible, and physically capable of working long hours.

It is therefore important to investigate how women physicians cope with these contradictory and gendered role prescriptions, and whether it affects their career motivation and investment. To study the way women physicians combine contradictory societal role expectations (that of the ‘ideal’ mother and that of the ‘ideal’ physician), I use the Framing Theory of Lindenberg and Frey (1993). This theory seeks to explain why and how people (subconsciously) come to prioritize one goal over another. The Framing Theory states that people’s needs for social approval and physical well-being are universal. In order to gain social approval, people create instrumental goals such as being ‘an ideal mother’ or ‘an ideal doctor’. However, these instrumental goals can be contradictory and therefore compete for people’s information, energy and time. For instance, if a woman’s dominant goal (‘frame’) is to be an excellent physician, her attention and other cognitive processes will be focused on achieving this goal (framing). This process “blinds” her to other worthwhile goals, which now appear to be distractions. However, changing circumstances can mean that other goals will influence this initial dominant goal. For example, when a woman becomes a mother, a changing circumstance, and she wants to gain social approval by being a
good mother according to traditional standards, her former career goals may be challenged by this new, alternative goal.

The question at stake, then, is whether the preference of women physicians for a certain frame – being an ‘ideal’ doctor (career frame) or being an ‘ideal’ mother (care frame) – or their attempt to combine or reject both ideals (switching or alternative frames) affects their career motivation and investment. The fourth research question that will be discussed and answered in this dissertation is therefore:

Q4: Do women physicians with switching frames have higher levels of career motivation (career centrality, career insight, career ambition) than women physicians with a care frame, but lower levels of career motivation than women physicians with a career frame?

1.2.2 Organizational aspects

The stream in the debate which focuses on individual aspects has now been introduced. However, as mentioned, organizational aspects also have a role to play in the career motivation and investment of women physicians.

Organizations are highly susceptible to their environments and have to take account of the wishes of other parties, such as trade unions and other representatives. They are sometimes also bound by Collective Labour Agreements (CLAs). As such, a disregard for their institutional environment would increase the risk of strikes and legal action (Boon, Paauwe, Boselie, & Den Hartog, 2009; Goodstein, 1994). Konrad and Mangel (2000) showed a positive correlation between the percentage of women employed and the development of more extensive work-life programmes in large U.S. (non-healthcare) organizations. So far, no such investigation has been carried out in the Dutch health care sector. In response to the increased priority given to the work-life balance among physicians (Heiligers & Hingstman, 2000), health care institutions have indeed tried to prevent women physicians from opting out or ‘burning out’ by trying to tackle the organizational conditions which may jeopardize their careers. For example, onsite childcare facilities or part-time contracting can be offered in order to retain employees, and work-life balance training courses or flexible working hours can be offered to preserve or even increase employees’ working hours. Other family-friendly HR arrangements – although perhaps ‘women friendly’ HR arrangements would fit the description better such as career advancement programmes for women or offering mentoring and coaching – are examples of ways in which organizations resist or try to counter gendered inequality regimes.
The studies into family-friendly HR arrangements conducted so far have focused on the uptake rates of the arrangements offered by organizations (e.g., Dikkers et al., 2007) and on whether the use of these provisions correlates with reduced work-life conflict (e.g., Saltzstein et al., 2001), job attraction (e.g., Honeycutt & Rosen, 1997) and organizational commitment (Grover & Crooker, 1995). So far, studies have not yet included any empirical investigation of whether offering family-friendly arrangements affect career motivation and investment among women physicians. Moreover, studies have focused mainly on the effects at the individual level (Coombs et al., 2007), although insight into possible adverse effects on organizational performance, such as elevated labour costs due to part-time working, could be helpful when seeking to explain the low uptake of family-friendly HR arrangements, or to establish more supportive work-home cultures (Lewis, 1997). In order to investigate the effects of family-friendly HR arrangements on career motivation and investment among women physicians, the arrangements in this study were categorized either according to the expected effects on women physicians' working hours (see Chapter 5) or according to the implicit (perhaps gendered) assumption that lies behind these family-friendly arrangements (see Chapter 6). For example, Chapter 5 distinguishes between Reduced Participation Arrangements (e.g., part-time work, extra leave arrangements) and Full Participation Arrangements (e.g., onsite childcare, flexible working hours), since the use of the first will clearly result in a decrease in working hours, whereas the latter may or may not have an effect on women physicians' working hours, or perhaps even increase their labour participation. In Chapter 6, the same family-friendly arrangements (referred to as Gender Equality Arrangements) are categorized as follows: Ideal Mother Arrangements (e.g., part-time working, extra leave arrangements), which help women physicians to be a good mother at home according to dominant societal norms; Ideal Worker Arrangements (e.g., management development training, mentoring, coaching), which emphasize the ideal worker norm of the individual employee adjusting him or herself to the organizations' demands; and Revising Work Culture Arrangements (e.g., flexible working hours, teleworking), which result in cultural and structural changes in the organization. For the sake of clarity and parsimony, I will here formulate a set of research questions that combines the more specific hypotheses presented in Chapter 5 and 6 of this dissertation. The fifth and sixth set of research questions that will be addressed are:

**Q5a: Do the feminization of medical specialties and the presence of CLAs positively affect the number of family-friendly arrangements that HCIs offer?**
Q5b: Does offering more Reduced Participation Arrangements negatively affect the number of contracted hours that women physicians work; and does offering more Full Participation Arrangements positively affect the number of contracted hours that women physicians work?

Q5c: Do women physicians using Reduced Participation Arrangements work fewer hours than those who do not use these arrangements; and do women physicians using Full Participation Arrangements work more hours than those who do not use these arrangements?

Q6a: Do Ideal Mother Arrangements affect women physicians' career motivation (career centrality, career insight and career ambition) negatively?

Q6b: Do Ideal Worker Arrangements and especially Revising Work Culture Arrangements affect women physicians' career motivation (career centrality, career insight and career ambition) positively?

Another organizational aspect that is often regarded as an impediment to continued career motivation among women physicians and to advancement in their careers is the lack of support that medical organizational work-home cultures provide for women with care obligations. Although some researchers (e.g., Dikkers et al., 2007) failed to find any differences between how parents and non-parents perceive the supportiveness of the work-home cultures, other researchers (Chertoff, Bird, & Amick, 2001) found that the work-family culture of an organization can be less family-friendly in reality than it purports to be. Employees may perceive their organization to be family-friendly until they actually have to take up the family-friendly arrangements offered – due to child birth for example – and encounter unexpected resistance, such as a supervisor's denial of requests to use those family-friendly arrangements. Researchers and policy makers often express their concerns regarding the negative effects that an unsupportive work-home culture can have on women's careers (Bailyn, 2006; Kelly, Ammons, Chermack, & Moen, 2010; Lewis & Smithson, 2001; Van Doorne-Huiskes & Conen, 2007). However, exactly to what extent and in which ways supportive work-home cultures can positively affect the career motivation and investment of women – and men – physicians has not yet been studied. The seventh set of research questions is therefore:

Q7a: Do women physicians with (young) children perceive the work-home culture as less supportive than those without children?

Q7b: Do women physicians with (young) children have lower levels of career motivation, and is this relationship mediated by their perception of the supportiveness of the work-home culture?
Q7c: Do men and women physicians who perceive the work-home culture in their organization as supportive have higher levels of career motivation than those who perceive their work-home culture as unsupportive?

Q7d: Do women physicians who perceive their organization's work-home culture as supportive of their work-life balance and absence of career hindrance work fewer contracted hours; and do women physicians who perceive the work-home culture as supportive regarding their career goals work longer contracted hours?

1.2.3. Interaction: individual notions and organizations intentions

De Jong, Heiligers, Groenewegen and Hingstman (2006) show that the number of hours worked by male Dutch medical specialists is falling. This could indicate an overall change in attitudes towards the number of hours medical specialists should work, or the development of more supportive work-home cultures in HClEs. However, researchers have often pointed out that the effectiveness of family-friendly HR arrangements is key to the organization's supportive work-home culture. This suggests that a certain level of 'system strength' (Bowen & Ostroff, 2004 p. 204) – in other words, proper interaction between HR practices and organizational culture – is necessary to achieve desirable HR outcomes, such as maintaining women physicians' working hours. The eighth set of hypotheses deals with the interaction effects of supportive work-home cultures on the relationship between the family-friendly arrangements offered and used, and career motivation and investment among women physicians. For the sake of clarity and brevity, I will here formulate two sets of research questions that combine the more specified hypotheses presented in Chapters 5 and 6 of this dissertation.

Q8a: Does a supportive work-home culture in terms of career support strengthen the positive effects of Full Participation Arrangements on women physicians' contracted working hours; and does it also temper the negative effects that the use of Reduced Participation Arrangements have on women physicians' contracted working hours?

Q8b: Does a supportive work-home culture in terms of support for work-life balance and absence of career hindrance strengthen the negative effects of the use of Reduced Participation Arrangements on the number of women physicians' contracted working hours; and does it also temper the positive effects that the use of Full Participation Arrangements have on the number of women physicians' contracted working hours?
By offering family-friendly HR arrangements, organizations try to challenge societal norms and beliefs concerning what a good mother and a good physician is expected to do. Regardless of the direct effects of these arrangements on career motivation, the question for organizations is whether the effects of women physicians' frames on career motivation can be countered. Changing environmental circumstances can alter the salience of roles and frames, resulting in different behaviour (Lindenberg & Frey, 1993; Stryker & Burke, 2000). The final set of research questions therefore concerns the interaction effects of the family-friendly HR arrangements offered on the relationship between frames and women physicians' career motivation. I not only expect different interaction effects of family-friendly HR arrangements on the relationship between frames and career motivation; I also expect them to be adverse to some extent. For instance, for a woman physician with a care frame, offering family-friendly arrangements - such as the possibility of working part-time or 'mother-contracts' - will prevent her from abandoning her career goals completely, and encourage her to combine her career with caretaking responsibilities. However, for a woman physician with a career frame or switching frames, these arrangements may have a different effect. In this example, this particular woman believes she has to live up to the ideal physician norm - which, as I hypothesize, correlates with higher levels of career motivation. For her, signals from the organization which emphasize her role as a mother outside the organization may distract and undermine her initial career motivation. This leads us to the following research questions (which are presented in a condensed form here, again – more detailed hypotheses can be found in Chapter 6) relating to the interaction effects of family-friendly HR arrangements on the relationship between women physicians’ frames and their career motivation:

Q9a: Do Ideal Mother Arrangements temper the negative effect of a care frame on women physicians' career motivation (career centrality, career insight and career ambition) and, do they also temper the positive effect of a career frame and switching frames on career motivation?

Q9b: Do Ideal Worker Arrangements strengthen the positive effect that a career frame and switching frames have on women physicians' career motivation (career centrality, career insight and career ambition) and, do they also strengthen the negative effect of a care frame on career motivation?

Q9c: Do Revising Work Culture Arrangements strengthen the positive effects of a career frame and switching frames on women physicians' career motivation (career centrality, career insight and career ambition) and do they also temper the negative effect of a care frame on career motivation?
However, as stated above, the effectiveness of family-friendly HR arrangements, including those designed to improve women physicians’ upward mobility, is the subject of some debate. Some researchers argue that the reason for the mixed track record of these arrangements can be ascribed to the organizational culture and the associated traditional career paths that do not change (e.g., Lewis, 2001). This may result in unfavourable career consequences for women with caring responsibilities and may even reinforce deeply rooted stereotypes about women’s commitment to their careers (Benschop, 2006). These gendered stereotypes are intertwined in the way men and women physicians talk about all the issues described so far. From a Foucauldian perspective, one could say that issues such as the need for work-life balance or the need to increase career motivation via upward mobility programmes illustrate resisting discourses relative to the normalized and dominant discourse (Thomas & Davies, 2005) of the ‘ideal’ physician norm. Resistance is understood here as an integral part of the exercise of power which can assume many forms and is a constant process of the adaptation, subversion and reinscription of dominant discourses (Karreman & Alvesson, 2009; Thomas & Davies, 2005). Both the dominant discourse of the ideal physician, as well as the resisting discourses, can positively affect women physicians’ career advancement, but they can also reproduce gender inequality in senior medical positions. As well as investigating to what extent individual (e.g., frames, having children) and organizational aspects (e.g., family-friendly HR arrangements, supportive work-home cultures) affect career motivation and investment among women physicians, I therefore also believe it is also important to investigate and reveal how the discourses in which all these aspects are embedded influence women physicians’ daily working lives. The final set of research questions is therefore:

Q10a: How do gendered assumptions regarding what women academic specialists want and need in order to advance in their career affect not only normalizing discourses, but also resisting and counter resisting discourses?

Q10b: How can gendered normalizing, resisting and counter-resisting discourses result in empowering more than one normalizing discourse?

Q10c: How can these gendered discourses eventually preserve inequality regimes in the medical sector?
1.3. Scientific relevance

This study contributes to several research areas, and each single research question fills a specific literature gap. The separate chapters of this work will explain the scientific relevance of the research questions and hypotheses more thoroughly. For now, I will therefore only present the most salient and important points.

**Individual aspects**

Many studies on the effects of having children and motherhood ideology on women’s careers have focused on their labour market participation, notably in terms of working hours (Himmelweit & Sigala, 2004; Marks & Houston, 2002; Nordenmark, 2002; Van Wel & Knijn, 2006; Vlasblom & Schippers, 2006). Although it is often assumed that working hours reflect highly educated women’s career motivation, several studies have shown that there is far more to career motivation than working hours alone (e.g., Stone, 2007). Moreover, most highly educated women in the Netherlands have a paid job (80%), and over 70% of those work more than twenty eight hours per week (SCP, 2008). For women physicians, average working hours are actually even higher. It seems high time, then, that we shifted attention from labour market participation to the issue of highly educated women’s absence from the more influential senior positions, since it is socially and economically important that women occupy senior positions (EU, 2008). Concentrating on women’s participation in the labour market alone ignores the potential contribution of women to society. With this study, I want to contribute to current literature by initiating further research on women’s labour market participation and investigating the effects of having children and of women’s views on motherhood on their career motivation and investment. Incidentally, this also implies that the effect of having children on men’s career motivation and investment should also gain attention, as their roles as parents tend to change (Kaufman & Uhlenberg, 2000; SCP, 2008).

The second contribution of this study to scientific research investigating the individual aspects of women’s careers is to include women physicians’ personal views on the ideal physician. Hitherto, only qualitative, feminist research areas have included power issues such as the ‘ideal’ worker in their studies on women’s careers (e.g., Acker, 1992, 2006; Benschop & Verloo, 2006). However, qualitative studies do not aim to draw general conclusions and cannot indicate the magnitude in which certain practices affect women’s career motivation and investment relative to other aspects. By combining insights from qualitative gender studies with ‘mainstream’ (often quantitative)
organizational behavioural studies, this study contributes to current research on women's careers by including such hidden 'subtexts' (Benschop & Doorewaard, 1998) in quantitative research. For example, I include not only women physicians' initialization of societal gendered role expectations regarding 'good' mothering; I also include their initialization of other dominant role expectations, which they are exposed to in other (public) domains, such as the 'ideal' physician in health care organizations. In doing so, I not only acknowledge women's often subordinate position in society, I also investigate how this affects their career motivation and investment.

Organizational aspects

Regarding the organizational aspects, the first main contribution of this study lies in the field of strategic human resource management (SHRM) research. This field currently is currently limited by its overrepresentation of traditional HRM practices in their studies and the exclusion of more recent developments such as family-friendly HR arrangements (Boslie, Dietz, & Boon, 2005; Kaarsemaker & Poutsma, 2006). This study contributes to SHRM literature by investigating the effects of family-friendly HR arrangements on career investment by women physicians, such as how many hours they work. In doing so, it tests not only the effectiveness of family-friendly HR arrangements in terms of HR outcomes, but also possible unwanted side-effects of family-friendly HR arrangements - for example, the load they place on HCIs cost-containment strategies is exposed.

A second contribution is that in research on family-friendly arrangements, the studied arrangements are often bundled according to their precise nature (i.e., flexible facilities versus childcare facilities) (e.g., Glass & Estes, 1997) or according to statistical analysis (i.e. principal axing factor analysis) (Perry-Smith & Blum, 2000). However, family-friendly HR arrangements are often offered by organizations on the basis of certain explicit and implicit gendered assumptions. I therefore believe it is important to study whether HR arrangements, including those that aim to promote gender equality, are indeed effective in those terms. Do they succeed in allowing women physicians to maintain longer working hours, thereby increasing their chance of obtaining a senior position? Or do they, as a result of the dominant underlying gendered assumptions, such as that all women physicians with children benefit from a better work-life balance, undermine career motivation and investment - albeit unintentionally - and subsequently, their positions in the organization?

The third contribution of this study is that it addresses the interests of several SHRM researchers who have addressed the importance of including
the perceived working environment of the organization in studies on the effectiveness of HR practices in terms of organizational performance (e.g., Kaarsemaker & Poutsma, 2006; Bowen & Ostroff, 2004). This is specifically investigated through the interaction effects of the supportive work-home culture on the relationship between family-friendly HR arrangements and women physicians’ working hours.

**Individual and organizational aspects**

Particularly in the field of career studies, there is a long history of repeated calls for the interdisciplinary study of careers (Chudzikowski & Mayrhofer, 2010; Khapova & Arthur, 2010). Many researchers studying women’s careers and career advancement tend to limit themselves to one end of the spectrum only, focusing on either individual or organizational aspects, and occasionally on the interaction between individuals and organizational practices. As the scope of a dissertation is ‘only’ restricted by the author’s (and his or her supervisors’) time and energy, I was able to investigate both sides of the spectrum more extensively, combining for example psychological theories and studies of career motivation (e.g., London, 1983) with sociological (Lindenberg & Frey, 1993) and organizational HRM (e.g., Wright, Dunford, & Snell, 2001) ones, while also including a critical perspective by including gender theories on role expectations (Eagly & Steffen, 1984) and theories on discourses and power (Alvesson & Karreman, 2000; Foucault, 1980; Karreman & Alvesson, 2009). This has enabled me to operate from an interdisciplinary perspective, in which both the individual (agency) and the social context (structure) are addressed in the research model, favouring neither of them over the other (Chudzikowski & Mayrhofer, 2010). This, I believe, has resulted in greater understanding not only of how both of these aspects affects (women) physicians’ career motivation and investment, but also of how they interact to affect (women) physicians’ career motivation and investment. For example, hitherto, women’s views of the ‘ideal’ mother were investigated in terms of labour market participation – mainly within the field of sociology. In this study, I not only shift the focus to career motivation, but I also investigate whether and how organizations are able to alter the effect that societal gendered role expectations have on women physicians’ career motivation and investment.
1.4. Societal relevance

Almost every month the Saturday morning newspaper runs a special edition on the labour market participation of Dutch women, the dominant motherhood ideology or gendered inequality in Dutch organizations and politics. It seems fairly certain, then, that this is a research subject that is relevant to society.

Nevertheless, as well as contributing to scientific literature, the purpose of this study is to improve our understanding of which aspects determine the career motivation and investment of women physicians. As the percentage of women entering the medical profession remains high, producing distinct demographic characteristics within the medical professional workforce, this understanding is needed to help policy makers, managers, supervisors and colleagues deal with these changes. For example, this study provides insight into how colleagues and supervisors can adjust the specific nature of their support to women physicians in order to maintain their working hours. Policymakers and HR managers can benefit from this study by gaining more awareness of how gendered assumptions regarding women physicians’ need for career advancement not only influence the effectiveness of their ‘women-friendly’ policies and programmes, but can even perpetuate the very gender inequality in senior medical positions that the policies were meant to tackle.

1.5. Outline of this book

All but one chapter in this volume (Chapter 5) combine both individual and organizational aspects, just as these two aspects converge in participants’ everyday lives. I have not, then, sought to separate the aspects throughout the book. The research model (see Figure 1) will serve as a map throughout the book.

Based on three quantitative datasets, Chapter 2 deals with the first research question, and will provide more understanding of the specific characteristics of men and women physicians and men and women academic specialists. Chapter 3, which is based on men and women academic specialists, discusses the relationships between parenthood and perceptions of the work-home cultures on the one hand, and men and women specialists’ career motivation on the other.

Chapters 4, 5 and 6 are based on data gathered from 1,070 Dutch women physicians. Chapter 4 investigates the (mediating) effects of having children, women physicians’ own views of the ‘ideal’ mother and the supportive
work-home culture on their career motivation. Chapter 5 is the only chapter that deals with organizational aspects alone. It discusses the effects of family-friendly HR arrangements and the supportive work-home culture on strategic HR outcomes, such as women physicians' working hours. Chapter 6 presents four frames that represent the way women physicians deal with conflicting role expectations and a categorization of family-friendly arrangements based on these same gendered role expectations. The chapter also goes into the (interaction) effects that these frames and arrangements have on women physicians' career motivation and investment. Chapter 7 is based on the transcripts of focus groups and small-group interviews that were conducted in a Dutch teaching hospital. It reveals how gender is intertwined in normalizing discourses on the 'ideal' physician, in resisting and counter-resisting discourses, and how this could reproduce gender inequality in medical regimes. Finally, Chapter 8 concludes by reflecting on the findings and by answering the main research questions as formulated in this introduction.

Finally, the research questions as posed in this chapter are formulated as hypotheses in the separate chapters. The supplementary sheet provides as an overview of which research question corresponds with which hypotheses; and in which chapter these research questions and hypotheses are discussed.

Several comments should be made at the outset. First, this dissertation is somewhere between a book – the generally accepted method of writing a dissertation in social sciences – and a bundle of scientific articles – a common format in medical sciences. Chapters 1, 2 and 8 were therefore written in the first person and – thus – reveal more of me as a researcher; Chapters 3 to 7 are based on scientific articles which were submitted to journals in several academic fields, and as such are characterized by a more formal writing style in which the researchers remain unobtrusive. I felt that leaving it this way reflected the multi-disciplinary nature of this field of study at yet another level.

Second, physicians and academic specialists are principally referred to in this book as 'physicians', although one dataset on which three studies in this dissertation are based includes physicians, all kinds of medical specialists including general practitioners and academic specialists. For sake of reading pleasure, I use the word 'physicians', unless I speak specifically of academic specialists (i.e., in Chapters 3 and 7).

Third, the construct of career motivation in this study embraces three dimensions – career centrality, career insight and career ambition. Where effects were found on all three dimensions, I will speak of career motivation. Otherwise, the specific dimensions will be named as such.
Finally, this study focuses specifically on women physicians’ careers. However, in order to gain more insight into gendered practices in the medical field, men physicians were also included in this study. When I refer to ‘physicians’, I mean both men and women physicians; on all other occasions the physicians’ sex is stated.

**Figure 1** Conceptual research model
2

DATA SOURCES, METHODOLOGY AND DESCRIPTIVES

- Feminization CIAs
- Family-friendly HR arrangements
- Perceived Work-home Culture
- Career Investments
  - Working hours
  - PhD degree
  - Work-related Side activities
- Children
- Frames
  - View of the Ideal Mother
  - View of the Ideal Physician
- Career Motivation
2.1. Introduction

This chapter will firstly describe how the data for this study were gathered, and secondly, describe the measurement instruments as used in the quantitative studies. Thirdly, a short overview of the techniques used will be provided in the Methodology section. Finally, descriptives of all the relevant variables included in the three quantitative studies will be presented in the Descriptives section. These descriptives will provide an answer to the first research question:

What are the characteristics of the households women physicians live in (e.g., partners work, children, views on motherhood); how do they perceive the family-friendliness of the organizations in which they work (e.g., the family-friendly arrangements offered, the use of these arrangements, supportive work-home cultures) and what are (women) physicians' career characteristics in terms of their career motivation (career centrality, career insight and career ambition) and career investment (e.g., working hours, PhD degree and work-related ancillary activities)?

2.2. Data sources

The empirical research had four phases and datasets: i) a pilot study among men and women physicians; ii) a national cross-sectional study among women physicians in the Netherlands across all specialties; iii) a cross-sectional case study among men and women academic specialists, and iv) three focus groups and two small-group interviews (qualitative method) among men and women academic specialists working in one teaching hospital in which the cross-sectional case study took place. With the exception of the pilot study, which was mainly used to test the measurement instruments, all other data sets are described in the following chapters. Each phase and the related dataset will be discussed briefly in the following sections.

Dataset 1: Pilot study

Prior to the pilot study, I studied theoretical and empirical literature from various scientific fields, ranging from psychological and managerial disciplines (organizational behaviour, career theory, gender in organizations, HRM studies) to economic and social disciplines (gender studies, labour market issues, culture ideologies, family studies). During this phase, various measurement instruments were collected for potential inclusion in the quantitative part of the present study. Existing questionnaires on career
motivation (London, 1993; Lopes, 2006; Noe, Noe, & Bachhuber, 1990),
motherhood ideology (Hays, 1996; Van Wel & Knijn, 2006) and 'the ideal
physician' (Price et al., 1971) were redesigned, resulting in new instruments
that were suitable for the medical setting. To measure the supportiveness of
the work-home culture, the Work-Home Culture Inventory developed by
Dikkers et al. (2007) was used. After discussing the instruments with various
experts and some of the 107 pilot study respondents, the measurements were
pre-tested in a small empirical study. The results of the pilot study were used
mainly to adjust the instruments and adapt the final questionnaire for the
larger cross-sectional study. However, since a reasonable number of
physicians responded and since a researcher's curiosity often gets the better
of him/her, some of the research questions were tested on this small dataset.
The results were presented in an article that is not included in this

Dataset 2: National cross-sectional study

The target population for this study included women physicians in the age
range of 25 to 50 years working in (teaching and general) hospitals, partnerships
(including general practitioners) and other health care institutions such as
elderly homes, youth health-care centres and insurance companies. According
to NIVEL (Van der Velden, Hingstman, Nienoord-Bure, & Van den Berg, 2001),
the current population of physicians in the Netherlands is approximately
33,500, of which 44% are women. The survey was sent to a representative
sample of the Dutch population of women physicians (physicians and assistant
physicians) – a total of 3,426 women physicians. The physician's year of birth
(in the age range 25-50 years) and specialty (all specialties) were used as criteria
for selecting the physicians from an official database of all the medical
registration commissions in the Netherlands (KNMG), in which all physicians
in the Netherlands are registered.

Respondents were invited by letter to complete the online questionnaire.
To do this, they needed the personal log-in code provided in the letter. After
three months and three reminders by mail and e-mail, 1,070 women
physicians had participated in the research, a response rate of 32%. This
response rate is acceptable, given that the average response rate for web
surveys in the Netherlands is between 25% and 45% (De Leeuw & De Heer,
2001). During the entire research period, a website was available (www.
onderzoekartsencarriere.nl) where participants could find information
concerning this research. The sample was representative of the Dutch
population of women physicians in terms of both age and specialty, when
compared to the latest figures from Van der Velden et al. (2008).
Dataset 3: cross-sectional case study among academic specialists

In the Netherlands, all teaching hospitals are bound by a single Collective Labour Agreement (CLA) and thus fringe benefits do not vary significantly between the academic specialisms. Teaching hospitals in particular suffer from a gender imbalance in senior medical positions. Regarding the specialties and the number of women working in the hospital used in this case study, this teaching hospital can be seen as representative of the eight Dutch teaching hospitals. The hospital has about 9,000 employees – including 520 academic physicians – and educates about 3,000 medical students. The organization is characterized by a low number of women physicians in the medical senior positions (Van Doorne-Huiskes & Van Beek, 2009).

In April 2009, an invitation to participate in this study was sent out by e-mail to all academic specialists in the hospital. Only academic specialists working for this particular hospital were invited (520). Of all the academic specialists in the hospital, 331 (64%) were men and 189 (36%) were women. The email contained a link to an online web survey, where participants had to enter a unique password that was in their email to access the web survey. After three weeks, an automatic reminder was sent to all participants who had not yet responded to the first email. In total, the data collection process took a period of five weeks. The response rate was 51% (264/520) of which 55% were men and 45% were women. In total, the sample was representative of the academic specialists working in the hospital in terms of specialty, respondents’ age and years of work experience. Of the men, 20% were surgeons and the others (80%) were non-surgeons. Of the women, 11% were surgeons and 89% were non-surgeons. After the survey was conducted, a written report was sent to the women's network of the teaching hospital and its Board of Directors.

Dataset 4: focus groups and small-group interviews with academic specialists

After the survey was conducted, all academic specialists in the hospital were invited to participate in one of the focus groups in an email from the chairwoman of the women's network. Participants could enter the focus groups by e-mailing their preferred date and time from a list in the previous email. All participants were given a place in their ‘first preference’ focus group, resulting in two all-women groups; one with only men, and two with men and women mixed. This categorization developed as a natural result of the academic specialists' preferences for dates and times and was not enforced by the researcher. However, it created the ideal setting to investigate how men and women discuss the topics in the survey together and separately.
In first instance, participants did not know who the other participants would be. For a full description of the anonymized characteristics of the participants, see Table 1 in Chapter 7.

The list of subjects for the focus groups and small-group interviews was semi-structured and included issues such as the family-friendliness of the work culture (i.e., support for work-life balance, support for career goals, experiences of career hindrance due to working part-time), the ‘ideal’ physician (i.e., long working hours, academic output, patient care), HR initiatives to address gendered inequality in senior positions (i.e., providing extra grants for promoting women, offering management development courses designed for women, women’s network meetings, diversity training for all heads of departments) and women’s (perceived) career ambition.

On average, each focus group and small-group interview lasted for about ninety minutes. I chaired the focus groups and was assisted by a student or colleague. In the introduction, I specifically expressed the intention of using the focus group technique, which was mainly to observe and register their conversation regarding topics, in which they were allowed to respond to each other, compare or contrast their experiences and ask each other questions. First, the list of subjects for discussion was first introduced briefly, after which I asked the respondents an open question to begin the conversation. If the topics of the discussion drifted off into unrelated topics (e.g. specific medical treatments, financial issues within certain departments), I intervened by either continuing to ask relevant questions regarding previous topics or by introducing a new topic. Also, the results from a survey on these topics were used to initiate a discussion, asking the participants to reflect on the findings. Sometimes, I asked the group what they thought the outcomes were. For example, the results of the survey showed that women academic specialists were just as motivated to succeed in their career as their men counterparts. On one occasion, this information was provided in advance, and participants were asked to reflect on this. However, this appeared to block the development of discussion, maybe because participants then did not share their initial different perceptions. I therefore decided to provide the results at the end of each focus group session. By the end of each focus group, each participant had received a full report on the outcomes of the quantitative study.

In addition to the survey, I studied the strategic plan of the Women Medical Specialists Network of the teaching hospital, together with reports on the Strategic Leadership for Women Course in the organization’s newspaper.
2.3. Measurements

Except for the Ideal Mother Inventory and some control variables, all measurements were used in all questionnaires and therefore included in all datasets.

Actual and contracted working hours

In several studies in this dissertation, ‘actual working hours’ and ‘contracted working hours’ were used as a continuous dependent variable, which – for actual working hours – included working hours in the hospital, plus work at home on research or catching up with e-mails, meetings outside office hours and (extra) training. Respondents were asked not to include commuting time. ‘Contracted working hours’ referred to the number of hours that respondents were, according to their contract, obliged to work for the health care institution.

PhD degree

Whether or not respondents held a PhD degree or whether they were currently conducting PhD research was measured with a dichotomous variable (‘0’ for neither holding nor working on a PhD degree, ‘1’ for holding or working on a PhD degree). We also asked whether respondents were in the process of conducting PhD research.

Performing work-related ancillary activities

The survey also included questions regarding whether respondents were engaged in work-related ancillary activities, such as being a member of a (specialists') commission, a pressure group, an employer's association or labour union, and/or a (patient) foundation. Performing work-related ancillary activities was measured by a dichotomous variable (‘0’ for not performing work-related ancillary activities, ‘1’ for performing work-related ancillary activities).

Career Motivation Inventory

Based on the Career Motivation Theory of London (1983) and the Career Motivation Inventory (London, 1993; Lopes, 2006; Noe, et al., 1990), a three dimensional construct of career motivation was developed, which includes ‘career centrality’, ‘career insight’ and ‘career resilience’. As well as the construct of career motivation, physicians' willingness to obtain higher and top positions was included in the construct of career motivation. The latter items were obtained from the Emancipation Monitor (SCP, 2008). However,
in both the pilot and the larger cross-sectional study, the item scale for career resilience proved unreliable (Cronbach's alpha < .50). The dimension of career resilience was therefore not used in any of the subsequent studies. After conducting factor analyses using the techniques of Oblimin rotation and Principal Axes Factoring in the pilot study, I decided to add more items obtained from the pro-active coping scale (Ouwehand, 2005) in the cross-sectional survey among women physicians. I slightly adjusted the items in order to make them suitable for the medical setting and to measure career-related coping. Eventually, only one item on this pro-active coping scale, which was intended to measure career resilience, apparently loaded well on career insight (see Appendix 1, Table 1, item marked with an asterisk *), whereas the others did not improve the dimension of career resilience. As the items that loaded on three different factors differed slightly from the original dimensions of London's Career Motivation Inventory, the dimensions in the present study were renamed career centrality, career insight and career ambition to reflect the construct that they referred to better. Items were measured on a five-point Likert scale ranging from 1 “totally disagree” to 5 “totally agree”.

**Ideal Mother Inventory**

To construct an inventory that reflected women physicians’ own notions of what constitutes a ‘good’ mother, I studied literature on motherhood ideology and existing scales, for example those used in the Emancipation Monitor (SCP, 2008). As international research has indicated (Marks & Houston, 2002), personal views on work and family roles can conflict with predominant societal or ideological views on motherhood. Items such as “A child can be looked after best by its own parents” reflect a more traditional motherhood ideology. Conceiving of the issue of child care in this way provides a respondent the opportunity to answer it with ‘I disagree’ since she does not agree that this statement is true in general. However, I was not interested in whether the respondent agreed or not with the general belief, but in who she believes is the best caretaker for her child(ren) in her particular family context. The items were therefore reformulated thus: “I believe it is important to share breakfast and dinner together with my children” (as opposed to: “It is important that a mother shares breakfast and dinner together with her children”). The items used for the Ideal Mother Inventory are presented in Appendix 1, Table 2. All items were measured on a five-point Likert scale ranging from 1 “totally disagree” to 5 “totally agree”. Values were reversed for the role model dimension.
Chapter 2

Ideal Physician Inventory

Although much has been written on the 'ideal worker' in qualitative research designs (Acker, 1992; Kelly, Ammons, Chermack, & Moen, 2010; Tienari, Quack, & Theobald, 2002), the notion of the ideal worker, who is always available, willing to work overtime and who organizes his or her home life around work, has – to my knowledge – not been empirically tested in quantitative research. Since the notion of the ideal worker is captured in professionals’ talk, and will thus manifest itself in different wordings for different professions (Meriläinen, Tienari, Thomas, & Davies, 2004), I sought to design statements that reflected the notion of the ideal worker, yet also the specific characteristics of the ideal physician (e.g., always on call) (Price, et al., 1971). In the cross-sectional case study among men and women academic specialists, I administered two sets of items. The first included items such as “I believe I am a good worker when I am willing to work overtime as a matter of routine”. The second was only different in that it used the word ‘physician’ rather than ‘worker’. Factor analyses and reliability tests revealed that the ‘Ideal Physician Inventory’ (see Appendix 1, Table 3) was a more reliable scale. Substantial differences were found in the reliability of scales over different datasets (Cronbach’s alpha of .84 for academic specialists’ dataset versus Cronbach’s alpha of .75 for women physician’s dataset). I therefore chose to conduct factor analyses and reliability-tests for each dataset and I used the most reliable scales. Further research into the reliability of these measurements should also focus on possible gender differences.

Again, the items were measured on a five-point Likert scale ranging from 1 “totally disagree” to 5 “totally agree”.

Perceptions of the supportiveness of the work-home culture

To measure perceptions of the supportiveness of the work-home culture, the eighteen-item Work-Home Culture Scale developed by Dikkers et al. (2007) was used. Factor analysis in the pilot study resulted in different dimensions than were distinguished by Dikkers et al., (2007), probably due to slight changes in the original items. Based on the principle axes factor analysis (PAF, oblimin rotation) in this study, three dimensions of the perceived supportive work-home culture were distinguished (see Table 4, Appendix 1): Career Support (CS) which included items such as ‘I believe my supervisor supports me in achieving my career goals’; Support for Work-Life Balance (SWLB) which included, for example, ‘My colleagues are sympathetic when I have to leave work unexpectedly due to unexpected emergencies at home’; and the Absence of Career Hindrance (ACH), which included items such as
Data sources, Methodology and Descriptives

'In this organization (staff/partnership), MDs are expected to prioritize their work over their private lives'.

All items were measured on a five-point Likert scale, with 1 signifying 'totally disagree' and 5 signifying 'totally agree'. Cases were included in the analysis if they had a valid score on at least three items of each of the dimensions of supportive work-home culture. This excluded a number of general practitioners, who sometimes have no supervisor or (direct) colleagues (solo GPs). Including them after missing value analyses (MVA) – even though it was impossible to have an 'objective' perception of a family-friendly workforce philosophy – severely distorted the results and these respondents were therefore excluded.

Perceptions of the family-friendly arrangements offered and used

Based on either the expected impact on working hours (Chapter 5), or on the implicit, gendered assumptions underlying the arrangements (perceived to be) offered (Chapter 6), I defined several clusters containing comparable family-friendly arrangements. Here, I will discuss each set of clusters separately in order of appearance in this dissertation.

In Chapter 5, these clusters are referred to as Reduced Participation Arrangements (RPAs) and Full Participation Arrangements (FPAs). Each cluster represents an unweighted summated scale. Nine items made up the category 'RPAs'. It was asked whether one or more of the following arrangements was offered (and used) to the knowledge of the respondent: the possibility of working part-time; the possibility of participating in part-time residency; extra arrangements for maternity, care, paternity, and adoption leave over and above the statutory minimum; the possibility of saving up holidays; the possibility of taking sabbatical(s); and the ability to take a part-time management position (job-sharing). The answer categories were 'not offered/don't know' (0) and 'offered' (1); and 'I do not use this arrangement' (0) and 'I currently use this arrangement' (1). For the summated scale of 'FPAs', fifteen items asked whether one or more of the following arrangements were offered (and used): flexible working hours (start and end of working day); teleworking; a say in rostering arrangements; 'mother-contracts' (a form of flexible working hours, working during school hours); onsite child care facilities; assistance with finding child care outside the home; financial support for child care; childcare arrangements at home; leave of absence; having a mentor; having a coach; facilities for breastfeeding; work-life balance courses; special support programmes for women in senior positions, to assist women in attaining these positions, or and women's networks. Correlations were tested between the 'RPAs/FPAs' offered and the
‘RPAs/FPAs’ used. The correlation between both sets of arrangements was not particularly strong (Pearson’s $r = .350$ ($p<0.01$, two-tailed) between ‘RPAs’ offered and used; and $r = .240$ ($p<0.01$, two-tailed) between offered and used ‘FPAs’) and they could thus be treated as two separate variables.

Whether respondents in fact make use of the family-friendly arrangements that are offered was measured by a dichotomous variable (‘0’ for not using any of the offered ‘RPAs and/or FPAs’, ‘1’ for using one or more of the ‘RPAs and/or FPAs’ offered).

In Chapter 6, I created different clusters regarding the family-friendly arrangements offered by health-care organizations (in Chapter 6 these are referred to as ‘Gender Equality Arrangements’). Based on literature on feminist theory (Ely & Meyerson, 2000), I subdivided family-friendly arrangements into three categories. The first category, *Ideal Mother Arrangements*, included offering the following arrangements: job sharing, mothers’ rooms to express milk, ‘mother-contracts’ (the possibility of working during school hours), the possibility of working part-time, part-time training programmes, extra (over and above the statutory minimum) maternity, paternity, adoption and care-leave, and leave-saving possibilities. The variable of Ideal Mother Arrangements was used as a continuous variable, with a minimum of zero arrangements and a maximum of ten arrangements.

The second category, *Ideal Worker Arrangements*, was also a continuous variable, with a minimum of zero and a maximum of eleven arrangements. It contained the provision of the following arrangements: onsite childcare, childcare arrangements in other care facilities, childcare at home (nanny/nurse), financial support for childcare, career break, mentoring, coaching, work-life balance training, tenure/track/moving-up programmes aimed at women, women’s networks and sabbatical leaves.

The third category, the variable *Revising Work Culture Arrangements*, was also constructed as a continuous variable, with a minimum of zero and a maximum of three arrangements. The three arrangements were: flexible start and end times for the working day, the possibility of working from home (teleworking), and having a say in scheduling.

This categorization differs from other research (e.g., Dikkers et al., 2007; Glass & Estes, 1997) in two ways. First, the three categories are distinguished on the basis of whether the organization is considered to be co-responsible for its employees’ work-life balance (Revising Work Culture Arrangements), or whether this is considered to be primarily or solely the responsibility of the individual employee (Ideal Worker/Ideal Mother Arrangements). Secondly, the latter category is divided into *Ideal Worker Arrangements* and *Ideal Mother Arrangements*, depending on which normative ideals were
primarily served. For example, by offering extra arrangements to extend statutory leave arrangements, female doctors are enabled to live up to the motherhood ideology, according to which women with infants stay home for as long as possible.

**Control variables**

Several control variables were used in the different models described in the following chapters. Some variables were used as 'standard' control variables, such as the respondent's actual working hours per week, their years of work experience as a physician, their medical specialty (0=general practitioners; 1=non-surgical specialists; and 2=surgical specialty), their age, whether or not he or she has a partner (1=yes, has a partner) and children (1=yes) and number of children living at home. Years of work experience as a physician were calculated by deducting the year in which they received their medical degree certificate from the year in which the survey was conducted (2008). Periods of maternity or parental leave were not included as factors affecting years of work experience.

**2.4. Methodology**

This dissertation is characterized by a multidisciplinary approach, which seeks to incorporate both the individual context and the social context (Chudzikowski & Mayrhofer, 2010). However, disciplines are often characterized by a dominant methodology – for example, the fields of psychology and economics are dominated by quantitative research methods, while gender studies are dominated by qualitative methods, although other research methods are not excluded in either of these two examples (Eriksson & Kovalainen, 2008). Interdisciplinary research calls for a variety of data collection methods (Khapova & Arthur, 2010), in which the methodology and methods used should be more closely linked to the nature of the questions under investigation in career research (Schein, 2007). I therefore adopted a multi-method research approach, which combined quantitative research techniques and resulted in cross-sectional data with critical discourse analysis, producing transcripts of the academic specialists’ narratives on the topics tested in the cross-sectional data. The latter method enabled me to reveal the dynamic processes that underlie and perpetuate (assumed) effects; the former enabled me to show the effect and the magnitude of these effects. By combining both quantitative and qualitative research techniques, I aimed to combine the best of both epistemological perspectives.
All the quantitative research was conducted with the statistical programme SPSS (14.0) and included descriptive analyses, one-way analysis of variance (T-tests), Pearson correlations, factor analyses (PAF, Oblimin rotated), a multiple mediator model as discussed by Preacher and Hayes (2004), and linear regression analyses.

The qualitative data (focus group transcripts) were analysed primarily using discourse analysis (Fairclough, 1992, 2003), in which the aim is to address the issues of social power by elites, institutions or groups that result in social inequality, including that of gender inequality (Van Dijk, 1995). Eriksson and Kovalainen (2008) distinguish three streams in discourse analysis: Foucauldian discourse theory and analysis; social psychological discourse analysis and Critical Discourse Analysis (CDA). The qualitative study described in Chapter 7 relies on a combination of Foucauldian and Critical Discourse Analysis. The Foucauldian perspective is used in this study to investigate organizational power-knowledge relations, such as the power of the normalizing discourse of the ‘ideal’ physician and how ‘truth’ is created around what women and men academic specialists want and need in their careers. However, the study also includes a critical perspective, inspired by the work of Fairclough (1992, 2003), which stems from analysing real instances of social interaction by combining linguistic analysis and ideological critique (Eriksson & Kovalainen, 2008). According to this critical perspective, social life is perceived as being constrained by social structures, but also as an active process that produces change (Eriksson & Kovalainen, 2008; Fairclough, 2003).

2.5. Descriptive results

Each individual chapter will provide more detailed descriptives regarding the variables that were used in that particular research model and will therefore provide more detailed information. However, descriptives will now be provided for all relevant variables included in the various chapters and for each quantitative dataset. This will not only reveal some of the career and household characteristics of the physicians, and the (perceived) characteristics of the organizations in which they work, it will also show how these three datasets mutually differ in certain respects. For the sake of brevity, I will only elaborate on the most striking results.
Household and individual characteristics

As Table I shows, respondents in Dataset 3 were older (mean = 46) than those in datasets 1 (mean = 37) and 2 (mean = 36.8). Although I do not want to speculate on possible relationships between variables based on the descriptives, this age difference probably explains some obvious differences between the household characteristics of respondents in dataset 3 and the other respondents.

A large majority of the physicians and academic specialists, in all datasets, have a partner (> 89.2%), many of them also working as physicians (>22.1%), although most have a partner who works in a sector other than health care (>39.4%). Regarding the contracted working hours of partners, the most remarkable result was that the overwhelming majority of men physicians (85.7% in Dataset 1) and academic specialists (80% in Dataset 3) have a partner that works part-time (< 36 hours per week) or is not employed at all; the majority of women physicians and academic specialists, by contrast, have a partner who works 36 hours or more (68.1% in Dataset 1; 68.1% in Dataset 2; 57.9% in Dataset 3). Nevertheless, a fair number of women physicians and women academic specialists in all three datasets have a partner who works part-time or who is not employed at all. The total percentages of women physicians’ partners who work part-time or who are unemployed were 31.9%, 42.2% and 41.9% respectively for the three datasets. These percentages are remarkable, considering that only 10% of the Dutch men work part-time (SCP, 2008). The outcomes of this study suggest that women physicians, with their demanding careers, are more likely to have created a household which resembles a ‘reversed’ breadwinner model or a reversed ‘one-and-a-half’ earners model than other highly educated Dutch women (SCP, 2008).

The majority of physicians and academic specialists, both men and women, have children (all Datasets). On average, 9.7% (Dataset 1) and 8.8% (Dataset 2) of the women questioned in the studies were pregnant when the research was conducted, and most physicians and academic specialists had two children living at home. Regarding the age of the youngest child, the majority of the men and women physicians/academic specialists in all the studies had children under 12 years old living at home (86.5% in Dataset 1; 89.5% in Dataset 2; 60.1% in Dataset 3). The most common childcare facility used by respondents in Dataset 2 and 3 were official day care centres (38.9% and 26.9%, respectively). Family or relatives also provided the necessary voluntary assistance. Only women physicians were questioned regarding their views of the ‘ideal’ mother with averages scores of 3.44 and 3.17 respectively.
Chapter 2

Perceived organizational characteristics

The following section discusses which health care organizations respondents worked in, and which family-friendly arrangements they used when the research was conducted. Furthermore, their perceptions of the family-friendly arrangements offered by the organizations and the perceived supportiveness of the work-home cultures are also discussed. To prevent misinterpretation, the percentages shown in Table II do not represent the percentages of health care institutions that offer a particular arrangement or fringe benefit. The percentages represent the relative number of respondents who stated that their organization offered such an arrangement.

As can be seen in Table II, most respondents in Dataset 1 worked in a teaching hospital (64.5%); whereas in Dataset 2, 26.4% of the women physicians worked in a family practitioners’ office.

Regarding part-time arrangements, the vast majority of men and women physicians/academic specialists in all datasets believed that it was possible to have a part-time contract (>76.2%) or a part-time residency (>63.8%). Part-time working seems to be the most common family-friendly arrangement offered to physicians and academic specialists. Women physicians are more likely to work part-time (average of 58%) or have a part-time residency (average of 19.7%) than not.

When looking at flexible arrangements, the majority of physicians and academic specialists believe it is possible to have a say in rostering (> 63%), although more men than women physicians perceive this as a possible. Academic specialists (Dataset 3) believe that flexible working hours are offered less often than other physicians (Dataset 1 and 2). Moreover, more men (23.8%) than women (14.4%) academic specialists believe that they have the possibility of working flexible working hours. Since flexible working hours are often agreed informally between supervisor and employee, the difference of 9.4% between the perceptions of women and men academic specialists is remarkable. Nevertheless, only 10% of the women and men academic specialists make use of this arrangement. The difference between the perceptions of men and women academic specialists regarding the possibility of working from home (teleworking), again an arrangement that is often informally agreed upon, was even bigger (17.5%). Also, more men (14.2%) than women (10.3%) academic specialists reported working from home, even though fulltime and fulltime-plus men academic specialists do not work more overtime, which could have explained a difference in working from home. Job sharing in higher positions and 'mother-contracts' were not perceived to be offered (<9.1%), nor used (<2.9%) very frequently.
### Table 1  Household characteristics of respondents in Datasets 1, 2 and 3

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<td>(N=35)</td>
<td>(N=107)</td>
<td>(N=119)</td>
<td>(N=145)</td>
<td>(N=264)</td>
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<td><strong>Average age respondents (SD)</strong></td>
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<td>36.1(6.67)</td>
<td>37(8.24)</td>
<td>36.8(6.55)</td>
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<td><strong>Partner (yes)</strong></td>
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<td>97.1%</td>
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</tr>
<tr>
<td>Unemployed</td>
<td>5.7%</td>
<td>11.8%</td>
<td>7.7%</td>
<td>3.6%</td>
<td>8.1%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Physician</td>
<td>22.9%</td>
<td>29.4%</td>
<td>25.0%</td>
<td>22.1%</td>
<td>31.5%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Working in health care sector</td>
<td>7.1%</td>
<td>20.6%</td>
<td>11.5%</td>
<td>6.9%</td>
<td>9.9%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Working in other sector</td>
<td>64.3%</td>
<td>38.2%</td>
<td>55.8%</td>
<td>67.4%</td>
<td>50.5%</td>
<td>30.4%</td>
</tr>
<tr>
<td><strong>Working hours partner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working &gt; 40 hours per week</td>
<td>43.1%</td>
<td>11.4%</td>
<td>32.7%</td>
<td>34.4%</td>
<td>40.3%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Working between 36 - 40 hours p.w.</td>
<td>25.0%</td>
<td>2.9%</td>
<td>17.8%</td>
<td>23.5%</td>
<td>17.6%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Working between 28 - 36 hours p.w.</td>
<td>18.1%</td>
<td>34.3%</td>
<td>23.4%</td>
<td>22.9%</td>
<td>21.8%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Working less than 28 hours p.w.</td>
<td>6.9%</td>
<td>40.0%</td>
<td>17.8%</td>
<td>6.2%</td>
<td>9.2%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Partner is unemployed</td>
<td>6.9%</td>
<td>11.4%</td>
<td>8.4%</td>
<td>13.1%</td>
<td>10.9%</td>
<td>15.2%</td>
</tr>
<tr>
<td><strong>Children (% having children)</strong></td>
<td>75.0%</td>
<td>80.0%</td>
<td>76.6%</td>
<td>62.1%</td>
<td>84.0%</td>
<td>89.7%</td>
</tr>
<tr>
<td><strong>Pregnant (at time of survey)</strong></td>
<td>9.7%</td>
<td>none</td>
<td>9.7%</td>
<td>8.8%</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Number of children living at home**</td>
<td>0 (no children)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>&gt; 4</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>11.1%</td>
<td>none</td>
<td>7.3%</td>
<td>1.7%</td>
<td>5.0%</td>
<td>26.4%</td>
</tr>
<tr>
<td>1</td>
<td>29.6%</td>
<td>28.6%</td>
<td>29.3%</td>
<td>28.5%</td>
<td>21.0%</td>
<td>12.8%</td>
</tr>
<tr>
<td>2</td>
<td>40.7%</td>
<td>32.1%</td>
<td>37.8%</td>
<td>42.7%</td>
<td>47.0%</td>
<td>37.6%</td>
</tr>
<tr>
<td>3</td>
<td>18.5%</td>
<td>35.7%</td>
<td>24.4%</td>
<td>22.8%</td>
<td>23.0%</td>
<td>16.8%</td>
</tr>
<tr>
<td>4</td>
<td>none</td>
<td>3.6%</td>
<td>1.2%</td>
<td>3.8%</td>
<td>4.0%</td>
<td>5.6%</td>
</tr>
<tr>
<td>&gt; 4</td>
<td>none</td>
<td>none</td>
<td>none</td>
<td>0.5%</td>
<td>none</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age of the youngest child*</th>
<th>&lt; 4 years old (pre-schooler)</th>
<th>Between 4 - 12 years old (elementary school)</th>
<th>Between 13 - 18 years old (high school)</th>
<th>Older than 18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>56.6%</td>
<td>26.4%</td>
<td>5.7%</td>
<td>11.3%</td>
</tr>
<tr>
<td></td>
<td>85.7%</td>
<td>26.4%</td>
<td>3.6%</td>
<td>3.6%</td>
</tr>
<tr>
<td></td>
<td>66.7%</td>
<td>7.1%</td>
<td>4.9%</td>
<td>8.6%</td>
</tr>
<tr>
<td></td>
<td>47.3%</td>
<td>19.8%</td>
<td>9.6%</td>
<td>0.9%</td>
</tr>
<tr>
<td></td>
<td>32.3%</td>
<td>42.2%</td>
<td>12.1%</td>
<td>8.1%</td>
</tr>
<tr>
<td></td>
<td>17.1%</td>
<td>47.5%</td>
<td>24.0%</td>
<td>31.0%</td>
</tr>
<tr>
<td></td>
<td>23.7%</td>
<td>27.9%</td>
<td>18.9%</td>
<td>21.1%</td>
</tr>
</tbody>
</table>

| Use of child care facilities***    | Official day-care centre     | n.a.                                        | n.a.                                     | 38.9%               |
|                                   | Family or relatives          | n.a.                                        | n.a.                                     | 24.3%               |
|                                   | Host parent                  | n.a.                                        | n.a.                                     | 16.7%               |
|                                   | Friends, neighbours, babysitters | n.a.                                      | n.a.                                     | 9.1%                |
|                                   | Other ^                      | n.a.                                        | n.a.                                     | 5.7%                |

| Ideal Mother Inventory (time allocation) (mean and (SD))**** | 3.44 ( .61) | n.a. | n.a. | 3.17 ( .58) |

* of those with a partner; ** of those with children; *** respondents could tick more than one box, therefore the percentages do not add up to 100; **** Scores on a 5-point Likert scale. n.a. refers ‘not asked in survey/data not available’. ^ In dataset 3, the answering category ‘babysitter’ was listed as ‘other’.
Table II  Organizational characteristics, in part as perceived by the respondents in Datasets 1, 2 and 3

<table>
<thead>
<tr>
<th>Type of organization</th>
<th>Dataset 1</th>
<th>Dataset 2</th>
<th>Dataset 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family practitioners office</td>
<td>26.4%</td>
<td>14.3%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Teaching hospital</td>
<td>59.7%</td>
<td>74.3%</td>
<td>64.5%</td>
</tr>
<tr>
<td>General hospital</td>
<td>6.9%</td>
<td>11.4%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Elderly home</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Area Health Authority (GG&amp;GD)</td>
<td>1.4%</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Governmental benefit institute (UWV/Health&amp;Safety Executives)</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Specialist hospital (e.g. MS Centre, children's hospital)</td>
<td>4.2%</td>
<td>none</td>
<td>2.8%</td>
</tr>
<tr>
<td>Independent Treatment Centre (ZBC)</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Private clinic</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Other (e.g., military, free-lance, youth welfare work)</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
</tbody>
</table>

(Perceived) Offered and use of part-time arrangements* 

<table>
<thead>
<tr>
<th></th>
<th>Dataset 1</th>
<th>Dataset 2</th>
<th>Dataset 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part-time working</td>
<td>91.7 (61.1)</td>
<td>76.5 (23.5)</td>
<td>86.8 (49.1)</td>
</tr>
<tr>
<td>Part-time residency</td>
<td>72.5 (36.2)</td>
<td>81.8 (24.2)</td>
<td>75.5 (32.4)</td>
</tr>
</tbody>
</table>

(Perceived) Offered and use of flexible arrangements* 

<table>
<thead>
<tr>
<th></th>
<th>Dataset 1</th>
<th>Dataset 2</th>
<th>Dataset 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible hours</td>
<td>27.5 (21.7)</td>
<td>21.9 (12.5)</td>
<td>25.7 (18.8)</td>
</tr>
<tr>
<td>Teleworking (working from home)</td>
<td>26.1 (18.8)</td>
<td>6.5 (3.2)</td>
<td>20 (14)</td>
</tr>
<tr>
<td>Say in scheduling</td>
<td>60 (37.1)</td>
<td>69.7 (33.3)</td>
<td>63.1 (35.9)</td>
</tr>
<tr>
<td>Job sharing in more senior positions</td>
<td>13.2 (2.9)</td>
<td>0 (0)</td>
<td>9.1 (2)</td>
</tr>
<tr>
<td>Mother contracts' (working hours attuned to school hours)</td>
<td>2.9% (0)</td>
<td>3.1 (0)</td>
<td>3 (0)</td>
</tr>
</tbody>
</table>
## (perceived) Offered and use of childcare arrangements*

<table>
<thead>
<tr>
<th>Childcare Arrangement</th>
<th>Mean (SD) Offered</th>
<th>Mean (SD) Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onsite child care facility</td>
<td>23.2 (5.8)</td>
<td>21.3 (3)</td>
</tr>
<tr>
<td>Childcare arrangements (reserved spots in local facilities)</td>
<td>n.a.</td>
<td>n.a.</td>
</tr>
<tr>
<td>Childcare arrangements at home</td>
<td>9.1 (0)</td>
<td>7.1 (1.9)</td>
</tr>
<tr>
<td>Financial assistance for child care</td>
<td>35.2 (12.7)</td>
<td>28.9 (2.3)</td>
</tr>
<tr>
<td>Nursery room/room for breastfeeding</td>
<td>67.1 (11.4)</td>
<td>41.5 (0.4)</td>
</tr>
</tbody>
</table>

## (Perceived) extra leave arrangements offered and used *

<table>
<thead>
<tr>
<th>Extra leave Type</th>
<th>Mean (SD) Offered</th>
<th>Mean (SD) Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra maternity leave</td>
<td>4.2 (1.4)</td>
<td>4.1 (0)</td>
</tr>
<tr>
<td>Extra parental leave</td>
<td>4.2 (0)</td>
<td>4.1 (0)</td>
</tr>
<tr>
<td>Extra paternity leave</td>
<td>2.8 (0)</td>
<td>1.7 (0)</td>
</tr>
<tr>
<td>Adoption leave</td>
<td>1.4 (0)</td>
<td>0.9 (0)</td>
</tr>
<tr>
<td>Care leave</td>
<td>38 (2.8)</td>
<td>32.5 (0.7)</td>
</tr>
<tr>
<td>Possibility of saving up leave days</td>
<td>27.5 (5.8)</td>
<td>24.1 (0.4)</td>
</tr>
</tbody>
</table>

## (Perceived) career arrangements offered and used *

<table>
<thead>
<tr>
<th>Career Arrangement</th>
<th>Mean (SD) Offered</th>
<th>Mean (SD) Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career interruption</td>
<td>31.4 (1.4)</td>
<td>29.4 (0)</td>
</tr>
<tr>
<td>Sabbatical</td>
<td>22.9 (0)</td>
<td>20.2 (0)</td>
</tr>
<tr>
<td>Mentor</td>
<td>32.4 (5.6)</td>
<td>29.9 (7.9)</td>
</tr>
<tr>
<td>Coach</td>
<td>15.3 (2.8)</td>
<td>16.9 (1.9)</td>
</tr>
<tr>
<td>Work-life balance training</td>
<td>19.4 (1.4)</td>
<td>22.2 (3.3)</td>
</tr>
<tr>
<td>Women Moving Up programmes</td>
<td>n.a.</td>
<td>7.6 (0)</td>
</tr>
<tr>
<td>Women's networks</td>
<td>15.5 (2.8)</td>
<td>9.8 (1.8)</td>
</tr>
</tbody>
</table>

## Perceived supportiveness of work-home culture**

### Mean and (SD)

<table>
<thead>
<tr>
<th>Type</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career support</td>
<td>3.74 (.62)</td>
</tr>
<tr>
<td>Support for work-life balance</td>
<td>3.41 (.71)</td>
</tr>
<tr>
<td>Absence of career hindrance</td>
<td>2.88 (.69)</td>
</tr>
</tbody>
</table>

*percentages of respondents that state arrangement is offered/percentages of respondents that use the offered arrangement, n.a. refers ‘not asked in survey/data not available’.

**Scores on a 5-point Likert scale.
Regarding childcare arrangements, almost half the respondents in all datasets believed that it was possible to find a room to breastfeed if necessary (>41.5%). Only 33.8% of the academic specialists in dataset 3 were aware of the onsite childcare facility that was available to them. According to a fair number of respondents (>18%), their organization offers financial aid to arrange some kind of child care elsewhere. The average percentage of respondents in all datasets that actually reported using childcare arrangements was relatively low (28.1% in Dataset 1; 20.8% in Dataset 2; 13.3% in Dataset 3), considering the large number of physicians and academic specialists with young children.

According to the perceptions of the respondents in all datasets, leave-arrangements - over and above the statutory minimum - are not frequently offered (<1.9%), except for care leave (average of 1.8%) and the possibility to save up leave days (average of 7.1%). Again, the number of respondents that actually use these types of arrangements was relatively low. The last category of family-friendly arrangements are career arrangements. As Table III shows, the most popular career arrangements - or those perceived to be most popular - are the possibility of a sabbatical (average of 21.6%), a mentor (average of 29.8%) or a coach (average of 20.3%). Men and women physicians and men and women academic specialists do not seem to differ in the extent to which they take up the offer of a mentor or a coach. Compared to, for example, the use of part-time arrangements, the percentage of respondents that reported making use of (one of the) career arrangements was much lower (12.7% for Dataset 1; 16.3% for Dataset 2 and 28.4% for Dataset 3). The low take-up rate for work-life balance training programmes can be explained by the fact that the respondents were only asked if they were currently making use of these facilities.

Perceived supportiveness of the work-home culture

Regarding the perceived supportiveness of the work-home culture in health care organizations, two aspects merit particular attention. First, in all datasets there seems to be a discrepancy between on the one hand the perceived support for career goals (career support) (mean=3.80 in Dataset 1; 3.71 in Dataset 2; and 3.62 in Dataset 3) and support for work-life balance (mean=3.44 in Dataset 1; 3.62 in Dataset 2; and 3.71 in Dataset 3), about which respondents are fairly positive; and on the other hand the perceived presence or fear of career hindrance (mean=2.91 in Dataset 1; 2.96 in Dataset 2; and 2.56 in Dataset 3) once family-friendly arrangements such as working

1 As I am familiar with the particular teaching hospital in which respondents from Dataset 3 worked, I confirmed whether onsite childcare was (theoretically) available.
part-time are actually taken up. Den Dulk and Peper (2006) define these mixed signals as 'contradictory work-home cultures' in their research, meaning that although employees feel supported in achieving a work-life balance, they also admit to feeling that the organization prefers full-time workers, providing them with more career support and opportunities for advancement than part-timers.

The second remarkable aspect is that women physicians in both Datasets 1 and 3 perceive the work-home culture as less supportive than their men counterparts. This difference in the perceived supportiveness of the work-home culture could be due to the fact that women physicians more often work part-time, thereby encountering more resistance, than those who have not (yet) had to confront their supervisors with their preferences.

Physicians' career characteristics

Table III describes the career characteristics of both men and women physicians included in all three datasets compiled during this study.

Regarding physicians' specialties, all three datasets show that a minority of the women are surgical specialists (25%; 6.9%; 10.9%). This outcome is not surprising and confirms the findings of several other studies (e.g., Van der Velden et al., 2008). Regarding the number of general practitioners, the percentage in Dataset 2, in particular, show that specialties such as family practitioner are feminizing, although the percentage of 56 includes residents. Regarding contracted working hours, all three datasets show the salient difference in working hours between men and women physicians and men and women academic specialists. Whereas in Datasets 1 and 3 the 'fulltime-plus' variant of contracted working hours is the dominant type of contract for men physicians/academic specialists (>60%), for women physicians/academic specialists the most common number of contracted hours is between 28 and 36 hours (31.9%; 38.5%; 51.3%) per week. However, regardless of the type of contract, a high number of both men and women physicians and men and women academic specialists in all datasets work long hours (between 6 and 16.3 extra hours per week). Academic specialists seem to work more overtime than the respondents in other datasets, with an average minimum of 14 hours per week. Although Dataset 2, containing only women physicians and (academic) specialists, shows a small decline in the number of extra hours as the number of contracted hours decline; this cannot be said for the other datasets. T-tests showed that men and women physicians/academic specialists who work part-time (Dataset 1 and 3) do not differ in the number of hours they work overtime compared to those working fulltime (p=.509 two-tailed in Dataset 1; p=.971 two-tailed in Dataset 3).
Table III  Career characteristics of respondents in Datasets 1, 2 and 3

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Dataset 1</th>
<th>Dataset 2</th>
<th>Dataset 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioners (e.g., family practitioner, health centre clinician, nursing home GP)</td>
<td>36.1%</td>
<td>17.1%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Non-surgical specialists (e.g., cardiology, internist, paediatrician)</td>
<td>38.9%</td>
<td>42.9%</td>
<td>40.2%</td>
</tr>
<tr>
<td>Surgeons (e.g., gynaecologist, surgeon, orthopaedist)</td>
<td>25.0%</td>
<td>40.0%</td>
<td>29.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Career progress</th>
<th>Dataset 1</th>
<th>Dataset 2</th>
<th>Dataset 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians not in training (ANIO)</td>
<td>2.8%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Residents (AIO)</td>
<td>53.5%</td>
<td>79.4%</td>
<td>61.9%</td>
</tr>
<tr>
<td>(Academic) specialists</td>
<td>43.7%</td>
<td>17.6%</td>
<td>35.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contracted working hours and average number of extra hours per week (overtime)</th>
<th>Dataset 1</th>
<th>Dataset 2</th>
<th>Dataset 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 40 hours per week</td>
<td>25% (6.9)</td>
<td>60% (8.4)</td>
<td>36.4% (7.7)</td>
</tr>
<tr>
<td>Between 37 and 40 hours per week</td>
<td>23.6% (8.2)</td>
<td>14.3% (10.6)</td>
<td>20.6% (8.7)</td>
</tr>
<tr>
<td>Between 28 and 36 hours per week</td>
<td>31.9% (8.6)</td>
<td>17.3% (7.3)</td>
<td>27.1% (8.3)</td>
</tr>
<tr>
<td>28 hours per week or less</td>
<td>18.1% (8.3)</td>
<td>none</td>
<td>12.1% (8.3)</td>
</tr>
<tr>
<td>No contract</td>
<td>1.4% / none</td>
<td>8.4% / none</td>
<td>3.7% / none</td>
</tr>
<tr>
<td>Satisfaction with number of contracted working hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>Would prefer to work more hours</td>
<td>6.9%</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Satisfied with current number of hours</td>
<td>72.2%</td>
<td>71.4%</td>
<td></td>
</tr>
<tr>
<td>Would prefer to work less hours</td>
<td>20.8%</td>
<td>28.6%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Terms of employment</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaried employment</td>
<td>90.3%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Partner in partnership/small business</td>
<td>9.7%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Locum</td>
<td>none</td>
<td>none</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Career motivation (mean (SD))*</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Career centrality</td>
<td>3.68 (.51)</td>
<td>3.73 (.43)</td>
</tr>
<tr>
<td>Career insight</td>
<td>3.50 (.46)</td>
<td>3.62 (.44)</td>
</tr>
<tr>
<td>Career ambition</td>
<td>3.08 (.72)</td>
<td>3.26 (.59)</td>
</tr>
</tbody>
</table>

| PhD degree (yes)                                    | 11.1% | 34.3% |
| Currently conducting PhD research                   | 34.4% | 36.4% |

<table>
<thead>
<tr>
<th>Work-related ancillary activities (e.g. commission, patients' association) (yes)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>40.3%</td>
<td>45.7%</td>
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</table>

<table>
<thead>
<tr>
<th>Ideal Physician Inventory (view of the ‘ideal’ physician) (mean/SD) *</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.97 (.52)</td>
<td>2.92 (.42)</td>
</tr>
</tbody>
</table>

* Scores on a 5-point Likert scale.
Regarding satisfaction with working hours, a clear majority of physicians and academic specialists throughout all datasets state that they are satisfied with their current number of contracted working hours (>72%). It was striking that more men than women physicians/academic specialists reported wanting to work less hours, both in Dataset 1 (28.6% of the men versus 20.8% of the women physicians) and Dataset 3 (15.9% of the men versus 14.3% of the women academic specialists). Similarly, more women than men physicians/academic specialists wanted to work more contracted hours than their current number of hours (0% of the men versus 6.9% of the women physicians in Dataset 1; 2.8% of the men versus 9.2% of the women academic specialists in Dataset 3).

Regarding terms of employment, the majority of the respondents that were included in all studies were employed by a health care institution (average of 90.7%).

As for career motivation, the three datasets show different means. In Dataset 1, scarcely a majority of the respondents are residents. Overall, career has a central position in the lives of all respondents in Dataset 1 (mean = 3.70). Respondents in Dataset 1 develop strategies to obtain career goals (mean = 3.54), yet they are fairly cautious in their expectations of achieving senior positions (career ambition) (mean = 3.14). For women physicians in the second dataset, career is a less central aspect in life (mean=2.85); they plan their career and think about which goals they hope to achieve (mean = 3.49), but they are moderately ambitious (mean = 3.12). What is striking in the third dataset, which included only academic specialists, is that men and women are very ambitious when it comes to obtaining a higher or senior position (mean = 4.31) in comparison to the respondents in the other datasets.

Evidently, academic specialists by far have the highest percentage of PhD degrees (58.7%), and men academic specialist are more likely to hold one than women academic specialists.

Despite their long working hours in the teaching hospital, academic specialists are more likely to be engaged in work-related ancillary activities (81.4%) than the respondents in the other datasets (42.1% in Dataset 1; 44.7% in Dataset 2).

On the questions regarding men and women physicians' views of the 'ideal' physician, respondents in all datasets disagreed somewhat with the traditional ideal of the ideal physician who is always available (mean = 2.96 in Dataset 1; 2.92 in Dataset 2; and 2.87 in Dataset 3). Women academic specialists seemed to have the most trouble with identifying with this 'ideal' notion of physicians (mean = 2.79).
2.6. Conclusion

With respect to household characteristics, the most striking finding was that women physicians and academic specialists seemed to be heading toward a reversed breadwinner model, in which they work more hours while their partners work part-time. Women physicians and women (academic) specialists are more likely to have a partner who works part-time than other highly qualified Dutch women. One could say that although women physicians and (academic) specialists face a rigid work-home culture in which the normalizing discourse of the 'ideal' physician still dominates and in which the position of women physicians is perhaps marginalized, a more emancipated division of labour does seem to be emerging in the homes of these women physicians and (academic) specialists.

Other studies have already revealed that women physicians and academic specialists are more likely to work part-time (e.g., Heiligers & Hingstman, 2000). However, the results as presented in this Chapter concerning especially women physicians' and academic specialists' household characteristics provide a better understanding of how these women organize their households in order to meet the demands of their professional lives. The majority of the respondents in all three datasets had children under the age of 12, still attending kindergarten and/or elementary school. Although official child care centres were the most common form of child care facility used by physicians and academic specialists, a substantial number of respondents also depended on voluntary assistance from family and relatives.

Regarding the perceived organizational characteristics, physicians and academic specialists perceived their organizations as family-friendly in terms of the possibility of working part-time, having a part-time residency, having a say in scheduling and having the opportunity to take care leave for a sick child or relative. According to the respondents, the other type of arrangements – flexible arrangements, childcare arrangements, extra leave arrangements and career arrangements – were less widespread. With the exception of part-time working arrangements, their uptake was relatively low. This may have been magnified by the randomized indication that asked which facilities respondents were using at that point in time. However, arrangements that were more continuous, such as the use of onsite child care facilities or financial aid for childcare arrangements, were not frequently used either.

Turning to the perceptions of the supportiveness of the work-home cultures, women physicians and academic specialists perceived the work-home
cultures in their organizations as less supportive than their male colleagues. With regard to the absence of career hindrance in particular, the results showed that both men and women physicians and academic specialists still expect to encounter career barriers if they begin working part-time. These findings provide more insight into the way health care institutions are perceived to be changing their HR policies as far as family-friendliness is concerned.

The most striking finding concerning the career characteristics of men and women physicians and men and women academic specialists was the substantial variation in the number of contracted working hours between men and women physicians and between men and women academic specialists. Women physicians and academic specialists work fewer contracted hours than men physicians and academic specialists. Most women physicians and women academic specialists work part-time (fewer than 36 contracted hours per week), and almost 20% work full-time (40 hours per week or more). However, women physicians and women academic specialists in part-time jobs still work a substantial number of overtime hours per week. Another interesting finding was that most men and women physicians and men and women academic specialists are satisfied with their current number of contracted working hours. However, women physicians and academic specialists in particular would like to work more contracted hours, whereas especially men physicians and academic specialists seem to want to work fewer hours.

Looking at levels of career motivation, women physicians did not score very high on career centrality, even though they work in a very demanding profession. Men and women academic specialists scored lower on career insight, which may be accounted for by the relatively rigid and clear career paths in medicine, especially in teaching hospitals. Nevertheless, compared to other physicians, men and women academic specialists were by far the most ambitious to obtain a more senior position in their field.

In terms of career investment, obviously academic specialists were more likely to have a PhD degree and perform work-related ancillary activities. Furthermore, more men than women physicians and academic specialists had a PhD degree.

Regarding physicians and academic specialists' view of the 'ideal' physician, they did not relate very much to the traditional view of the 'ideal' physician. This was a surprising outcome, given that they work long hours.
Table 1  Career Motivation Inventory (N=1.070)

<table>
<thead>
<tr>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Career centrality</strong></td>
</tr>
<tr>
<td>I am very focused on my career.</td>
</tr>
<tr>
<td>I am willing to sacrifice a certain amount of my (free) time for my career.</td>
</tr>
<tr>
<td>For me, my career comes first.</td>
</tr>
<tr>
<td>My career means a lot to me.</td>
</tr>
<tr>
<td>I am an absolute career woman.</td>
</tr>
<tr>
<td>I get the most satisfaction in life out of my career.</td>
</tr>
<tr>
<td><strong>Career insight</strong></td>
</tr>
<tr>
<td>I have formulated clear career goals for myself.</td>
</tr>
<tr>
<td>I have defined what I need in order to succeed in my career goals.*</td>
</tr>
<tr>
<td>I have created a strategy how to achieve my career goals.</td>
</tr>
<tr>
<td><strong>Career ambition</strong></td>
</tr>
<tr>
<td>I want to achieve a top position in my field.</td>
</tr>
<tr>
<td>I want to obtain (maintain) a managerial/supervising position.</td>
</tr>
<tr>
<td>I want to obtain a senior position in my work.</td>
</tr>
<tr>
<td>I want to earn a higher salary.</td>
</tr>
<tr>
<td>Cronbach's alpha</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>.85</td>
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</table>
Table 2  Ideal Mother Inventory (N=1,070)

<table>
<thead>
<tr>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time allocation</strong></td>
</tr>
<tr>
<td>I want to spend much time with my children.</td>
</tr>
<tr>
<td>I find it important to share breakfast and dinner together with my</td>
</tr>
<tr>
<td>children during the (work) week.</td>
</tr>
<tr>
<td>When I am frequently away from home, I am afraid my children will</td>
</tr>
<tr>
<td>become more attached to others than myself.</td>
</tr>
<tr>
<td>I find it important to be at home in case my child is sick.</td>
</tr>
<tr>
<td>I find it terribly awful when I see my child(ren) only a few hours</td>
</tr>
<tr>
<td>per day.</td>
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<tr>
<td>I definitely do not want to miss out on any of the developmental</td>
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<tr>
<td>phases of my child(ren) during the first two years of his/her life.</td>
</tr>
<tr>
<td>I want to take my child(ren) to bed every evening.</td>
</tr>
<tr>
<td><strong>Role model (reversed)</strong></td>
</tr>
<tr>
<td>I believe it is important to set an example as a working parent for</td>
</tr>
<tr>
<td>my children.</td>
</tr>
<tr>
<td>I find it very important to show my children that my career is as</td>
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<tr>
<td>important as that of my partner.</td>
</tr>
<tr>
<td>Cronbach's alpha</td>
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<tr>
<td>------------------</td>
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<tr>
<td>.77</td>
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<td>.65</td>
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</tbody>
</table>
### Table 3  Ideal Physician Inventory (N=1,070)

<table>
<thead>
<tr>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>I believe I am a good physician when...</em></td>
</tr>
<tr>
<td>I do not mind to work long hours.</td>
</tr>
<tr>
<td>I do not mind to work overtime on a structural basis.</td>
</tr>
<tr>
<td>I am physically capable to work long hours.</td>
</tr>
<tr>
<td>I am willing to relocate for my work.</td>
</tr>
<tr>
<td>I am always available.</td>
</tr>
<tr>
<td>I am very respected by my colleagues.</td>
</tr>
<tr>
<td>I am very respected by my patients.</td>
</tr>
<tr>
<td>I am very respected by my nurses and residents.</td>
</tr>
<tr>
<td>Cronbach’s alpha</td>
</tr>
<tr>
<td>------------------</td>
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<tr>
<td>.78</td>
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<td></td>
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<td></td>
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<tr>
<td>Items</td>
</tr>
<tr>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Career support</strong></td>
</tr>
<tr>
<td>I believe my supervisor(s) support(s) me in achieving my career goals.</td>
</tr>
<tr>
<td>I believe my colleague(s) support(s) me in achieving my career goals.</td>
</tr>
<tr>
<td>I believe my supervisor(s) wants to support me in achieving a more senior position.</td>
</tr>
<tr>
<td>I believe my colleague(s) want(s) to support me in achieving a more senior position.</td>
</tr>
<tr>
<td>My supervisor and I get along well.</td>
</tr>
<tr>
<td><strong>Support for work-life balance</strong></td>
</tr>
<tr>
<td>My supervisor would show his/her sympathy when I have to leave work unexpectedly due to unforeseen circumstances at home.</td>
</tr>
<tr>
<td>My colleague(s) would show his/her/their sympathy when I have to leave work unexpectedly due to unforeseen circumstances at home.</td>
</tr>
<tr>
<td>Within our organization supervisors believe it is important that employees have enough time for their private life next to their work.</td>
</tr>
<tr>
<td>Within our organization colleagues believe it is important that employees have enough time for their private life next to their work.</td>
</tr>
<tr>
<td>My colleagues do not mind to take over my practice temporarily.</td>
</tr>
<tr>
<td>My supervisor would easily accept my request for a room with privacy arrangements to express milk in case I would need one.</td>
</tr>
<tr>
<td>Cronbach's alpha</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>.83</td>
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<tr>
<td></td>
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</tbody>
</table>
Absence of career hindrance

Not responding to career opportunities due to private reasons is considered bad for your career in this organization (staff/partnership).

To advance in this organization (staff/partnership), MDs are expected to work overtime on a regular basis.

In this organization (staff/partnership), MDs are expected to prioritize their work over their private lives.

MDs working fewer hours due to private reasons are perceived as less ambitious by supervisors in this organization (staff, partnership).

MDs working fewer hours due to private reasons are perceived as less ambitious by colleagues in this organization (other staff members/partners).

IN this organization, part-time working female MDs are perceived as less ambitious than part-time working male MDs.

MDs working less hours (part-time) advance less quickly to a more senior position.
3

CHALLENGING GENDERED STEREOTYPES:

The effects of work-home culture and parenthood on the career motivation of Dutch academic specialists
Abstract

The objective of this study was to identify sex differences in the effect of work-home culture and parenthood on career motivation among Dutch academic specialists. In total, 267 academic specialists in a Dutch teaching hospital participated in a web survey that was distributed in 2009. As this study revealed, offering a supportive work-home culture has different effects on men and women academic specialists' career motivation. To our surprise, women benefit mostly from support for achieving their career goals, whereas men become more motivated when they feel supported in achieving a work-life balance. Moreover, parents have higher levels of career motivation than non-parents, with the exception of fathers with a child of younger than 4 years old, who, it seems, focus more on other roles and aspects in life than their career. The findings suggest that teaching hospitals' current personnel policies designed to promote a better work-life balance among especially their female employees are in fact based on gendered stereotypes concerning what men and women need to stay motivated in their career.
3.1. Introduction

Despite the feminization of the medical profession in the Netherlands, women physicians are underrepresented in more senior and influential academic medical positions, with percentages varying between 0 and 15% (De Jong, Heiligers, Groenewegen, & Hingstman, 2006; Van Doorne-Huiskes & Van Beek, 2009). The general debate and current scientific discussions on the gender disparity in senior medical positions have centred on the causes of this disparity. One stream in the debate focuses on women physicians' assumed 'shortcomings', such as their own underestimation of their skills, and their alleged lack of career motivation compared to their men counterparts (De Jong & Lagro-Janssen, 2006). The latter is attributed particularly to women's child-care responsibilities that are closely tied to the societal motherhood ideology that women face to a greater extent than men, with significant tensions between societal expectations at home and at work (Bassin, Honey, & Kaplan, 1994; De Jong & Lagro-Janssen, 2006; SCP, 2008). Another stream of literature emphasizes the lack of support provided by organizations for working women with care obligations and possible indirect barriers such as anticipated difficulties in achieving the desired work-life balance and a lack of opportunities for flexible working (Hamel, Ingelfinger, Phimister, & Solomon, 2006; Nattinger, 2007; Taylor, Lambert, & Goldacre, 2009; Van Doorne-Huiskes & Conen, 2007).

So far, research on career progression among women physicians has focused on explaining the gendered disparity in senior medical positions by investigating the number of hours that women are willing to work and how that relates to their career preferences, career progression and attainment (Buddeberg-Fischer, Klaghofer, Abel, & Buddeberg, 2006; Fels, 2004; Heiligers & Hingstman, 2002; McKinstry, Colthart, Elliott, & Hunter, 2006; McManus, Keeling, & Paice, 2004; Nattinger, 2007; Taylor et al., 2009). Other studies have shown how historical facts, such as the number of women entering medical school, explain the low proportions of women consultants and in senior medical positions (McManus & Sproston, 2000). Working hours, however, are not equivalent to career motivation. Although working hours correlate positively with career motivation, the construct of career motivation extends beyond time allocation and includes attitudes regarding the importance of work in one's self-definition and the will to attain a senior position in one's field (Bailyn, 2006; Judge, Cable, Boudreau, & Bretz, 1995). In a working environment in which an average working week means forty hours or more, working hours alone cannot be the decisive predictor of career advancement. It is often assumed, however, that professionals who
work part-time are less ambitious and career-oriented than full-timers (Bailyn, 2006; Sools, Van Engen, & Baerveldt, 2007). What is more, by focusing exclusively on medical physicians’ working hours as predictors of career advancement, gendered stereotype expectations regarding men and women’s roles that could affect their career motivation are neglected.

Researchers in other studies conclude by stressing the importance of the possible impact of work cultures on preferences for working hours and career attainment (Heiligers & Hingstman, 2000; Taylor et al., 2009). The number of hours worked by Dutch medical specialists is declining, among both women and men (Heiligers & Hingstman, 2000). This would seem to indicate a general shift in attitudes to the number of hours medical specialists should work, or at least that the work-home culture is becoming increasingly ‘family-friendly’. By work-home culture, we mean the degree to which the culture of an organization supports and values the integration of employees’ work and family lives as perceived by the employee (e.g., Thompson, Beauvais, & Lyness, 1999). To our knowledge, the family-friendliness of the work-home culture has not been included in empirical studies on medical specialists’ career motivation so far.

Household characteristics, such as being a parent and domestic arrangements, have been investigated as predictors of working hours and preferences for working hours, but not as predictors of career motivation among medical specialists (Taylor et al., 2009). Although the effect of parenthood on women’s labour market participation has well been documented, little attention has been given to the potentially significant link between parenthood and career motivation among men. The ‘good-provider’ model predicts that fathers will focus more on their career than non-fathers, while the ‘involved-father’ model predicts that fatherhood may encourage men to focus less on their career (Uhlenberg, 2000).

This article contributes to the scientific and societal debates on the gendered disparity in senior medical positions by investigating both the effects of the perceived work-home culture and parenthood on career motivation among academic specialists of both sexes.

3.2. Methods

Procedure and population

All teaching hospitals in the Netherlands are bound by a Collective Labour Agreement (CLA) and thus fringe benefits are essentially equivalent for all academic specialists. In April 2009, a request to participate in this
study was sent out by email to all (520) academic specialists working in a Dutch academic hospital. With respect to specialty and the number of women academic specialists, the hospital could be considered as representative of the eight Dutch academic hospitals (Van Doorne-Huiskes & Van Beek, 2009). Of all the 520 academic specialists working in this hospital, 331 (64%) were men and 189 (36%) were women. The e-mail contained a link to an online survey, and participants had to fill in a unique password to access to this survey. After three weeks, a reminder was sent to participants who had not yet responded to the first request. The whole data collection process lasted five weeks.

**Survey instrument and definitions**

The questionnaire covered a broad range of subjects including employment characteristics (i.e., number of contracted and actual working hours, years of work experience as a physician,) and household characteristics (i.e., number of children in different age categories, presence of a partner). To investigate the effects of parenthood and perceptions regarding work-home culture on the career motivation of men and women physicians, we used existing scales (Table 1). All items were measured on a five-point Likert scale ranging from ‘1’ referring to “I totally disagree” to ‘5’ “I totally agree”. The scale scores were obtained as the mean of the values (ranging from 1 to 5) for the items of each scale.

**Career motivation** Based on the work of London, we were interested in academic specialists’ career motivation, which consisted of i) how academic specialists position their career in relation to other aspects in life (career centrality), and ii) to what extent academic specialists are interested in upward mobility on a vertical career ladder such as obtaining a senior or management position (career ambition) (London, 1983, 1997; SCP, 2008).

**Work-home culture** We distinguished three dimensions of the family-friendliness of the work-home culture – namely i) perceived support for one’s career goals; ii) academic specialists’ perceptions of the support for work-life balance; and iii) academic specialists’ perceived absence of career hindrance, such as no career penalties or slower career progression due to – for instance – working part-time.

**Parenthood** was measured by asking the respondent whether he or she had (step) children. The survey also asked for the age of the youngest child. On the basis of this information, we created the following four categories: 0) no children; 1) (youngest) child between 0 and 3 years old; 2) (youngest) child between 4 and 11; and 3) (youngest) child 12 or older than 12. The first group served as a reference category.
Control variables: The analyses were adjusted for medical specialty (surgical (0) or non-surgical (1)), work experience (in years), the age of the respondent and having a partner (0=no; 1=yes).

Data analysis

Descriptive analyses were used to obtain the mean levels of men and women's perceptions of the work-home culture and their mean levels of career motivation (career centrality and career ambition) (Table 1). We subsequently conducted multiple regression analyses to determine the effects of parenthood and work-home culture on career motivation for men and women separately (Table 2). We regarded p<0.05 (*) as minimum evidence of a significant effect, but we also reported p-values of p<0.01 (**). We used different types of scales (i.e., parenthood is a dichotomous variable whereas the other scales are 5-point Likert scales) and we thus obtained both the unstandardized (first columns, B's) and the standardized (second columns, beta's/β's) regression effects.

3.3. Results

Response rates and demographics

The response rate was 51% (264/520). Of the 267 physicians, 145 (55%) were men and 119 (45%) were women. The sample was representative of academic specialists in the Netherlands in terms of the type of specialty, respondents' age and years of work experience (Van Doorne-Huiskes & Van Beek, 2009). Regarding the number of men and women in our sample, slightly fewer men and slightly more women responded to the survey than are present in the population of academic specialists as a whole. Of the men, 20% were surgeons and 80% were non-surgeons. Of the women, 11% were surgeons and 89% were non-surgeons. The men academic specialists had, on average, 15.37 years of work experience (SD=9.45), worked 43.40 contracted hours per week (SD=7.45), were aged 49.47 (SD=8.91) years (mean), and 88% of them had children. Of the men with children, 15% had a youngest child of less than 4 years old, 25% had a youngest child between age 4 to 12, and 49% had a child older than 12 years. On average, women had 8.23 years of work experience as an academic specialist (SD=6.35), worked 36.72 hours per week (SD=6.77), were aged 42.5 years (SD=6.76), and 82% of them had children. Of those with children, 32.3% had a youngest child of up to 4 years old, 47.5% had a youngest child between age 4 to 12, and 20.2% had a youngest child older than 12 years.
Men had an average score of 3.24 on the 5-point scale (Table 1) of career centrality. They were highly interested in obtaining a (more) senior position in their field (4.37) (career ambition). Overall, they perceived the work-home culture as fairly family-friendly. They felt supported by supervisors and colleagues in achieving their career goals (3.81), but also in obtaining or maintaining a healthy work-life balance (3.70). However, they also believed part-timers would be hindered in their career advancement, as shown by their lower score on the absence of career hindrance (2.64).

Women had an average score of 3.22 on career centrality and they also wanted to achieve a (more) senior position (4.25). Although they seemed to be content with the family-friendliness of the work-home culture, they appeared to be a little less positive than their male colleagues. For example, they were only mildly positive about the support they received from supervisors and colleagues in achieving their career goals (3.59). The same goes for the perceived support for work-life balance (3.52). Women, like men, believed that part-timers are hindered in their career (2.48). Overall, men and women did not significantly differ in their levels of career centrality and career ambition. Men did have a significantly more positive perception of the family-friendliness of the work-home culture than women (see Table I).

Work-home culture and career centrality

The work-home culture hardly seemed to affect men’s career centrality (Table 2), except for the perceived support that they received from supervisors and colleagues in attaining a work-life balance ($\beta = .207^*; p<0.05$, one-tailed). We found that men who felt more strongly supported in attaining a work-life balance, found their career more important than men who felt less supported. Perceived absence of career hindrance negatively affected their career centrality ($\beta = -.165; p<0.05$ one-tailed).

For women (Table 2), it was not the support for work-life balance that had a positive effect on their career centrality ($\beta = .068$, p not significant), but the support they received from supervisors and/or colleagues for achieving their career goals ($\beta = .226; p<0.05$, one-tailed). In other words, the women who felt better supported in progressing in their career, found their career more important than those women who felt less supported.

Support for work-life balance and support for career goals seemed to affect men’s and women’s career centrality differently. Contrary to what is often assumed to be the case, more support for work-life balance did not have a positive effect on women’s career centrality but on that of men. Support for career goals, on the other hand, had a positive effect on women’s career centrality, and not on men’s.
<table>
<thead>
<tr>
<th>Dimensions and scales</th>
<th>Example item</th>
<th>Number of items</th>
<th>Reliability (Cronbach’s alpha)</th>
<th>Mean (SD) Women</th>
<th>Mean (SD) Men</th>
<th>Significance of mean difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Career Motivation</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Career centrality</td>
<td>“I gain most satisfaction in life from my career”</td>
<td>6</td>
<td>0.84</td>
<td>3.22 (0.61)</td>
<td>3.24 (0.60)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Career Ambition</td>
<td>“I want to obtain (or maintain) a senior position in the field that I work in”</td>
<td>4</td>
<td>0.71</td>
<td>4.23 (0.68)</td>
<td>4.37 (0.55)</td>
<td>n.s.</td>
</tr>
<tr>
<td><strong>Work-Home Culture</strong></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Career Support</td>
<td>“I believe my supervisor(s) support(s) me in achieving my career goals”</td>
<td>5</td>
<td>0.77</td>
<td>3.59 (0.73)</td>
<td>3.81 (0.64)</td>
<td>**</td>
</tr>
<tr>
<td>Support for Work-life Balance</td>
<td>“My colleagues are sympathetic when I have to leave work due to unexpected emergencies at home”</td>
<td>6</td>
<td>0.85</td>
<td>3.52 (0.70)</td>
<td>3.70 (0.57)</td>
<td>**</td>
</tr>
<tr>
<td>Absence of Career Hindrance</td>
<td>“Employees who (temporarily) work fewer hours due to caretaking responsibilities are regarded as less ambitious in our organization”</td>
<td>7</td>
<td>0.80</td>
<td>2.48 (0.61)</td>
<td>2.64 (0.48)</td>
<td>**</td>
</tr>
</tbody>
</table>

** p<0.01; n.s. indicates ‘not significant’.
Work-home culture and career ambition

The career ambition of men was not significantly affected by the family-friendliness of the work-home culture (Table 2). However, women who felt supported in their career goals scored higher levels of career ambition than women who felt less supported ($\beta = .270; p<0.05$, one-tailed). The results also revealed that a perceived absence of career hindrance had a negative effect on women’s career ambition ($\beta = -.246, p<0.05$, one-tailed). Moreover, among women, career support had a slightly stronger effect on career ambition than the absence of career hindrance.

Parenthood and career centrality

Having a child of less than 4 years of age had a negative effect on men’s career centrality ($B = -.344, p<0.05$, one-tailed). Men with children older than 4 years did not differ significantly in their career centrality from men without children. For women, however, the presence of a young child under the age of 4 years did not significantly affect her career centrality ($B = .294; p$ not significant), and women with children older than 4 years had significant higher levels of career centrality than their childless women colleagues ($B = .304; p<0.05$, one-tailed, for youngest child between 4 to 12 years; $B = .547; p<0.05$, one-tailed, for the youngest child older than 12 years).

Parenthood and career ambition

Having children older than 4 years had a positive effect on the career ambition of both men and women (for men $B = .328$ and $B = .458$ respectively, in both cases $p<0.05$, one-tailed; for women $B = .467$ and $B = .621$ respectively, in both cases $p<0.05$, one-tailed).

Having a partner and career motivation

Our control variables showed that for men, but not for women, there were significant positive relationships between having a partner and career centrality and career ambition. The respondent’s age, years of work experience did not have a significant effect on the career motivation of academic specialists. Men surgeons, however, had significant higher levels of career centrality and career ambition than men non-surgeons.
Table 2: (Un)standardized regression coefficients for effects of parenthood and work-home culture on career centrality and career ambition among men and women

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
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<th>Women</th>
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<tbody>
<tr>
<td></td>
<td>B</td>
<td>β</td>
<td>B</td>
<td>B</td>
<td>β</td>
<td>B</td>
</tr>
<tr>
<td>Youngest child &lt; 4 years</td>
<td>-.344*</td>
<td>-.220*</td>
<td>-.053</td>
<td>-.036</td>
<td>.294</td>
<td>.230</td>
</tr>
<tr>
<td>Youngest child 4 to 12 years</td>
<td>-.019</td>
<td>-.014</td>
<td>.328*</td>
<td>.268*</td>
<td>.304*</td>
<td>.258*</td>
</tr>
<tr>
<td>Youngest child &gt; 12 years</td>
<td>-.127</td>
<td>-.108</td>
<td>.458*</td>
<td>.423*</td>
<td>.547*</td>
<td>.330*</td>
</tr>
<tr>
<td>Career Support</td>
<td>.058</td>
<td>.63</td>
<td>-.009</td>
<td>-.010</td>
<td>.183*</td>
<td>.226*</td>
</tr>
<tr>
<td>Support for Work-life Balance</td>
<td>.225*</td>
<td>.207*</td>
<td>.134</td>
<td>.131</td>
<td>.058</td>
<td>.068</td>
</tr>
<tr>
<td>Absence of Career Hindrance</td>
<td>-.199*</td>
<td>-.165*</td>
<td>-.115</td>
<td>-.103</td>
<td>.064</td>
<td>.066</td>
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Control variables

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</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>β</td>
<td>B</td>
<td>B</td>
<td>β</td>
<td>B</td>
</tr>
<tr>
<td>Partner</td>
<td>.423*</td>
<td>.166*</td>
<td>.631**</td>
<td>.269**</td>
<td>.019</td>
<td>.007</td>
</tr>
<tr>
<td>Age</td>
<td>-.030</td>
<td>-.453</td>
<td>-.026</td>
<td>-.422</td>
<td>.002</td>
<td>.022</td>
</tr>
<tr>
<td>Years of work experience</td>
<td>.029</td>
<td>.464</td>
<td>.003</td>
<td>.059</td>
<td>.006</td>
<td>.066</td>
</tr>
<tr>
<td>Surgeon</td>
<td>.264*</td>
<td>.175*</td>
<td>.250*</td>
<td>.179*</td>
<td>-.152</td>
<td>-.081</td>
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</table>

Adj. R square

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
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<th></th>
<th>Women</th>
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<tbody>
<tr>
<td></td>
<td>9.1%*</td>
<td></td>
<td></td>
<td>14.3%**</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5.6%*</td>
<td></td>
<td></td>
<td>10.9%*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<0.01; *p<0.05 (one-tailed), n.s. refers to ‘not significant’.
Chapter 3

3.4. Discussion

Our study into the effect of the work-home culture on career motivation among men and women physicians produced two remarkable findings. Firstly, for women, it is not the support they receive to attain a work-life balance, but the support they receive for their career goals that is positively associated with their career centrality and career ambition. For men, on the other hand, the opposite applies: the more supported they feel in attaining a work-life balance, the higher their level of career centrality. This suggests that traditional perceptions regarding what men and women academic specialists want or need in order to combine their career with parenthood are perhaps out-dated. Women, it seems, need and want to be addressed as academic specialists who are valuable to the organization. Women thus respond positively to support for their career progression; the men in our study, by contrast, want to be liberated from the dominant, gendered stereotypes that require them to be focused solely on their career, leaving little room for their personal lives.

The absence of career hindrance when working part-time makes men score lower on career centrality and women lower on career ambition. A possible explanation for this remarkable finding could be a causal effect. For example, women who are less ambitious have not – yet – had to deal with the same prejudices against part-time working that women in more senior positions may encounter. For this reason, less ambitious women may therefore perceive less career hindrance.

Secondly, we found no evidence that parenthood causes women to be less focused on their career or less ambitious in attaining a (more) senior position. Although the cross-sectional design of this study prevents us from drawing any causal conclusions regarding the influence of motherhood on a woman's career motivation, it is remarkable to find that the common assumption that women with children are less ambitious than those without was not supported by our data. On the contrary, our results suggest that women with children find their career more important and are more ambitious than women without children.

However, we did find a negative correlation between parenthood and career motivation in men. Fathers with young children in particular are less focused on their career than men without children. This could be because nowadays men with young children are more addressed in their role as a father and caretaker by their social environment (SCP, 2008; Uhlenberg, 2000). Parenthood thus seems to have different and unexpected effects on men and women's career centrality. Whereas the presence of young children (perhaps
temporarily) negatively affects men’s career centrality, women with children have higher levels of career centrality than women without children.

These two remarkable findings would appear to suggest that traditional, gendered stereotypes regarding men’s and women’s roles – women being the stay-at-home caregiver and men working outside the house – are perhaps changing among the younger generation of academic specialists. Men physicians marry highly educated women more often than a few decades ago, and their wives often also have a career which they want to continue after their children are born (Gjerberg, 2003; Sobecks et al., 1999). Discussions within young physicians’ families revolve around the fact that there are now two careers that have to be combined with taking care of children. Our results also show that men with a partner have higher levels of career centrality and career ambition, while among women having a partner does not affect their career centrality, nor their career ambition. This is probably because men are more likely to have a stay-at-home wife, whereas women are less likely to have a partner who takes care of family matters. It would appear that partners (and their careers) play an important but varying role in explaining men and women academic specialists’ career motivation. In that respect, our study shows that one should be cautious of comparing the career motivation of men and women, since other gendered role expectations may well play an important explanatory role.

3.5. Strengths and limitations

One of the strengths of our study is that we investigated men and women physicians’ perceptions of the work-home culture and its effect on career centrality and career ambition. Hitherto, researchers have suggested that organizations can improve labour participation and career progression among women physicians by providing “support for an improved work-life balance” (Noordenbos, 1997; Taylor et al., 2009). Although this study is based on self-reports and carries the risk of self-selection bias, our findings provide interesting and surprising results regarding what women and men need to combine their work with their family life. Another contribution is that we investigated how the presence of (young) children affects men and women’s career motivation. This produced the insight that parenthood has a significant and positive correlation with career motivation in women, but a negative correlation with career motivation in men. Both sexes perhaps want to counter stereotyped expectations regarding their role as a mother or as a career-oriented breadwinner.
Further longitudinal research including information on (past) career achievements is needed to expose possible other predictors. For instance, future research on this topic should include the possible effects of the seniority of women's positions. It is possible that women who have reached more senior positions have received more career support in the past, so they may perceive the work-home culture as more supportive towards their career goals.

Our study focused on academic specialists who had finished their years of training and were well underway with their career. Although this can be considered a strength in our study – since other research on career preferences is often based on residents or medical students (Buddeberg-Fischer et al., 2006; McManus et al., 2004) – future research among young residents could provide more insight into changing preferences on the balance between career progress and family life among the next generation of medical specialists.

Other predictors that were not included in this study, and which could be included in future research, were the provision and take-up of family-friendly arrangements. It is conceivable that the men and women who actually make use of family-friendly arrangements may face more career hindrance than colleagues who do not use such arrangements. Because the latter do not have to confront their supervisors with their personal wishes and their inability to manage a full-time job and family responsibilities simultaneously, their perception of the family-friendliness of their organization may be more positive.

A final limitation of this study lies in its cross-sectional design. Longitudinal research on this topic is needed to investigate changes in career motivation due to childbirth and work-home culture at the individual level. Nevertheless, our cross-sectional findings suggest that previous assumptions concerning the importance of support for work-life balance especially for women and the assumed negative relationship between parenthood and especially women's career centrality could be based on gendered role patterns.

3.6. Comparison with other studies

Our findings are consistent with other studies. A qualitative study reports that women consultants in the UK were more likely than men consultants to have a dominant career orientation (indicating higher levels of career centrality) and men consultants were less satisfied with their work-life
balance than their women colleagues (Dumelow, Littlejohns, & Griffiths, 2000). These findings support our result that especially men physicians seem to benefit from support for work-life balance.

Another study carried out in the Netherlands showed that – again, contrary to what is often expected – home domain characteristics (such as the children’s age) affect men medical specialists’ preferences for working hours more than those of women medical specialists (Heiligers & Hingstman, 2000). This study also concluded that work is becoming less central among both men and women medical physicians. This corresponds with our results that all the physicians in our study scored only moderately (3.23 on a 5-point scale) on the item “I gain the most satisfaction in life from my career”.

3.7. Policy implications

To prevent women physicians with caretaking responsibilities at home from dropping out, most Dutch academic hospitals provide work-life balance arrangements, such as offering the possibility of working part-time or working flexible working hours. These arrangements are designed to support work-family balance and reduce stress levels among women physicians (Robinson, 2003). Support for work-life balance is often prescribed as the cure for the lack of women in senior medical positions (Buddeberg-Fischer et al., 2006; Nattinger, 2007). However, gendered expectations regarding how men and women specialists want to combine work with family life seem to be the basis for policies in which women academic specialists are either treated as ‘men in skirts’ or as working mothers who continually have one foot outside the hospital. In reality, neither of these descriptions fits most of the highly trained and dedicated women academic specialists working in teaching hospitals. Our study provides reason to question the effectiveness of these policies, although we do want to stress that providing part-time and/or flexible working arrangements is still necessary.

We showed that women in particular seem to benefit from support from their supervisors and colleagues in achieving their career goals, rather than a work environment that stresses the importance of a better work-life balance. Teaching hospital policies should beware of basing their policies on gendered stereotypes. This could also account for the lack of support for work-life balance that (young) men physicians seem to encounter, and for whom support for work-life balance is often neglected and more scrutinized by men supervisors and colleagues.
Instead, hospital personnel policies should focus more on gender awareness among the supervisors and colleagues who promote and support both men and women academic specialists who are working towards more senior positions. They should become aware that it is not (only) women academic specialists with children who are their primary subjects of concern when it comes to career motivation. A woman academic specialist who decides not to have children, or a man academic specialist who has recently become a father may be more liable to run into personal or motivational issues later on in their careers. Having made sacrifices for their job, they may later come to regret those career decisions and become less motivated. Greater gender awareness of different academic medical career paths and work-life balance would also clear the path for men who no longer want to suppress their preference for participating more actively in taking care of their children, without running into stereotypes on career ambition.

3.8. Conclusion

Contrary to what is often the implicit basis of teaching hospitals’ personnel policies, it is men physicians who benefit most from supervisors and colleagues assistance in achieving a good work-life balance, which enables them to maintain motivation for their career goals. However, women benefit more from assistance from supervisors and colleagues to attain their career goals. Also, men with a youngest child aged 4 years or under are less focused on their career than men without children. Even more interesting is that women physicians with children have higher levels of career motivation than women physicians without children. All these findings suggest that it is time for a critical assessment of the impact of gender in work-life balance policies in teaching hospitals. These policies currently seem to assume that men academic specialists focus solely on their careers and women as (future) mothers with one foot outside the hospital doors – and, as such, they are expected to benefit from support in achieving work-life balance. The focus should lie on gendered stereotypical beliefs among supervisors and colleagues which leave little room to improve academic specialists’ attempts to combine a promising career with raising children.
EXPLAINING CAREER MOTIVATION AMONG DUTCH WOMEN PHYSICIANS:

The effects of children, views on motherhood and work-home cultures

This chapter will appear as:
Explaining career motivation among Dutch women physicians

Abstract

The gender imbalance in senior medical positions is often attributed to an alleged lack of motivation on the part of women physicians, especially those with young children. Some researchers argue that an unsupportive work-home culture in the medical workplace also plays a role. This study investigates whether having children (and the age of the youngest child) affects women physicians' career motivation and whether this relationship is mediated by views on motherhood and the supportiveness of the work-home culture. Cross-sectional data collected on 1,070 Dutch women physicians in 2008 indicates that neither having children nor the age of the youngest child significantly affects the career motivation of women physicians. However, views on motherhood and a supportive work-home culture do affect women physicians' career motivation. Governmental and organizational policies aimed at maternal employment and improving the work-life balance are discussed in terms of their effectiveness in supporting highly educated working women.
Chapter 4

4.1. Introduction

For decades, the participation of women in labour markets, regardless of whether it is combined with unpaid care-taking responsibilities, has been the subject of numerous studies. Various possible explanations for the number of hours worked by women have been explored, such as the effects of having children, the age of those children (Van Wel & Knijn, 2006; Vlasblom and Schippers, 2006), the domestic division of labour (Crompton et al., 20005), attitudes regarding motherhood and what others believe to be 'good' mothering (Marks & Houston, 2002; Nordenmark, 2002; Himmelweit & Sigala, 2004). Other studies focus on the effect of external constraints on women's working hours, such as the availability of governmental policies which are supportive of maternal employment (e.g., Gash, 2008; Gornick et al., 1997) and employers' attitudes toward working mothers (e.g., Lewis, 2001; Stone, 2007). The contribution of this study, however, is to focus on highly educated Dutch working women's career motivation, rather than on their level of labour participation. The reason for focusing on career motivation is twofold.

The first reason lies in the fact that in the Netherlands, 80 percent of highly educated (holding a Master's degree) women with children have a paid job (SCP, 2008). Of these, 45 percent work full-time (over thirty-five hours per week) and 75 percent work over twenty-eight hours per week (SCP, 2008). The policies of the Dutch government still primarily aim to persuade women to work more hours (SCP, 2009; The Dutch Ministry of Social Affairs and Employment, SZW, 2007), rather than promoting gender equality in senior positions, leaving gender equality policy to the responsibility of single organizations. As emphasized by a recent EU report (2008), it is socially and economically important that women occupy senior positions and within bodies such as boards and committees, since their absence inevitably means that their individual and collective opinions are less likely to be voiced in policy and decision-making processes.

The second reason for focusing on career motivation is that although the number of working hours is an important predictor of whether a senior position is attained, it is often explicitly and implicitly suggested that working hours closely reflect career motivation. Working part-time is thus often considered an indication of a lack of career motivation and an explanation of why women fail to obtain higher positions, which involve long working hours (e.g., Judge et al., 1995; Taylor et al., 2009). However, working part-time can only partly explain the gendered inequality in senior positions. First of all, women's career motivation involves more than just
Explaining career motivation among Dutch women physicians

their decisions on working hours. Women interviewed in other studies have also stated that their work and ambitions were important in defining their ‘identity’ and that they wanted to contribute to society (Duncan et al., 2003; Stone, 2007). Secondly, sectors in which women also work long hours, such as the medical profession, are also characterized by gendered inequality in senior positions (SCP, 2008). Despite the feminization of the medical profession over the last decades (Van der Velden et al., 2008), women physicians are still greatly underrepresented in the higher echelons of medical academia and medical administration in the Netherlands – between 0 and 15 percent – and overrepresented in lower-paid and lower-prestige specialties such as primary care (Boulis, 2004; Van der Velden et al., 2008; Van Doorne-Huiskes & Van Beek, 2009). Therefore, and also compared to other industries in the Netherlands, women physicians are still unequally represented in the higher echelons, despite their relatively longer working hours (SCP, 2008).

The causes of the gender disparity in senior medical positions are the subject of scientific discussion as well as a debate within wider society. One stream in the debate focuses on an alleged lack of career motivation among women physicians. According to this argument, child-raising responsibilities are the most salient factor in explaining the career motivation and achievements of women physicians (Keizer, 1997; Metz & Tharenou, 2001), even though they often delay childbirth for the sake of their career (Robinson, 2003). On average, Dutch women physicians bear their first child even later (this study) than the average for highly educated Dutch women (being thirty-one years of age when giving birth to their first child, Van Agtmaal-Wobma & Van Huis, 2008). According to Hakim’s categorization (2002), Dutch women physicians can thus be perceived as highly adaptive: women who first opt for a professional career and subsequently attempt to combine their career with raising children. But in spite of women physicians’ ‘adaptiveness’, most women physicians do eventually become mothers (Taylor et al., 2009). In terms of gaining social approval (Lindenberg & Frey, 1993), women physicians with young children, like other working mothers, face an internal conflict and are forced to perform ‘cognitive aerobatics’ when trying to combine motherhood with a professional career. A demanding career is not compatible with the predominant ideology of motherhood in the Netherlands, according to which a ‘good’ mother should work no more than three days a week outside the home (SCP, 2008). The question remains, then, how does having children affect the career motivation of women physicians, and is this relationship mediated by their views on motherhood?

Another strand of the debate, meanwhile, emphasizes the lack of support
that medical organizational cultures provide for working women with care obligations. Working part-time is not generally considered acceptable in most medical specialties, and what is more, the associated career demands – such as obtaining a PhD degree to enhance one’s career prospects – make it almost impossible to advance one’s career while working part-time (Heiligers and Hingstman, 2000). Studies show that the effectiveness of family-friendly arrangements, such as the possibility of working part-time, flexible working times and (on-site) child-care facilities, depend on the ‘work-home culture’ within organizations (Lewis, 2001). The work-home culture refers to “the degree to which the culture of an organization supports and values the integration of employees’ work and family lives, according to the employee” (Thompson et al., 1999, p.394). Most studies have focused on how family-friendly arrangements and a supportive work-home culture affect the work-family conflict or feelings of time-pressure (e.g., Dikkers et al., 2007; Van der Lippe, 2007). Qualitative studies (e.g., Stone, 2007) show that the lack of support from supervisors and colleagues for combining work and family responsibilities is also a reason for women to abandon promising careers. However, an aspect that has hitherto been neglected is whether a supportive work-home culture has a positive effect on the career motivation of women physicians. Additionally, it is interesting to investigate whether a supportive work-home culture mediates the relationship between having children and levels of career motivation.

This study is an empirical investigation of whether views on motherhood and the supportiveness of the work-home culture play a mediating role in the relation between having children and women physicians’ career motivation in the Netherlands. Data was used from a national cross-sectional survey conducted in 2008.

4.2. Theoretical background and hypotheses

Career motivation

By examining career motivation, it is possible to gain a broader view of women physicians’ attitudes towards their careers in medicine. Career motivation is conceptualized here as a multidimensional construct internal to the individual, influenced by both family and work-related situations, and reflected in the individual’s attitudes, decisions and behaviour regarding his or her career (London, 1983). Other researchers have focused on how attitudes regarding motherhood affect specific behaviour, such as working hours (Himmelweit & Sigala, 2004; Bertie et al., 2006). However, the concept
Explaining career motivation among Dutch women physicians

of career motivation as used in this study focuses more on the interests, attitude and personality variables that are potentially relevant to one's career (London, 1983). On the basis of the work of London (1997), three dimensions of career motivation are distinguished here, namely career centrality - (the centrality of career within an individual's life) (London, 1997), career insight (whether an individual believes he or she formulates clear career goals and a strategy on how to attain those goals) (London, 1997; Ouwehand, 2005) and career ambition (whether an individual aspires to attain a senior position in the hierarchy) (SCP, 2008).

Views on motherhood

As an ideology, motherhood is rooted in issues concerning care-giving and time allocation (Arendell, 2000), as well as issues such as aspiring to be a role model in terms of work and family life (Marshall et al., 2007). The Dutch ideology of motherhood used to resemble Hays' "ideology of intensive mothering" (1996), in which mothers (rather than fathers) should spend large amounts of time, physical and emotional energy, and money (earned by fathers) in raising children (Beets et al., 1997). The dominant motherhood ideology has now shifted somewhat toward a less traditional motherhood ideology, in which women are expected to work at least a few days per week, yet they also are expected to mother intensively when at home (SCP, 2008).

Marks and Houston (2002) state that there is evidence from international research that an individual may experience conflicting ideological and personal views regarding work and family roles. For instance, a mother may disagree with prevailing attitudes on motherhood in principle, but may actually accept the dominant ideology on a personal level. In this study, the focus lies on women physicians' personal views on motherhood, and not whether they agree with the prevalent societal ideology of motherhood. In line with previous qualitative research (e.g., Arendell, 2000; Johnston and Swanson, 2006; Marshall et al., 2007), two dimensions were distinguished within views on motherhood among women physicians in this study. The first dimension is time allocation, which refers to a women physician's view on how she should divide her time between her family/children and other aspects such as work. A very traditional attitude to time allocation would indicate that a women physician believes she personally should not be working outside the home and should spend as much time as possible with her children. The second dimension is that of the role model, which refers to whether a woman physician believes it is important to set an example to her children as a working mother outside the home and the importance she attaches to her own career relative to that of her husband. A traditional
attitude to being a role model would indicate that a mother believes providing an example for her children as a mother working outside the home is not important, and that her career is less important than that of her husband.

Studies in the Netherlands have shown that most women (> 50 percent) and men (> 60 percent) believe that the best form of care for children under the age of five (henceforth referred to as ‘pre-schoolers’) during the working week is to be looked after by one of the parents, rather than in a day-care centre (SCP 2006; 2008). This also applies to women with children aged between five and twelve (henceforth referred to as ‘children in elementary school’), although the number of days viewed as acceptable will differ, varying between two and four days per week (SCP, 2008). Since women with children invest more time and energy in child-raising than men or women without children, they risk a loss of social approval when they fail to live up to the traditional Dutch motherhood ideology. Our first hypothesis (H1) is therefore that women physicians with children – particularly those whose youngest child is a pre-schooler or is in elementary school – hold more traditional views on motherhood (regarding time allocation and being a role model), than women physicians without children.

Life with children and the supportive work-home culture

De Jong et al. (2006) found that a significant and growing number of physicians, both male and women, would like to work fewer hours, and speculate that their results could indicate a growing willingness to accept part-time colleagues. Despite the trend to accept part-time working, the work-home culture in the medical setting is unsupportive of physicians who want to combine their private lives with a career. Particularly for women with pre-schoolers and those with children in elementary school, there are significant time constraints when balancing work with care responsibilities (Hochschild, 1997). In this research, three dimensions of the perceived supportiveness of the work-home culture were distinguished, namely: career support, which refers to attention from supervisors and colleagues for career goals; work-life balance support, referring to supervisors and colleagues’ sympathy for work-family balance; and the absence of career hindrance, which refers to the perceived support for upward career mobility despite adapting one’s work to suit family arrangements such as working part-time. In our second hypothesis (H2), we expect to find that women physicians with children – particularly those whose youngest child is a pre-schooler or is in elementary school – will perceive the work-home culture as less supportive (less career support, less support for work-life balance and more career hindrance) than women physicians without children.
Views on motherhood and career motivation

In studying the mutual effects of attitudes towards motherhood and the work-home culture on career motivation, it is important to integrate the effect of what 'significant others' may believe is 'the right thing' (Himmelweit & Sigala, 2004). In order to do so, the Framing Theory (Lindenberg & Frey, 1993) was used, according to which people's need for 'social approval' and 'physical well-being' are universal and all other goals in life ultimately contribute to either one or both of these universal goals. These universal goals lead to the creation of instrumental goals that ultimately contribute to one or both of the universal goals. The superior instrumental goal is only replaced by another, previously subordinate instrumental goal, when the benefits of the second instrumental goal outweigh the benefits of the superior goal, or when the cost of maintaining the superior goal becomes too high in relation to the cost of the other goal. When a superior instrumental goal is replaced by an inferior one, a “frame switch” occurs leading to different decisions.

A women physician who is also a mother has two instrumental goals through which she receives social approval: one goal is to succeed in her role as a physician; the other goal is succeed in her role as a mother. However, although one can pursue both these goals, it is impossible to gain full approval for both roles simultaneously. A women physician must therefore choose – though perhaps not always consciously – between her competing roles (Baaijens et al., 2005). The more social approval she expects to gain through a certain role or identity, the more likely it is that this role will come to dominate. Several researchers have pointed out that internal constraints such as views on motherhood could affect work orientation or labour participation, in which negative attitudes discriminate between workers and non-workers (e.g., Hakim, 2002; Himmelweit & Sigala, 2004; Marks & Houston, 2002). The number of working hours is not a perfect indicator of career motivation, yet the negative effect of traditional views on motherhood on working hours that has already been found by other researchers (e.g., Hakim, 2002) provides the basis for our third hypothesis (H3): Women physicians with more traditional views on motherhood (regarding time allocation and being a role model) will have lower career motivation (career centrality, career insight, and career ambition) than women physicians with less traditional views on motherhood.
Supportive work-home culture and career motivation

Many organizations have implemented family-friendly policies and arrangements. However, the effect of these policies on employees’ behaviour – for example their organizational commitment and turnover intentions – are still unclear and seem highly dependent on the work-home culture of an organization (Allen, 2001; Lewis, 2001). Working mothers may believe that their work ethics have not changed due to motherhood, yet they sometimes fear that others in their work environment question their level of motivation (Himmelweit & Sigala, 2004). More family-friendly work-home cultures were found to correlate positively with job satisfaction and negatively to work-family conflict (Allen, 2001; Thompson et al., 1999). It, therefore, seems reasonable to assume then that a family-friendly work-home culture which signals that obtaining work-life balance is feasible, positively correlates with career motivation (Greenhaus & Beutell, 1985). Our fourth hypothesis (H4) therefore states that women physicians who perceive the work-home culture of their organization as supportive (a high level of career support, work-life balance support and less career hindrance) will have higher levels of career motivation (career centrality, career insight, and career ambition) than women physicians who perceive the work-home culture of their organization as less supportive.

Mediating roles of views on motherhood and supportive work-home cultures

In addition to the direct effects discussed above, it can be expected that views on motherhood and a supportive work-home culture will mediate the alleged negative correlation between having children and career motivation. A women physician’s view on motherhood determines how she positions her career with regard to raising children. Furthermore, many organizations believe that by offering family-friendly benefits and providing a supportive work-home culture, they retain women – especially mothers – who would otherwise drop out of their career paths (Lewis, 2001). Our fifth (H5) hypothesis therefore is: women physicians with children – particularly those whose youngest child is a preschooler or in elementary school – will have lower levels of career motivation, but that this relationship is mediated by their views on motherhood and their perception of the supportiveness of the work-home culture.

An overview of the hypothesized relationships is provided in Figure 1.
Figure 1 Conceptual model

- View on Motherhood
  - Time Allocation
  - Role model

- Career Motivation
  - Career Centrality
  - Career Insight
  - Career Ambition

- Work-home Culture
  - Career Support
  - Support for Work-life Balance
  - Absence of Career Hindrance

- Children
  - preschoolers (< 5)
  - elementary school (5-12)
  - secondary school (>13)

- Career Support

*Women physicians without children serving as reference group.*
4.3. Data

Participants
To test our hypotheses, a national cross-sectional survey was conducted in the Netherlands in summer of 2008. The survey was sent to a representative sample of 3,426 women physicians (including physician assistants). Age (between 25 and 50 years) and specialty (all specialties) were used as criteria to select the physicians from an official database of all the medical registration commissions in the Netherlands (KNMG), in which all physicians in the Netherlands are registered. Respondents were invited to participate by letter and asked to visit the website where the online questionnaire was posted. To participate, they needed the personal log-in code provided in the letter. After three months and three reminders by mail and e-mail, 1,070 women physicians had participated in the research, constituting a response rate of 32 percent. The response rate was reasonable, given that the average response rate for web surveys in the Netherlands varies between 25 percent and 45 percent (De Leeuw & De Heer, 2001).

Of the 1,070 respondents, 594 were general practitioners (55.5 percent), 402 were non-surgical specialists (37.6 percent) and 74 were surgeons (6.9 percent). These proportions closely match the overall figures for Dutch women physicians (Van der Velden et al., 2008). Their average number of actual working hours was 42.18 per week (SD=11.81) and the average number of years of work experience as a medical physician was 10.27 years (SD=6.11). The average age of the respondents was 36.8 (SD=6.51). The average age of the respondents when they first became a mother was 31.8 years (SD=3.32), which is slightly higher than average for highly educated mothers in the Netherlands (31.0). The majority of the women (955) in our sample had a partner (89.2 percent) and most also had children (61 percent). Of those with children, 38.9 percent had a youngest child who was a pre-schooler, 20.4 percent had a youngest child in elementary school, and 1.7 percent had a youngest child older than 13 years old (in secondary school or no longer attending school).

Materials
The scales used in this study were subjected to principal axing factor analyses with oblimin rotation. The results are summarized in Table 1. Where a clear factor structure was confirmed, the items were summed and averaged to create indices for each scale. Internal reliability was assessed using Cronbach’s alpha. For the scales relating to ‘Career Motivation’, ‘Views on Motherhood’ and ‘Work-home Culture’, items were measured on a five-point Likert scale ranging from 1 “totally disagree” to 5 “totally agree.”
Table 1  Scales, item examples and scale characteristics, means and standard deviations (SD) and significance of differences in means

<table>
<thead>
<tr>
<th>Scales and dimensions</th>
<th>No. of items</th>
<th>Examples of Items</th>
<th>Total variance explained %</th>
<th>Cronbach’s alpha</th>
<th>All communalities &gt; than</th>
<th>All loadings &gt; than</th>
<th>Mean (SD) Women without children</th>
<th>Mean (SD) Women with children</th>
<th>Sign, difference means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Career Motivation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Career Centrality</td>
<td>6</td>
<td>“I am very focused on my career” “I get the most satisfaction in life out of my career”</td>
<td>60.</td>
<td>.85</td>
<td>.33</td>
<td>.58</td>
<td>3.0 (.66)</td>
<td>2.7 (.63)</td>
<td>***</td>
</tr>
<tr>
<td>Career Insight</td>
<td>3</td>
<td>“I have formulated clear career goals for myself” “I have developed a strategy how to obtain my career goals”</td>
<td>72.0</td>
<td>.81</td>
<td>.51</td>
<td>.72</td>
<td>3.3 (.60)</td>
<td>3.2 (.60)</td>
<td>***</td>
</tr>
<tr>
<td>Career Ambition</td>
<td>4</td>
<td>“I want to obtain a top position in my field” “I want to obtain a position with a higher salary level”</td>
<td>60.6</td>
<td>.78</td>
<td>.37</td>
<td>.61</td>
<td>3.0 (.67)</td>
<td>2.8 (.73)</td>
<td>***</td>
</tr>
<tr>
<td>Views on Motherhood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Allocation</td>
<td>7</td>
<td>“I want to spend much time with my children” “I find it important to share breakfast and dinner together with my children during the (work) week”</td>
<td>41.9</td>
<td>.77</td>
<td>.25</td>
<td>.51</td>
<td>3.3 (.57)</td>
<td>3.1 (.60)</td>
<td>***</td>
</tr>
</tbody>
</table>
| Role Model (R) | 2 | “I believe it is important to set an example as a working parent for my children”
| | | “I find it very important to show my children that my career is as important as that of my partner”

<table>
<thead>
<tr>
<th>Work-home Culture</th>
</tr>
</thead>
</table>
| Career Support | 5 | “I believe my supervisor supports me in obtaining a higher position”
| | | “My colleagues support my professional development”

<table>
<thead>
<tr>
<th>Support for Work-life Balance</th>
</tr>
</thead>
</table>
| | 6 | “My colleagues show their sympathy when I have to leave work unexpectedly due to unforeseen circumstances at home”
| | | “Within our organization (staff) supervisors believe it is important that employees have enough time for their private life next to their work”

<table>
<thead>
<tr>
<th>Absence of Career Hindrance (R)</th>
</tr>
</thead>
</table>
| | 7 | “I this organization, MDs are expected to prioritize their work over their private lives”
| | | “To advance in this organization, MDs are expected to work overtime on a regular basis”

N=758
(R) refers to reversed items.
***p < 0.001; n.s. not significant
<table>
<thead>
<tr>
<th></th>
<th>74.5</th>
<th>.65</th>
<th>.49</th>
<th>.69</th>
<th>2.2 (.71)</th>
<th>2.0 (.68)</th>
<th>***</th>
</tr>
</thead>
<tbody>
<tr>
<td>59.7</td>
<td>.83</td>
<td>.36</td>
<td>.60</td>
<td>3.8 (.57)</td>
<td>3.7 (.65)</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>52.1</td>
<td>.82</td>
<td>.40</td>
<td>.41</td>
<td>3.5 (.63)</td>
<td>3.7 (.64)</td>
<td>***</td>
<td></td>
</tr>
<tr>
<td>52.1</td>
<td>.85</td>
<td>.34</td>
<td>.57</td>
<td>2.9 (.68)</td>
<td>2.9 (.68)</td>
<td>n.s.</td>
<td></td>
</tr>
</tbody>
</table>
Explaining career motivation among Dutch women physicians

Career motivation

The career motivation items were based on the Career Motivation Inventory (London, 1997), the Emancipation Monitor (SCP, 2008), and a Proactive Coping Scale (Ouwehand, 2005). Using principal axes factor analysis (PAF, Oblimin rotated), three sub-dimensions were identified, namely career centrality, career insight and career ambition (see Table I).

Views on motherhood

This instrument has two dimensions: Time Allocation and Role model. The scales were specifically designed for this study and tested in a pilot study. Women with no children were also asked what they thought about the propositions concerning parenting (see Table I).

Perceived supportiveness of work-home culture

To measure the organizational supportiveness of the work-home culture, the eighteen-item Work-Home Culture Scale developed by Dikkers et al. (2007) was used. Three sub-dimensions of the supportive work-home culture were identified, namely Career Support (CS); Work-Life Balance Support (WLB) and Absence of Career Hindrance (ACH).

Age of the youngest child

On the basis of whether respondents had children and the age of their youngest child, four categories were distinguished: 1) women physicians whose youngest child is a pre-schooler; 2) women physicians whose youngest child is in elementary school; 3) women physicians whose youngest child is in secondary school or no longer in school (thirteen years or older); and 4) women physicians with no children. The latter served as a reference group in the analyses.

Control variables

The control variables were the respondent’s actual working hours per week, her years of work experience as a physician, her medical specialty (0=general practitioners; 1=non-surgical specialists; and 2=surgical specialty), her age and whether or not she has a partner (1=yes, has a partner).
4.4. Methods

A one-way analysis of variance (see Table I) was conducted to determine whether women physicians with and without children differ significantly in their views on motherhood and the supportiveness of the work-home culture. To test the direct (first step) and indirect (second step) effects of motherhood and the number of children in different age categories, the multiple mediator model as discussed by Preacher & Hayes (2004) (see Table II) was used.

The regression analyses were conducted after the listwise deletion of missing values. The number of cases included in the analyses was N=758.

4.5. Results

Having children and views on motherhood

As the results in Table I reveal, it seems that women physicians without children have significantly higher levels of career motivation and are more traditional in their views on motherhood. Regarding the work-home culture, women physicians without children perceive their work environment as significantly more supportive towards their career goals, yet significantly less supportive for attaining a work-life balance, compared to women physicians with children.

Firstly, the independent variable ‘age of the youngest child’ was entered in the regression analysis. The significant relationships between our independent and dependent variables are summarized in Table II.

The results show that women physicians with a youngest child in elementary school are significantly less traditional in their opinions regarding time allocation. Women whose youngest child is a pre-schooler and women with a youngest child in secondary school believe that it is important to be a good role model as a working mother for their children, and more so than women without children (see Table II). It can thus be concluded that women physicians with children – though not particularly those whose youngest child is a pre-schoolers or in elementary school – have less traditional views on motherhood than women physicians without children. Our first hypothesis, which predicted that women physicians with children would hold more traditional views on motherhood, is thus not supported.
Table II  Unstandardized direct, indirect and total effects of age of the youngest child, views on motherhood and supportiveness of the work-home culture on women physicians’ career centrality, career insight, and career ambition

<table>
<thead>
<tr>
<th>Mediating variables</th>
<th>Career centrality</th>
<th></th>
<th></th>
<th>Career insight</th>
<th></th>
<th></th>
<th>Career ambition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Direct effect</td>
<td>Indirect effect</td>
<td>Total effect</td>
<td>Direct effect</td>
<td>Indirect effect</td>
<td>Total effect</td>
<td>Direct effect</td>
<td>Indirect effect</td>
</tr>
<tr>
<td></td>
<td>TA</td>
<td>RM</td>
<td>CS</td>
<td>WLB</td>
<td>CH</td>
<td>TA</td>
<td>RM</td>
<td>CS</td>
</tr>
<tr>
<td>View on Motherhood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time allocation (TA)</td>
<td>-.136***</td>
<td>.012</td>
<td>-.087*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Role model (RM)</td>
<td>-.191***</td>
<td>-.113***</td>
<td>-.152***</td>
<td></td>
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<tr>
<td>Work-home culture</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Career support (CS)</td>
<td>.067*</td>
<td>.074*</td>
<td>.110*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for WLB (WLB)</td>
<td>-.013</td>
<td>.021</td>
<td>.004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Career hindrance (CH)</td>
<td>-.058*</td>
<td>-.079*</td>
<td>-.128**</td>
<td></td>
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</tbody>
</table>

Explaining career motivation among Dutch women physicians
### Independent variables

*Age of youngest child:*

<table>
<thead>
<tr>
<th>Age of youngest child</th>
<th>0.019</th>
<th>-0.114*</th>
<th>-0.007</th>
<th>0.042</th>
<th>-0.055</th>
<th>-0.065</th>
<th>0.021</th>
<th>0.044</th>
<th>-0.091</th>
<th>0.018</th>
<th>-0.073</th>
<th>-0.094</th>
<th>0.022</th>
<th>-0.072</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5 years old</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>5-12 years old</td>
<td>-0.152*</td>
<td>-0.124</td>
<td>0.143*</td>
<td>0.066</td>
<td>0.111</td>
<td>-0.007</td>
<td>0.047</td>
<td>0.039</td>
<td>-0.095</td>
<td>0.015</td>
<td>-0.080</td>
<td>-0.011</td>
<td>0.034</td>
<td>0.023</td>
</tr>
<tr>
<td>≥ 13 years old</td>
<td>-0.016</td>
<td>-0.374*</td>
<td>0.248</td>
<td>0.221</td>
<td>-0.160</td>
<td>-0.003</td>
<td>0.097</td>
<td>0.093</td>
<td>0.207</td>
<td>0.078</td>
<td>0.285</td>
<td>0.055</td>
<td>0.107</td>
<td>0.162</td>
</tr>
<tr>
<td>Adj. R²</td>
<td>0.298***</td>
<td></td>
<td></td>
<td></td>
<td>0.064***</td>
<td></td>
<td></td>
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</table>

The program INDIRECT by Preacher & Hayes (2006) was used to assess the significance of the indirect effects. The standard errors of the indirect effects are obtained by bootstrapping using 1,000 bootstrap samples. The standard errors for the other effects are obtained by OLS. The parameters estimates are controlled for specialty, years of work experience, respondent's age, actual working hours per week and having a partner.

Reference category is women physicians without children.

*** p < .001; ** p < .01 * p < .05, one-tailed.
Having children, age of the youngest child and supportiveness of the work-home culture

Table II show that only women physicians with a youngest child in elementary school believe their work environments offer more support for their career than women physicians without children. For women whose youngest child is a pre-schooler and those whose youngest child is in secondary school, no significant differences were found in their perceptions of the supportiveness of the organizational work-home culture compared to their childless counterparts. Our second hypothesis – namely that women physicians with children, particularly those whose youngest child is a pre-schooler or in elementary school, are less positive about the organizational work-home culture than women physicians without children – is thus not supported by our data.

Views on motherhood and career motivation

Table II (the ‘total effect’ column) shows that the more traditional women physicians’ views on motherhood are (both with regard to time allocation and being a role model), the lower their levels of career centrality, insight and career ambition. Only women physicians’ views on time allocation did not significantly affect their career insight. Our third hypothesis is therefore supported, for the most part: women physicians with more traditional views on motherhood have lower levels of career motivation than women physicians with less traditional views on motherhood. A comparison of the standardized effects (not reported in Table II) showed that the positive effect of wanting to be a role model for their children on all three dimensions of career motivation was stronger ($\beta = -.163$; $p < .001$; reversed scale) than the negative effect of holding traditional views on time allocation (e.g., for career centrality $\beta = -.225$; $p < .001$).

Supportive work-home culture and career motivation

The results show that support for work-life balance has no significant effect on any of the dimensions of career motivation (see Table II). However, women physicians who perceive their organization's work-home culture as supportive in terms of their career goals, also report higher levels of career centrality, career insight and career ambition than colleagues who do not feel supported. To our surprise, the results showed that women physicians who do not feel hindered in their career (those with a high score on the absence of career hindrance) reported lower levels of career centrality and career insight (general and focused). In other words, those who feel hindered in their careers have higher levels of career motivation. The fourth
hypothesis, which predicted that a supportive organizational work-home culture would have a positive effect on the career motivation of women physicians, thus turns out to be only partially supported.

**Views on motherhood and work-home culture as mediating factors**

Our first step was to test the direct effects of having children and the age of the youngest child on views on motherhood and the perceived supportiveness of the organizational work-home culture on one hand, and the direct effects of views on motherhood and the supportive work-home culture on career motivation, on the other. The second step of the analysis, in which we tested whether views on motherhood and the perceived supportiveness of the work environment have any mediating (indirect) effects on the career motivation of women physicians, will now be discussed.

Table II show that none of the direct effects of having children or youngest child in a certain age category have a significant effect on any of the dimensions of career motivation (see Table II, columns ‘direct effect’). Moreover, no significant indirect effects of having children on career motivation via views on motherhood or supportive work-home culture were found (see Table II, “indirect effect” columns). The total effects (direct effects plus the indirect effects) are non-significant, and there is thus no significant mediating effect (Baron & Kenny, 1986).

To summarize, women physicians with children, regardless of the age of the youngest child, do not differ significantly in their career motivation from women physicians without children. Also, the relationship between having children and women physicians’ career motivation is not mediated by their views on motherhood, nor by the perceived supportiveness of the organizational work-home culture. Our fifth hypothesis is therefore not supported by our data.

**Control variables**

Besides the respondents’ medical specialty and working hours, other control variables such as their age, number of years of work experience and whether they have a partner, did not have any significant effect on the dependent variables.
4.6. Conclusion and discussion

Overall, the results showed that neither having children nor the age of the youngest child has any significant effect, direct or indirect, on women physicians' career motivation. The general assumption that motherhood has a negative effect on women physicians' career motivation is thus not supported by this study. However, our analyses also demonstrated that views on motherhood and the supportiveness of the organizational work-home culture do play an important role in explaining working women physicians' career motivation.

Surprisingly, women physicians with children have less traditional views on motherhood regarding their time allocation and believe that it is important to be a role model for their children as a working mother with a career. There are two possible explanations for the fact that women physicians with children hold a less traditional view on motherhood. Firstly, women physicians with children could have adjusted their views on motherhood over time and have become more flexible when it comes to dividing their scarce time between care and career. Secondly, this finding may also indicate a selection effect: women physicians with very traditional views on motherhood either decide not to have children or become stay-at-home mothers.

Another important finding was that among women physicians, the more traditional their views on motherhood are, the less motivated they are to strive for career advancement. What is interesting in that respect is the finding that the positive effect of wanting to be a role model for their children on career motivation was stronger than the negative effect of a traditional attitude to time allocation. The stronger effect of wanting to be a role model provides an interesting perspective on current policies, arrangements and practices on the part of government and employers. These policies often broadcasting the importance of the work-life balance, with the underlying message that combining work with family life is stressful, increases levels of cognitive dissonance (Bertie, Himmelweit & Trigg, 2006) – or at least increases the ‘cognitive combat’ between two conflicting roles. An alternative strategy through which to encourage working women to maintain their initial career motivation would be to emphasize the positive aspects of being a working mother – namely, providing a role model for the next generation.

Our findings regarding the effectiveness of family-friendly work-home cultures in organizations are in line with the previous argument. The positive effect of a supportive work-home culture on career motivation has
been shown to depend primarily on the perceived support for one's career, and strangely enough, not on support for the work-life balance. Organizations increasingly offer fringe benefits to support the work-life balance of their employees. The results of our study suggest that such policies and practices to improve the work-life balance of employees could be a 'hygiene factor' (Herzberg, 1966): not offering these benefits could negatively affect the career motivation of women workers, but offering them does not positively affect their career motivation. For that, individual support for career goals from supervisors and colleagues appears to be more effective. The negative effect of the perceived absence of career hindrance on women physicians' career motivation could be due to a selection effect. It could be that only very ambitious women experience career hindrance, which would explain our findings. Our results are all based on cross-sectional data, which prevents us from drawing any conclusions regarding causal relationships between the individual view of women physicians on motherhood, the perceived work-home culture in her organization and her career motivation. Longitudinal research is needed to further explore these relationships.

This research has provided evidence that 'maternal employment' is something else than 'maternal career motivation' and should thus not be approached as its equivalent. Highly educated working women with children, especially those working in Dutch hospitals, have already put their careers before their families and private lives. Governments and employers should develop policies which stop treating working women primarily as mothers with 'one foot outside the office door', due to the small proportion of highly educated women who decide to quit their jobs. Future studies and government policies should focus more on how working women with children can be supported in aiming for positions that suit their prior efforts, rather than solely offering fringe benefits for work-life balance expecting that it fixes the gendered inequality in top medical positions.
FEMINIZATION OF THE MEDICAL PROFESSION: A STRATEGIC HRM DILEMMA?

The effects of family-friendly HR practices on women physicians’ contracted working hours

This chapter will appear as:
Abstract

Health care institutions face a strategic HR dilemma. They need to attract women physicians from a tight, feminized labor market by offering family-friendly HR practices (e.g., part-time employment), often based on Collective Labor Agreements (CLAs), meanwhile trying to contain their labour costs by employing as many full-timers as possible. In this study we investigate which family-friendly arrangements serve health care institutions' HR strategies best in terms of retaining women physicians' working hours.

Data collected in 2008 from 1,070 Dutch women physicians indicate that offering family-friendly HR practices such as flexible working hours (in contrast to part-time working) minimize the strategic HR dilemma since it offers scope for improving the work-life balance without encouraging women physicians to work less hours. However, the effect of family-friendly arrangements on working hours is dependent on the family-friendly workforce philosophy: only with proper support for career goals do women using family-friendly arrangements work more hours.
Chapter 5

5.1. Introduction

The health care industry in the Netherlands is, as in many other countries, characterized by long working hours and the high personal demand it places on employees to provide good quality care (Heiligers & Hingstman, 2000). Furthermore, in most European countries more women enter the medical profession, ranging from 50% of all medical practitioners being women in Finland to an average of 35% for other European countries such as France, Germany and the UK (McKinstry et al., 2006; Van der Velden et al., 2008; OECD, 2009). Together with the feminization of the medical profession, there is a worldwide trend among male and women physicians to work less hours (De Jong, Heiligers, Groenewegen, & Hingstman, 2006). For example, in the UK, the number of physicians working part-time slowly increased over the last five years, with currently 8.4% of the British male physicians working part-time, compared to 20.6% of the women physicians (NHS Information Centre, 2010). This trend of working part-time as a medical physician is in clear contrast with the increasing demand for health care services and the shortage of health care professionals. As a result, hospitals depend heavily on the growing number of women physicians in the medical profession and their willingness to work (Shewchuk & Sherrill, 2010).

The Dutch health care industry is currently characterized by cost-containment strategies, which include keeping down labor costs (Schut & Van de Ven, 2005). In order to reduce labor costs and optimize their human capital (Becker, 1993), medical institutions will first try to hire as many full-timers as possible because replacing one full-timer with, say, two part-timers involves twice the level of quasi-fixed costs (such as administrative costs, costs for searching, hiring and training a new worker) (Montgomery, 1988). This is particularly true within large organizations, such as hospitals where unionization is widespread and Collective Labor Agreements (CLAs) are in force. Considerable amounts are invested in staff training, leading to higher administrative costs (Montgomery, 1988). In view of all that, the more contracted hours women physicians are willing to work, the greater it will benefit the health care institution’s competitive strategy. So while health care institutions strive to optimize their human capital and organizational performance by keeping their quasi-fixed labor costs as low as possible, they also need to ensure that they attract and retain medical specialists in a labor market characterized by a shortage of supply. According to the standard causal model for the relationship between HRM and performance (Boselie et al., 2005), both HR strategies - the first concerning attracting and retaining medical physicians by satisfying their need for work-life balance, the second
Feminization of the medical profession: a strategic HRM dilemma?

Striving for optimization of human capital - are translated into HR activities, such as offering family-friendly arrangements (Giardini & Kabst, 2008). However, HR activities, such as family-friendly arrangements, can also result in different and less desired HR related outcomes. For example, although offering part-time working arrangements could benefit the HR strategy of preventing women physicians' turnover intentions, it meanwhile jeopardizes the HR strategy of optimizing human capital in which organization benefit most from full-time working employees. Women physicians' working hours can thus be perceived as a desired HR-related outcome regarding the first HR strategy. However, women physicians' (possible decline in number of) working hours can also become an undesired HR-related outcome in terms of the second HR strategy, since it increases labour costs and thus negatively affects organizational performance.

This strategic HR dilemma provides the starting point for this study and leads us to the following research question: which family-friendly HR practices are best suited to combine both the demands of the labor market (external pressures) with organizations' internal (cost-containment) strategies? To deal with both sides of this dilemma, we propose to divide our research question into two parts. Firstly, we are interested in whether the feminization of the medical profession (Van der Velden et al., 2008) – which has resulted in the preference for working fewer hours (Heiligers & Hingstman, 2000) – affects the number of family-friendly arrangements that health care institutions (e.g., hospitals) offer to women physicians. Besides feminization, large health care institutions in particular have to concede to the wishes of other parties, such as trade unions and other representatives, since a disregard for their institutional environment would increase the risk of strikes and legal claims (Boon, Paauwe, Boselie, & Den Hartog, 2009; Goodstein, 1994). Konrad and Mangel (2000) showed a positive correlation between the percentage of women employed and the development of more extensive work-life programs in large US (non-healthcare) organizations. To date, however, we have no insight into whether the feminization of certain medical specialties and the presence of CLAs, which would suggest high external pressures to maintain a certain 'institutional' fit, can explain differences in what is offered to women physicians in terms of family-friendly HR practices (from hereon referred to as 'family-friendly arrangements').

The second part of our research question deals with the effects of the family-friendly arrangements offered on the working hours of women physicians. Following a recent trend in SHRM literature, we combine Organizational Behavior (OB) literature with that of SHRM (Paauwe, 2009; Wright & Nishii, 2004). OB research mainly focuses on how people, individuals and groups act
in organizations and – especially in the more psychological research areas - focuses mainly on the individual level (Boselie, 2010). Strategic HRM (SHRM) is the part of HRM theory and research that deals with the link between the business strategy, designing high performance work systems (HPWS), and adding value through HRM activities in order to obtain competitive advantage (Gerhart 1996; Boselie, 2010; Delery & Doty, 1996; Kaarsemaker & Poutsma, 2006). HPWS are separate, but interconnected, HR practices such as selection procedures, incentive compensation which are designed to enhance employee and firm performance outcomes through improving workforce competence, attitudes, and motivation (Huselid, 1995). SHRM researchers nowadays stress the importance of including the individual level of analysis (Wright & Nishii, 2004; Paauwe, 2009) in studying HRM and (organizational) performance in which HR practices serve as communication mechanisms signaling employees to engage in certain behaviors (Wright and Nishii, 2004). By combining insight from OB literature on the effects of family-friendly arrangements on the individual level with insights from SHRM literature, this study contributes in three ways.

Firstly, studies on family-friendly arrangements so far focused on whether the use of these provisions correlates with outcomes related to the individual employee, such as reduced work-life conflict (e.g., Saltzstein, Ting, & Saltzstein, 2001) and job attraction (Honeycutt & Rosen, 1997). However, these studies mostly focus on the effects on the individual level (Coombs et al. 2007), whilst insights in possible counter-effects on organizational performance could be helpful when seeking to explain the lack of uptake of family-friendly arrangements, or establishing supportive work-home cultures (Lewis, 1997).

Secondly, SHRM research also carries certain limitations, such as an overrepresentation of traditional HRM practices and exclusion of more recent developments such as family-friendly arrangements (Boselie et al., 2005; Kaarsemaker & Poutsma, 2006). By offering these arrangements, organizations expect to improve work performance and productivity (Plantenga & Remery, 2006). Whether organizational performances indeed improve due to family-friendly arrangements has hardly been studied so far (Giardini & Kabst, 2008).

Thirdly, SHRM researchers generally agree that HR practices are at least weakly related to firm performance (e.g. Paauwe & Boselie, 2005; Wright & Boswell 2002). As stated earlier, employees' perceptions of HR practices ('perceived HRM practices') should be included in the analyses to further explain how HR activities affect organizational performance. For example, perceived HR practices could differ substantially from intended HR practices,
nor are they always similar to the actual HR practices as implemented in the organization (Wright & Nishii, 2004). Next to employees' perception of offered HR practices, SHRM researchers have addressed the important of HR practices fitting in the organization's work climate. Researchers in SHRM speak of 'strength of the HRM system' (Bowen & Ostroff, 2004; p. 204) and a 'workforce philosophy' (Kaarsemaker & Poutsma 2006; p. 671-674). The latter refers to (senior) management's "values, beliefs about the relative role and value of workers" (Kaarsemaker & Poutsma 2006, p. 671). The workforce philosophy (and also system strength) addresses the extent to which HR practices are integrated into the organization's culture, on which 'the choice and allocation of HRM practices is ultimately founded' (p. 674). Researchers in OB, on the other hand, speak of a construct called the 'perceived supportive work-home cultures', which stresses the values and beliefs that supervisors and colleagues hold regarding the importance of work-life balance, according to the employee. In this study, we are interested in both attitudes surrounding the value of employees (human capital) and attitudes surrounding employees' work-life balances. Here, we speak of the family-friendly workforce philosophy, to refer to the perceived support (or lack of it) from supervisors and/or colleagues for career goals (as a token of their value as human capital) and work-life balance, according to Dutch women physicians. Researchers (e.g. Lewis 1997; Thompson, Beauvais, & Lyness, 1999) have often pointed out that the effectiveness of family-friendly arrangements is key to the organization's family-friendly workforce philosophy, suggesting that a certain level of 'system strength' – proper interaction between HR practices and organizational culture – is necessary to achieve desirable HR outcomes. We are therefore also interested in whether a family-friendly workforce philosophy interacts in the relationship between family-friendly arrangements and contracted working hours.

Family-friendly arrangements are often bundled according to their precise nature (e.g. flexible facilities versus childcare facilities) (e.g., Glass & Estes, 1997) or according to statistical analysis (i.e. principal axing factor analysis) (Perry-Smith & Blum, 2000). As Guest et al. (2004) suggest, we rely here on a theoretical basis for bundling family-friendly arrangements, by anticipating the effect that family-friendly arrangements will have on women physicians' contracted working hours. For instance, most health care organizations offer part-time work or reduced hours arrangements, part-time (medical) training programs, or (additional) leave arrangements. We define these arrangements as 'reduced participation arrangements' (RPAs), since if taken up they will result in a reduction of employees' contracted working hours. In addition to the RPAs, organizations also offer arrangements that
do not necessarily affect the number of contracted working hours, or may even increase working hours. Examples of such arrangements are onsite childcare, flexible working hours, and work-life balance training programs. In this study, these arrangements are referred to as ‘full participation arrangements’ (FPAs).

To summarize, our study contributes to current literature by providing insight into i) the effect of the feminization of the medical profession and the presence of CLAs on offered family-friendly HR practices; ii) the effectiveness of offered and used family-friendly HR practices (RPAs and FPAs) on the organizational performance of health care institutions, as measured in terms of women physicians’ working hours; iii) the effect of employees’ perceptions regarding the family-friendly workforce philosophy on contracted working hours; and iv) the moderating effect of the perceived family-friendly workforce philosophy on the relationship between the family-friendly HR practices used and women physicians’ contracted working hours.

5.2. Theoretical background and hypotheses

Dealing with external pressures

We are interested in whether the feminization of medical specialties and the presence of CLAs can account for differences in what is offered in terms of family-friendly arrangements. Overall, the medical profession in the Netherlands is feminizing, with 35% of the medical specialists and 56% of the medical specialists currently in training being women (Van der Velden et al., 2008). However, the percentages vary by medical specialty; for example, only 5 to 10% of surgeons in 2007 were women (and less than 30% of the surgeons in training). On the other hand, in clinical genetics, clinical geriatrics, pediatrics and health care for the mentally handicapped, to name a few, women make up the large majority of practitioners (> 75%). This difference in feminization of medical specialties is reflected in a gender segregation in the health care industry (Boulis, 2004). We expect that health care institutions who are dealing with more feminized medical specialties (e.g., elderly homes or mental health care institutions) will respond to this situation by offering more family-friendly arrangements than institutions that are less dependent on and affected by feminized specialties (e.g., private clinics for (plastic) surgery). Moreover, according to Boon et al. (2009), large organizations, such as hospitals, will seek to align their HRM strategy and the institutions’ environment, creating an ‘institutional’ fit. Organizations
which negotiate with unions over employees' rights and benefits, as laid down in CLAs, could thus be more inclined to offer family-friendly arrangements than organizations which are not obliged to adhere to such agreements - treating each request for staff benefits independently and differently. Our first set of hypotheses is, therefore:

**H1a:** The feminization of medical specialties (working within health care institutions) has a positive effect on the number of family-friendly arrangements (RPAs and FPAs) offered.

**H1b:** The presence of CLAs has a positive effect on the number of family-friendly arrangements (RPAs and FPAs) offered.

**Family-friendly arrangements and contracted working hours**

It is often argued that women physicians prefer to work in health care institutions – or specialties – which permit them to work part time or in which the male, full-time work ethic is less prevalent (Heiligers & Hingstman, 2000; Soethout, Van der Wal & Ten Cate, 2007). Several researchers (e.g., Kaarsemaker & Poutsma, 2006; Pfeffer, 1981) argue that experiences within an organization, and specifically with relation to HR practices, shape employee beliefs regarding the terms of the employee-organization exchange relationship (i.e. the psychological contract) and that certain HR practices can help an organization send a consistent message to employees regarding mutual expectations. The consistency of the message plays an important role in the effectiveness of HRM practices. The message sent out by the HRM policies or bundle of HRM practices, will affect employees' perceptions of what is expected from them or at least, which behavior is acceptable (Kaarsemaker & Poutsma, 2006). The more the organization is perceived as trustworthy in its family-friendliness by future employees, which can be achieved by offering a wide range of family-friendly arrangements, the more this organization will be able to attract those employees who are seeking part-time or flexible employment. Also, women physicians already working for the organization who struggle with time demands will be more inclined to reduce their contracted working hours - if they wish to do so - perhaps instead of quitting their jobs altogether.

We expect RPAs and FPAs to affect the contracted working hours of women physicians differently. On the one hand, offering RPAs will send out the signal that it is acceptable to work part-time for the benefit of one's work-life balance. Offering FPAs, on the other hand, signals that the organization is willing to help women physicians to maintain or even increase their contracted working hours, while balancing work and family.
Notice that most large Dutch organizations (such as hospitals) often offer both RPAs and FPAs, yet we assume that their effect on working hours differs. Our second hypothesis therefore is:

**H2a**: The more RPAs a HCI offers, the less contracted hours women physicians work.

**H2b**: The more FPAs a HCI offers, the more contracted hours women physicians work.

The family-friendliness of the workforce philosophy can send out mixed signals to employees. Here, we distinguish between three dimensions of the family-friendly workforce philosophy, namely i) employees’ perceptions of support for their work-life balance, ii) employees’ perceptions of a deterioration in their career prospects when – for instance – working part-time (from here on referred to as career hindrance), and iii) perceived support for one’s career goals. Den Dulk and Peper (2006) define these mixed signals as ‘contradictory work-home cultures’ in their research, meaning that although employees feel supported in achieving a work-life balance, they also admit to feeling that the organization values full-time workers above all, providing them with more career support and advancement than part-timers. These contradictory perceptions and expectations can have various effects on the number of hours worked. For instance, other research (Pas et al., 2008) has shown that women physicians who feel supported in achieving their career goals are more motivated to work hard to achieve these goals, which extends to a willingness to work longer hours if necessary. We thus expect that perceived support for work-life balance and the absence of career hindrance will result in fewer contracted working hours. Perceived support for career goals, on the other hand, will have the opposite effect on women physicians’ contracted working hours, since in this case the organization is sending out a signal that employees are valued and needed (Grover & Crooker, 1995). Note that a women physician may perceive the family-friendly workforce philosophy to be supportive of a work-life balance, without fear of any negative career impact, and yet at the same time feel supported in achieving her career goals, even though this might affect her decisions on time allocation differently.

**H3a**: Women physicians who perceive the family-friendly workforce philosophy as supportive of work-life balance and absence of career hindrance, work fewer contracted hours than women physicians who do not feel supported.

**H3b**: Women physicians who perceive the family-friendly workforce philosophy as supportive in achieving their career goals work longer contracted hours than women physicians who do not feel supported.
Offering the opportunity to work part-time can imply a better ‘institutional’ fit (Boon, et al., 2009), if this corresponds with the (future) employees’ preferences to work reduced hours so that they can combine work with family life. Yet, this may not always be the most effective and efficient option in terms of organizational or HRM goals, such as implementing a cost-containment strategy (Jaffee, 2001). This HRM dilemma holds particularly true for RPAs, since the use of these arrangements can be expected to have a negative effect on contracted working hours. However, FPAs may not have a negative effect on working hours, and could even have a positive effect, since they offer the possibility of combining work and family life, without necessarily reducing employees’ working hours. We thus hypothesize that:

**H4a:** Use of RPAs has a negative effect on women physicians’ contracted working hours.

**H4b:** Use of FPAs has a positive effect on women physicians’ contracted working hours.

Although most hospitals offer family-friendly arrangements, research has shown that hospitals in particular are not so keen on accepting part-time employment as a way of dealing with the demands of the labor market and are thus not perceived as having a family-friendly workforce philosophy (Du Moulin, Heymans, & Noordenbos, 2000; Heiligers & Hingstman, 2000). The effectiveness of family-friendly arrangements in improving HR outcomes, such as reducing work-life conflict, is highly dependent on the support that is perceived to be forthcoming from supervisors and colleagues in terms of enhancing the employee’s work-life balance (or career hindrance) (Dikkers et al., 2007; Lewis, 1997; Thompson et al., 1999). We therefore believe that the family-friendly workforce philosophy also affects (moderates) the relationship between the use of RPAs and FPAs on the one hand, and contracted working hours on the other. For example, women physicians who take up the possibility to work part-time will further reduce their working hours if they feel supported in achieving a work-life balance by their supervisors and/or colleagues – which might unintentionally stress their caretaking role – and do not perceive any disadvantage to their career as a result. However, perceived support for career goals – stressing the valuable role of employees within the organization – may temper the negative effect of RPAs on contracted working hours. In other words, we expect the family-friendly workforce philosophy to have different moderating effects in the relationship between family-friendly arrangements and contracted working hours. With regard to the three dimensions of the perceived family-friendly workforce philosophy, we formulate the following four hypotheses:
H5a: Support for career goals tempers the negative effect of RPAs on women physicians’ contracted working hours.

H5b: Support for work-life balance and absence of career hindrance strengthens the negative effect of use of RPAs on women physicians’ contracted working hours.

H5c: Support for career goals strengthens the positive effect of use of FPAs on women physicians’ contracted working hours.

H5d: Support for work-life balance and absence of career hindrance tempers the positive effect of use of FPAs on women physicians’ contracted working hours.

5.3. Data

Participants

To test our hypotheses, we conducted a web survey in the summer of 2008 entitled “Physician and Career”. The survey was sent to a representative sample of the Dutch women population of medical physicians (physicians and assistant physicians). Year of birth (between the age of 25-50) and specialty (all specialties) were used as criteria to select 3,500 women physicians from the official database of medical registration commissions in the Netherlands (KNMG), in which all physicians in the Netherlands are registered. Respondents were invited to participate by letter and asked to visit the website where an online questionnaire was posted. To do this, they needed a personal log-in code provided in the letter. After three months and three reminders by mail and email, 1,070 women physicians had completed the survey, constituting a response rate of 32% (the number of apparent incorrect addresses were distracted from the original sample number). This is a satisfactory figure given that the average response rate for web surveys in the Netherlands varies between 25% and 45% (De Leeuw & De Heer, 2001; Kruijthof, 2005). We are unable to examine if responders to the survey differed from nonresponders in relevant ways, as we lack detailed nonresponder information. However, comparisons of age, medical specialty and working hours distributions in the responding sample with corresponding population figures for Dutch women physicians (Meijer & Heesen, 2005; Van der Velden et al., 2008; Wagenvoort & Lagro-Janssen, 2010) revealed no significant differences.

Our sample included 486 medical specialists and 401 medical physicians in training to become specialists. The remaining 183 medical physicians were neither medical specialists nor in training to become one, and were thus working otherwise as a medical physician (for insurance companies, for
instance). A total of 428 women physicians worked in large health care institutions (e.g., (academic) hospitals), 268 respondents worked in medium-sized health care institutions (e.g., categorical hospitals such as psychiatric institutions or rehabilitation centers) and 349 women physicians in small health care institutions (e.g., private clinics, GP practices). The average number of years of work experience as a medical physician was 10.27 (SD=6.11). The majority of the women in our sample had a partner (89.2%). Most women in our study also had children (62%).

5.4. Methods

**Contracted working hours**

In line with Heiligers and Hingstman, (2000), the analysis used 'contracted working hours' as a continuous dependent variable. In this study, women physicians have an average of 35 contracted working hours per week. Dutch medical physicians have an official maximum of 36 to 40 contracted working hours per week, excluding being on call and night- and weekend shifts. Working more than 36 hours has to be negotiated between employer and employee. An official work week including shifts has a maximum of 52 actual hours.

**Feminization of the medical specialties**

Van der Velden, Hingstman, Heiligers and Hansen (2008), who included their latest estimates for the Capaciteitsorgaan², presented an overview of the number of women physicians in each specialty in 2007. On the basis of the respondents' specialties, we created the dichotomous variable 'feminization' (yes=1, no=0). Any specialty in which more than half the specialists are women (>50%) scored '1' on this variable. In this study, 55% of the women physicians worked in a feminized specialty.

**The presence of CLAs**

In the Netherlands, medical physicians working in an academic hospital are paid by the hospital and work under the terms of a CLA for academic hospitals. This also applies within health care institutions such as elderly homes, mental institutions and the Health and Safety Executives. Medical physicians in training are also on the payroll of an academic or general hospital. There is no CLA when a medical physician works as a partner in a partnership, as a hired medical specialist for a partnership or as a general

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² Dutch Institution that estimates the need for medical specialists in the future.
practitioner or specialist in a private or general practice. The presence of a CLA was measured by a dichotomous variable “CLA” (yes=1, no=0). More than half of the respondents worked in an organization with a CLA (66%).

**Family-friendly arrangements offered**

Based on the expected impact on working hours, we defined two clusters: RPAs and FPAs. Each cluster represents an unweighted summated scale. Nine items constituted the category “arrangements for reduced participation (RPAs)”. It was asked whether one or more of the following arrangements were offered (and used) to the knowledge of the respondent: possibility to work part-time; possibility to participate in part-time training program; whether there were extra maternity-, care-, paternity-, and adoption-leave arrangements on top of the statutory minimum; the possibility of saving up holidays; the possibility of taking sabbatical(s); and the ability to take a part-time management position (job-sharing). Answer categories were ‘not offered/I don’t know’ (0) and ‘offered’ (1) and ‘I do not use this arrangement’ (0) and ‘I currently use this arrangement’ (1). For the summated scale of ‘arrangements for full participation (FPAs)’, fifteen items asked whether one or more of the following arrangements were offered (and used): possibility of flexible working hours (start and end of working day); teleworking; an input into scheduling; ‘mother-contracts’ (as a form of flexible working hours, working during school hours); onsite child care facilities; financial support for child care; offer of childcare arrangements at home; offer of assistance with finding child care outside the home; leave of absence; having a mentor; having a coach; facilities for breastfeeding; work-life balance courses; special support programs for women (getting) in top positions and women’s networks. Due to the single respondents’ answers on what arrangements are offered and used, correlation was tested between offered RPAs/FPAs and use of RPAs/FPAs. The correlation between both sets of arrangements was not too high (Pearson’s r = .350 (p<0.01, two-tailed) between offered and used RPAs; and r = .240 (p<0.01, two-tailed) between offered and used FPAs) and could thus be treated as two separate variables. On average, an HCI offers 2.38 RPAs (out of the 9 suggested arrangements) and 3.71 FPAs (out of the 15 suggested arrangements).

Whether respondents in fact take up the family-friendly arrangements that are offered was measured by a dichotomous variable ‘0’ for not using one or more of the offered RPAs and/or FPAs, ‘1’ for using one or more of the RPAs and/or FPAs offered). A little over of half the respondents made use of RPAs (54%) and FPAs (57%) at the time of the survey.
Perceived family-friendly workforce philosophy

To measure the family-friendly workforce philosophy, we used the eighteen-item Work-Home Culture Scale developed by Dikkers et al. (2007). Based on principle axes factor analysis (PAF, oblimin rotation), we defined three dimensions of the family-friendly workforce philosophy: Career Support (CS) which included items such as 'I believe my supervisor supports me in achieving my career goals' (Cronbach's alpha = 0.83; five items); Support for Work-Life Balance (SWLB) which included, for example 'My colleagues show their sympathy when I have to leave work unexpectedly due to calamities at home' (Cronbach's alpha = 0.82; six items); and Absence of Career Hindrance (ACH) which included items such as 'Employees who (temporarily) reduce their working hours for private reasons are less likely to advance their career in this organization' (Cronbach's alpha = 0.85; seven items).

All family-friendly workforce philosophy items were measured on a five-point Likert scale, with 1 representing "totally disagree" and 5 representing "totally agree". Cases were included in the analysis if they had a valid score on at least three items of each of the dimensions of family-friendly workforce philosophy. This excluded some general practitioners, who often do not have supervisors and/or (direct) colleagues (solo GPs). Including them after missing value analyses (MVA) - even though it was impossible to have an 'objective' perception of a family-friendly workforce philosophy - severely distorted the results and these respondents were therefore excluded.

Women physicians appeared to be fairly satisfied with the support they receive for their career goals and work-life balance (mean = 3.71 and 3.62), yet they also perceived to be hindered in their career due to working part-time (mean = 2.96).

Control variables

Other control variables were the number of years of work experience, whether or not the respondent had a partner (0=no; 1=yes) and whether or not the respondent had children (0=no; 1=yes).

Methods

Descriptive analyses were conducted to identify the following: the number of contracted working hours; the percentage of women working in a feminized specialty; the percentage of women working for organizations with a CLA; the number of family-friendly arrangements offered (RPAs and FPAs); the percentage of women physicians that make use of RPAs and FPAs; and women physicians' perceptions regarding the family-friendly workforce philosophy, as reported above (see Table 1). Pearson correlations were also
obtained to check for multicollinearity, which was only found between ‘years of work experience’ and ‘respondent’s age’. The latter was thus removed from in further analyses.

Before we could conduct linear regression, we had to center the variables of RPAs and FPAs offered and the three dimensions of the family-friendly workforce philosophy due to high collinearity (see Echambadi & Hess, (2007) for an overview of limitations and techniques for centering in case of multicollinearity). Moreover, to test the direct and interaction effects of RPAs and FPAs offered and used and the family-friendly workforce philosophy on the one hand, and the number of working hours on the other hand, we conducted regression analyses (see Table 1, Model 1 and Model 2). All parameters estimates were controlled for years of work experience, having a partner and having children.

All the regression analyses were conducted after listwise deletion of missing values. The number of cases included in the analyses was N=667.

5.5. Results

Our first linear regression analysis concerned the effect of external pressures, such as the feminization of the medical profession and the presence of CLAs on the number of family-friendly arrangements that health care institutions offer their employees. Feminization had a positive effect on the number RPAs offered ($\beta = .131; p < .001$ one-tailed) (see Table 1, Model 1) and FPAs offered ($\beta = .187; p < .001$ one-tailed). The presence of CLAs also had a significant effect on the number of RPAs ($\beta = .175; p < .001$ one-tailed) and FPAs offered ($\beta = .333; p < .001$ one-tailed). Our first set of hypotheses (H1a/H1b) is thus supported by the data.

Regarding our second set of hypotheses, we expected that offering RPAs would decrease women physicians’ contracted working hours, whereas offering FPAs would increase their contracted working hours. We found that offering RPAs had a significant negative effect on contracted working hours (Table 1, Model 1: $\beta = -.060; p < .05$ one-tailed). We also found that offering FPAs had a significant positive effect on women physicians’ contracted working hours (Table 1, Model 1: $\beta = .065; p < .05$ one-tailed). Our second set of hypotheses is thus also supported by our data (H2a/H2b).

The perceived family-friendly workforce philosophy also plays an important role in explaining women physicians’ contracted working hours. Our results show that women physicians who feel supported in seeking to improve their work-life balance work fewer hours than women physicians...
Table 1 Unstandardized and standardized regression coefficients for direct (Model 1) and interaction (Model 2) effects of offered and used family-friendly arrangements and family-friendly workforce philosophy (career support, support for work-life balance and absence of career hindrance) on contracted working hours per week.

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<th>Offered RPAs</th>
<th>Offered FPAs</th>
<th>Contracted hours</th>
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<td><strong>Independent variables</strong></td>
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<td>.895 .187***</td>
<td>-5.446 .305***</td>
<td>-5.423 .304***</td>
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<td>2.537 .125***</td>
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WLBS * use of FPAs
CH * use of FPAs

**Control variables**

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*Adjusted R Square*  
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*Change in adjusted R square*
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Chapter 5
who do not feel supported in this area (Table 1, Model 1: $\beta = -.154$; $p < .01$ one-tailed). However, women physicians who believe that they will be hindered in their career due to the uptake of family-friendly arrangements, work fewer hours than women physicians who do not perceive to be hindered in their career development (Table 1, Model 1: $\beta = -.027$; $p < .05$ one-tailed). This is contrary to what we expected; hypothesis H3a is therefore only partly supported by our data. However, women physicians who feel supported in seeking to achieve their career goals work more hours than women physicians who do not feel supported in this area (Table 1, Model 1: $\beta = .076$; $p < 0.01$ one-tailed). The second part of our third hypothesis (H3b) is therefore fully supported.

Our fourth hypothesis dealt with the impact that the use of RPAs and FPAs has on women physicians’ contracted working hours. The use of RPAs has a strong negative effect on women physicians’ contracted working hours (Table 1, Model 1: $\beta = -.388$; $p < .001$ one-tailed), whereas the use of FPAs did not have a significant positive effect on contracted working hours (Table 1, Model 1: $\beta = .033$; n.s.), although it does not significantly decrease contracted working hours. Our fourth hypothesis H4a/H4b) is thus partly supported.

Our final set of hypotheses concerned the moderating effect of the perceived workforce philosophy on the relationship between the use of family-friendly arrangements and women physicians’ contracted working hours. It appears that offering support for career goals tempers the negative effect that the use of RPAs has on contracted working hours (Table 1, Model 2: $\beta = .140$; $p < .001$, one-tailed) (see Figure 1, Appendix I, for interaction diagram). Perceived career hindrance tempers the negative effect of the use of RPAs on working hours (Table 1, Model 2, $\beta = -.145$; $p < 0.01$ one-tailed, see also Figure 2 in Appendix I), even though women physicians who do not use RPAs and feel hindered in their career work fewer hours than women physicians who do not feel hindered. We also found that perceived career support had a significant moderating effect on the relationship between the use of FPAs and contracted working hours. It appears that of those women physicians who use FPAs, those who feel supported in achieving their career goals work more hours than those who do not feel supported in achieving their career goals. Looking at the interaction diagram (Figure 3, Appendix I), we can conclude that the use of FPAs causes women physicians to work fewer hours, except where they coincide with a perception that there is support for the physician’s career development, in which case the use of FPAs has a positive effect on contracted working hours. Finally, we found that support for work-life balance has a negative effect on the relationship between the use of FPAs and contracted working hours (see Figure 4, Appendix I). Of those
women physicians who use FPAs, those who feel supported in seeking to improve or maintain their work-life balance work fewer hours than those who do not feel supported in this. Our fifth hypothesis is thus party supported (H5a, H5b H5c and partly H5d), by our data.

5.6. Conclusion and discussion

Healthcare institutions seem to be struggling to find the right balance between making concessions to external pressures such as the feminization of the medical profession and CLAs on the one hand, and trying to survive in a competitive market in which cost containment is crucial on the other. This study contributes to SHRM literature in three ways. First of all, our study showed that women physicians' contracted working hours can be perceived as a desired, as well as an undesired HR-related outcome. Regarding working hours as an HRM outcome perhaps provides an interesting mediator in the relationship between HR practices and organizational performance in future studies. A second contribution to current HR theory is that we introduced contemporary family-friendly HR practices into the debate on the effectiveness of HR practices, meanwhile providing an example how family-friendly practices can be clustered differently based on their expected contribution to HR strategy (e.g., retaining especially women professionals). And finally, we incorporated the effect of the perceived family-friendly workforce philosophy in our research on the relationship between HR practices and working hours, thereby answering to the call of several researchers to include the employee's perceptions in research on HR and performance (Paauwe & Boselie, 2005).

Our study shows that the feminization of the medical profession and the presence of CLAs can partly account for the number of family-friendly HR practices that are offered. This conclusion is open to misinterpretation in terms of the direction of causality, yet it shows that the feminization does, in one way or another, affect organizations' HRM strategies. With the feminization of the medical profession becoming stronger in most European countries – for the Netherlands it is estimated that in 2027 70% of all medical specialties will be feminized (Van der Velden et al., 2008) – there is no way that organizations can avoid dealing with it. Although not hypothesized, our results show that feminization of the medical profession has a negative effect on contracted working hours. Women physicians working part-time thus certainly present a strategic HR dilemma, but there are ways for practitioners to counter these negative effects.
This study showed that offering RPAs has a negative effect on women physicians' contracted working hours (regardless of whether they actually make use of these arrangements), whereas offering FPAs do not negatively affect contracted working hours. It was not our intention to plead for taking away acquired rights such as the Dutch legislation to work part-time. On the contrary, we wanted to show how these rights and retention policies clash with other organizational goals resulting in a strategic HR dilemma. Fortunately, we found that a way of countering the negative effect of feminization is to offer more FPAs, instead of RPAs, since it appears to be an effective alternative in terms of maintaining women physicians' contracted working hours. By offering FPAs, the organization still has to deliver some flexibility in the way work processes are designed, but in return their employees can work more hours resulting in greater (cost) efficiency.

However, our results also show that the family-friendly workforce philosophy impacts on the effectiveness of family-friendly HR practices and could serve as a second strategy in dealing with the strategic HR dilemma of feminization. Where women physicians make use of family-friendly arrangements, we found that perceived career support is particularly effective in tempering the negative effects of part-time working on working hours, while it supports the positive effects that the use of FPAs (flexible arrangements) can have on working hours. Although we did not find a significant positive effect for FPAs on contracted working hours, the use of FPAs does not appear to have a negative effect on working hours and can have a positive effect when women physicians feel supported in achieving their career goals.

Perceived support for achieving work-life balance, however, tempers the positive effect that use of FPA can have on contracted working hours. Perhaps supporting women physicians in improving their work-life balance unintentionally stresses their role as a caretaker, causes women to favor part-time working and reduces the positive effect that FPAs can have on contracted working hours. It should also be noted here that a selection effect may be at work: women physicians who wish to work part-time may already anticipate future work environments and acceptance for part-time work and choose a specialty and/or organization that is known to have a family-friendly organizational culture. However, although they are based on a cross-sectional research design and single informant data, our results do provide an interesting suggestion that colleagues and supervisors are capable of affecting the scope of a part-time job.

The results on perceived career hindrance suggest that women physicians who do not use RPAs (i.e., do not work part-time) have a less negative
perception of career hindrance in their organization than women physicians who actually work part-time. The direction of the causality might play a role in this. An explanation could be that one only experiences career barriers after working part-time for a while. Nevertheless, it illustrates an example of a ‘contradictive work-home culture’ (Den Dulk, 2001) in which women physicians on the one hand believe they are supported regarding work-life balance and their career, yet on the other hand also experience career hindrance. These mixed signals leaves health care professionals in the dark about what behavior is expected. Further research should look into how a family-friendly workforce philosophy affects the ‘psychological contract’ (Guest, 1998), since a good employer-employee understanding can benefit the performance of both the individual and the organization (Perry-Smith & Blum, 2000). In line with that, we suggest investigating how family-friendly arrangements interact with other HR practices, such as career tracks and promotion systems. As long as full-time employees stand a better chance of promotion, such mixed signals will undermine the positive effects (i.e. longer hours) that the family-friendly workforce philosophy can have on organizational performance.

Our study has focused on the effects that the feminization of the Dutch health care sector is having on HRM strategies and how family-friendly practices and the family-friendly workforce philosophy are in turn affecting women physicians’ working hours. More research to combine the perceptions of multiple stakeholders (such as supervisors and HR managers) is needed to shed light on how others perceive the effectiveness of family-friendly HR practices. The perceptions of male physicians in these matters can provide an interesting insight. For instance, research by Heiligers and Hingstman (2000) indicates that male medical physicians would also prefer to work fewer hours. In that case, it is not so much the entrance of women in the medical profession that explains the increase in attention for work-life balance, but a call from all health care professionals for a reduction in working hours and an improved work-life balance. HR practitioners in health care institutions should carefully choose how they balance a successful recruitment strategy including family-friendly arrangements with other strategic HR strategies, such as labour cost containment.

Finally, this study purposely investigated a single population of professional employees. When different professions are compared using data from quite different types of organizations, one might wonder whether effects that are due to organizational type, rather than profession, are at play. This study therefore took care to use similar organizations (hospitals) in a similar type of industry (health care), thus defusing this particular
concern. While the survey design is likely a good one, it leaves us with the questions whether the results holds up well, simply because a particular set of employees in a certain type of organization is used. To answer this question, additional replication is needed with varied samples of occupational groups to examine the boundary conditions of the effects of family-friendly HR practices on outcomes such as working hours.
Appendix I: figures 1 to 4.

**Figure 1** Use of RPA * Career support

**Figure 2** Use of RPA * career hindrance
Feminization of the medical profession: a strategic HRM dilemma?

**Figure 3** Use of FPA * Career support

![Graph showing the relationship between use of FPA and career support.](image1)

**Figure 4** Use of FPA * Support for work-life balance

![Graph showing the relationship between use of FPA and support for work-life balance.](image2)
PLAYING DOCTORS AND PLAYING HOUSE:

The effects of Dutch women physicians’ frames and Gender Equality Arrangements on their career motivation and investment
Abstract

Women physicians are confronted with incompatible gendered role prescriptions, in which that of the ‘ideal’ mother who only work a few days per week sharply contrasts with that of the organizational culture in which the ‘ideal’ physician is highly dedicated and (thus) always available. This study introduces four frames which reflect how women physicians internalize these conflicting gendered role prescriptions. Moreover, based on which cultural role prescriptions are implicitly supported or resisted - we distinguish three categories of Gender Equality Arrangements as provided by healthcare institutions.

Cross-sectional data on 1,070 Dutch women physicians collected in 2008 indicate that Gender Equality Arrangements that mainly support one particular role prescription fail to support women physicians trying to merge these conflicting cultural expectations. However, arrangements that aim at revising the work culture seem to be more effective in serving both women physicians’ career motivation as well as their career investments.
6.1. Introduction

Empirical research conducted over the years in various scientific fields has substantially improved our knowledge of women's career paths. Studies have examined societal, organizational, household and individual characteristics as predictors for women's labour participation and career development. One source of controversy within the debate on women's employment is the priority accorded to women's roles as caregivers, domestic activities and family life (e.g., Hakim, 2002; Walsh, 1999). The role of motherhood ideology, or what is believed to be good mothering, is introduced in some studies as a critical aspect that not only affects rates of women's labour participation, but also women's career motivation (Himmelweit & Sigala, 2004; Raskin, 2006; Stone, 2007). The feminist critique of this type of research is that it mainly emphasizes women's roles as mothers and that it runs the risk of reproducing ideological stereotypes that motherhood is incompatible with career commitment and advancement, reinforcing the traditional sex specific public-private divide (Benschop, 2006). Moreover, studies concentrating on the effects of motherhood and societal motherhood ideology on women's career investment have neglected the inherently multifaceted nature of social identity and the complex way in which individuals combine different roles when constructing their identity (Bodenhausen, 2010). Highly educated women in particular, such as physicians, invest a great deal of time and energy in their career. Working and aiming for professional growth and career development is an important part of a woman's creation of her self-identity (Stone, 2007). Moreover, highly educated working women, such as the women physicians whose attitudes this study investigates, face not only stereotypical beliefs regarding the 'ideal' mother, but also encounter gendered beliefs regarding the 'ideal' worker (Acker, 1992; Bailyn, 2006). The characteristics of an ideal worker are straightforward and, often indirectly, gendered (Acker, 1992). The ideal worker is willing to work overtime, to sacrifice private life for work, to be on call, and to relocate for work; he or she is highly appreciated by colleagues, not 'encumbered' with caretaking responsibilities and physically capable of working long hours. The ideal physician resembles the ideal worker in that he or she is expected to be dedicated and always available, which obviously results in working overtime as a matter of routine (e.g., Brennan & Zinner, 2003). The role conflict emerges because one – by definition – cannot be an ‘ideal’ mother and an ‘ideal physician’ at the same time, although researchers have already noted the white image of “superwoman” – the working mother who does it all – or at least tries to (Thompson & Walker, 1989). Research
combining the troubled interaction of family and work roles has so far studied the effect of the work-home conflict, with role and time constraints as bases for psychological distress (Raskin, 2006). However, these studies have not examined whether women are subject to, or whether they internalize, gendered norms about being an ideal mother and an ideal worker; rather, they have taken this conflict as a given and tested to what extent it is possible to deal with this conflict. The most important contribution of this study is that, based on the Framing Theory (Lindenberg & Frey, 1993), we introduce a typology of four frames in which women cognitively—though perhaps not consciously—internalize role prescriptions regarding the 'ideal' mother and the 'ideal' physician in order to gain approval from their social environment. As such, this study does not implicitly perceive working women such as women physicians either as working mothers or as organizations' 'human capital'—since both of these approaches would result in a one-sided interest either in their views on motherhood or in their views on ideal worker norms. Instead, our aim is to investigate how women physicians actually deal with both role these prescriptions on a daily basis, and how this affects their career motivation.

The second contribution of this study concerns women physicians' career motivation and investments. In both general and scientific debates on gendered inequality in senior positions, it is often—implicitly, explicitly or for convenience's sake—assumed that women's working hours can be explained by their (alleged) lack of career motivation (e.g., Hakim, 1993; Taylor, Lambert, & Goldacre, 2009; Van Vianen & Keizer, 1996). However,
only few studies have provided evidence of any significant positive relationship between career motivation – or similar concepts such as career commitment – and working hours (Judge, Cable, Boudreau, & Bretz, 1995; Porter, Bigley, & Steers, 2003; Taylor et al., 2009). This study focuses on career motivation, which is directed towards interests, attitudes and personality variables that are potentially relevant to career development (London, 1983). The construct of career motivation in this study includes aspects of i) career centrality, ii) career insight and, iii) career ambition. Moreover, in a profession in which long working hours are regarded as standard, working hours can hardly be used to discriminate between medical physicians in terms of their motivation. Besides actual working hours, other career investment, such as having a PhD degree or taking on extra duties such as committee membership, are important in order to be considered for promotion. Career investments are therefore here defined as the investment – in terms of time and energy – made by women physicians in enhancing their chances of career advancement and/or contributing to society. By investigating the relationship between career motivation and career investments, we widen the contemporary focus on women’s labour participation to include other indicators of women’s worth in the public sphere, namely their contribution to science (performing PhD research) and by participation in, for example, commission work (work-related side activities) which is often on a voluntary basis. We are thus responding to Pringle and McCulloch Dixon’s (2003) call for a more holistic view of women’s careers.

A third contribution made by this study is to incorporate the effects of HR practices designed to overcome gender inequality on health care institutions. Organizations have developed and introduced family-responsive policies or work-life balance policies, which are mainly intended to help their employees manage the balance between paid work and other activities in life (e.g., Benschop, 2006; Den Dulk, 2001; Dikkers et al., 2007). We introduce three categories of Gender Equality Arrangements, which we will refer to as Ideal Mother Arrangements, Ideal Worker Arrangements and Revising Work Culture Arrangements. Studies conducted on the effectiveness of HR arrangements have hitherto yielded contradictory results regarding the effectiveness of these arrangements on workers’ psychological distress (e.g., Dikkers et al., 2007) and commitment (Lewis, 2001; Scheibl & Dex, 1998). To our knowledge, the effect of Gender Equality Arrangements on career motivation has not yet been studied empirically, and nor is it clear whether Gender Equality Arrangements are capable of altering (moderating) the effects of women physicians’ frames relating to career motivation.
Prior to investigating our research questions, we are interested in the characteristics of women physicians with different frames in terms of their career (e.g., specialty, years of work experience, career progress) and family life (e.g., having children, having a partner, age). Using data from a cross-sectional study of 1,070 women physicians conducted in the Netherlands in 2008, we investigated the effects of internalized gendered role prescriptions and Gender Equality Arrangements on the career motivation of women physicians. We are also interested in whether Gender Equality Arrangements can alter (moderate) the effects of the frames of women physicians regarding professional and private roles on their career motivation. Finally, we tested whether career motivation indeed accounts for women's career investments.

6.2. Theoretical framework and hypotheses

Frames

The Framing Theory of Lindenberg and Frey (1993) states that the need for social approval and the need for physical well-being are universal. In order to gain social approval, women – for instance – create instrumental goals such as being ‘an ideal mother’ or ‘an ideal physician’. Instrumental goals can be contradictory and therefore compete for one's information, energy and time. For instance, if one's dominant goal (‘frame’) is to be an excellent physician, one's attention and other cognitive processes will focus on achieving this goal (framing), thereby "blinding" oneself to other worthy information that now appears to be distracting. However, changing circumstances can alter the priority and hierarchy between these instrumental goals. For example, when a woman becomes a mother – a changing circumstance – and wants to gain social approval by being a good mother according to traditional standards, this new goal may challenge her career goals. We now take this one step further: as the societal environment confronts women physicians with contradictory role prescriptions, two questions arise. The first question is to what extent women physicians submit to, or internalize these normative beliefs; the second question deals with how women physicians cognitively combine or prioritize these internalized beliefs. To analyse the framing processes of women physicians further, we introduce a typology of four frames based on women physicians' own internalized notion of the ideal physician and the ideal mother (see Figure 1).
The horizontal axis (dimension) represents the notion of a good mother among women physicians, and ranges from a traditional notion of the 'good' mother (e.g., "I believe that I am a good mother when I do not work outside the home, take care of children and household tasks") to a non-traditional notion of the ideal mother. The question here is thus: to what extent does a woman agree with traditional societal role expectations regarding good mothering? The vertical axis in the typology represents women physician's notion of the ideal physician and ranges from a traditional role-identity of a medical physician (e.g., "I believe I am a good physician when I am always available and routinely work overtime, fully devoted to medicine, willing to move in order to pursue my medical career and not bothered by other responsibilities in life") to a non-traditional role-identity. Again, we are interested in the extent to which a woman has internalized societal norms regarding the ideal physician (worker).

These two axes form four quadrants, which together represent different combinations of how women combine their notions of the ideal physician and the ideal mother. For instance, a woman physician with a traditional care frame believes that she has to be at home with her children at least four
Playing doctors and playing house

days a week and only works three days outside the home (SCP, 2008), but she also believes that she does not have to work overtime routinely in order to be a good physician. She has thus internalized gendered role prescriptions regarding motherhood, yet has not internalized role traditional prescriptions relating to being an ideal physician. In this example, the woman physician prioritizes her role as a mother over that of a medical physician in order to receive social approval. A physician with a career frame does the exact opposite; she has internalized and prioritized role prescriptions of the traditional ‘ideal’ physician in order to obtain social approval – principally for her role as a medical physician – and disagrees with normative role prescriptions regarding motherhood. Rather than prioritizing one role over the other, women physicians can also decide to internalize both role prescriptions, resulting in switching frames, depending on the environment they are in or through which of their roles they expect to receive the most approval. Women physicians with switching frames find both roles and associated social approval equally important, and switch between both frames depending on the situation. Johnston and Swanson (2007) call this a coping strategy in which the contradiction is neutralized by satisfying both competing needs to some extent, but without fully realizing either. Women physicians who neither internalize the traditional view of the ideal physician, nor the traditional view of the ideal mother are here defined as having non-traditional frames. Women physicians with non-traditional frames construct personal concepts of good motherhood and being a good physician in the way that best suits their abilities and current private circumstances. Their career motivation may be high, or it may be that they seek social approval through the traditional role prescription of the ideal physician. For example, a woman physician may focus on career progression because she continuously needs new challenges or because she feels the need to educate herself. On the other hand, it could also be that a woman physician just enjoys her work and is less concerned by what position she may attain in the future.

Career Motivation

In behavioural psychology, there are numerous concepts associated with career motivation such as ‘career aspiration’ (Rainy & Borders, 1997), ‘achievement ambition’ and ‘career commitment’ (Murphy & Alexander, 2000). However, many existing theoretical concepts are one-dimensional, dealing with only one or a few aspects of a person’s motivation to succeed in their career, such as their need for success or achievement (Mitchell & Daniels, 2003). London (1983, 1997), in contrast, conceptualizes career motivation as a multidimensional construct internal to the individual,
which is influenced by both family and work-related situations, and reflected in the individual's attitudes, decisions and behaviour regarding his or her career. In this study we build on London's conceptualization and distinguish three dimensions of career motivation: career centrality, which is the importance of career in one's life; career insight, which is the degree to which one plans out a strategy to obtain certain career goals; and career ambition, which is the will to achieve a higher position in one's field.

By combining the Framing Theory (Lindenberg & Frey, 1993) with the construct of career motivation, we provide a new theoretical explanation for the interaction between internalized gendered role expectations (notions) stemming from the need for social approval and women physicians' career motivation and investment. As indicated, the four quadrants represent four different cognitive frames. We have reason to believe that each frame has a different effect on career motivation, as will be discussed in the next section.

All in all, we expect that women physicians with different frames will differ in their levels of career motivation (career centrality, career insight and career ambition). We will focus particularly on the possible effect of switching frames on career motivation compared to women physicians with other frames. As tempting as this coping strategy may appear – it seems to offer the possibility of living up to both gendered role prescriptions at once – it risks leading to frustration due to lack of social approval (Stryker & Burke, 2000; Tsushima & Burke, 1999). It is often suggested that the feeling of falling short of expectations in both domains is what leads women to “opt-out” (Hewlett & Luce, 2005; Mainiero & Sullivan, 2005). Consequently, it could also result in lower levels of career motivation. Our first hypothesis regarding the relationship between women physicians' frames and their career motivation is therefore:

H1: Women physicians with switching frames have higher levels of career motivation (career centrality, career insight and career ambition) than women physicians with a care frame, but lower than women with a career frame.

Gender Equality Arrangements

Nowadays, large organizations, especially those that employ many women, offer family-friendly HR arrangements which are often written into the terms of their Collective Labour Agreements (Den Dulk, 2001). Although these arrangements are ostensibly gender-neutral and intended for men and women alike, these policies or arrangements tend to focus tacitly on women and consist of so-called ‘mommy tracks’ (women's working hours are rostered during their children's school hours), leave opportunities and childcare
provisions (e.g., Benschop, 2006; Mescher, Benschop, & Doorewaard, 2010). Several classifications of approaches to gender equality and change have been described in literature on feminist theory (Calás & Smircich, 2006; Ely & Meyerson, 2000). We here make a distinction between Ideal Mother Arrangements, Ideal Worker Arrangements and Revising Work Culture Arrangements. Ideal Mother Arrangements are – for example – the opportunity to work part-time, job share and additional leave arrangements. These measures are basically to enable women to be at home with their children more, and thus conform to the ideal of the ideal mother norm to some extent. By reducing structural barriers and biases, the aim of these arrangements is to create equal opportunities. Although these arrangements could ease the tension between work and family in women's lives, the work-family balance remains a 'woman's problem' and the arrangements risk being counter-productive (Ely & Meyerson, 2000). Our second category, Ideal Worker Arrangements, includes measures to equip women better to meet gendered ideal worker norms, such as extra (management development) training, mentoring and coaching. Women's networks and positive gender discrimination policies (i.e., bonuses for appointing women in higher positions) also fall into this category. Feminists have characterized these arrangements as either 'fixing' or 'blaming' women, since women are blamed for not being motivated enough or lacking the required (networking) skills (Ely & Meyerson, 2000). Another type of arrangement is associated with a 'value the feminine' approach, in which women's skills are still seen as different from those of men, yet they are more recognized and valued. Here, for the sake of simplicity and convenience, we combine both of these approaches within the category of Ideal Worker Arrangements, since both approaches leave in place processes that produce difference, such as the ideal worker norm. Our third category, Revising Work Culture Arrangements, includes arrangements that increase the flexibility of the organization, such as offering flexible working hours (at the beginning and end of the work day), teleworking and having a say in scheduling. The main difference between Ideal Mother Arrangements and Revising Work Culture Arrangements is that the latter are often not presented specifically as a strategy to counter gender inequality, but are introduced as ways to tackle commuting problems and reduce overhead costs (Peters, Tijdens, & Wetzels, 2004).

Several researchers have studied the effectiveness of family-friendly arrangements on work-family conflict and work-home interference, and (intended) behaviour such as turnover and absenteeism (Allen, 2001; Thompson, Beauvais, & Lyness, 1999). Apart from some studies into the effect of part-time working on women's careers (e.g., Roman, Fouarge, & Luijkhx,
2004), to our knowledge, hardly any empirical research has been done into the effects of Gender Equality Arrangements on the career motivation of women physicians. Moreover, we are interested in whether bundling arrangements based on organizations' strategies to deal with gender inequality will help us understand the effect of HR arrangements on the career motivation of women physicians. Since Ideal Mother Arrangements implicitly refer to women physicians' roles as (future) mothers, we would expect these arrangements to have a negative effect on career motivation. However, Ideal Worker Arrangements and particularly Revising Work Culture Arrangements can be expected to have a positive effect on the career motivation of women physicians, since by offering these type of arrangements, the organization signals that they value women and are willing to invest in them by offering training and mentoring; they are even prepared to restructure work processes in order to facilitate women's work-life balance. In doing so, they tap into women physicians' career goals, thereby presenting these goals as more feasible. Our second set of hypotheses is therefore:

**H2a:** Ideal Mother Arrangements have a negative effect on the career motivation of women physicians (career centrality, career insight and career ambition).

**H2b:** Ideal Worker Arrangements and particularly Revising Work Culture Arrangements have a positive effect on the career motivation of women physicians.

By offering Gender Equality Arrangements, organizations try to challenge societal norms and beliefs relating to how a good mother and a good physician are supposed to behave. Regardless of the direct effect of these arrangements on the career motivation of women physicians, the question for organization is whether the effects of frames on career motivation can be countered by offering Gender Equality Arrangements. Changing environmental circumstances can alter the salience of roles and frames, leading to different behaviour (Stryker & Burke, 2000; Lindenberg & Frey, 1993). Our third set of hypotheses therefore concerns the moderating effect of the Gender Equality Arrangements offered on the relationship between frames and the career motivation of women physicians. We not only expect different moderating effects of Gender Equality Arrangements on the relationship between frames and career motivation, we also expect them to be counter-effective to some extent. For instance, for a woman physician with a care frame, offering Ideal Mother Arrangements may deter her from abandoning her career goals, and encourage her to combine her career with caretaking responsibilities. However, for women physicians with a career frame or with switching frames Ideal Mother Arrangements might have a
different effect. Since these women believe they have to live up to the ideal worker norm, signals from the organization that emphasize women's roles as mothers may distract these women physicians from their initial career motivation. Ideal Worker Arrangements risk backfiring in the same way. Although Ideal Worker Arrangements can be expected to strengthen the positive effect of a career frame and switching frames on career motivation, they may also discourage women physicians with a care frame because they send out the signal that in order to achieve a higher position in the organization, one has to put in extra effort (such as participating in training programmes). Since Revising Work Culture Arrangements do not build on gendered societal ideals about the ideal mother and the ideal physician, we expect these arrangements to reinforce the positive effect of both a career frame and switching frames on career motivation, but to temper the negative effect of a care frame on career motivation.

H3a: Ideal Mother Arrangements temper the negative effect that a care frame has on the career motivation of women physicians; yet also temper the positive effect that a career frame and switching frames have on career motivation.

H3b: Ideal Worker Arrangements strengthen the positive effect that a career frame and switching frames have on the career motivation of women physicians; yet reinforce the negative effect that a care frame has on career motivation.

H3c: Revising Work Culture Arrangements strengthen the positive effect of a career frame and switching frames on the career motivation of women physicians, and temper the negative effect of a care frame on career motivation.

Career motivation and career investment

In general and scientific debates, it is often implicitly or explicitly assumed that women who do not work long hours every week and/or do not 'go the extra mile' to increase their chance of promotion to a higher position, lack career motivation (Hakim, 1993; Van Vianen & Fischer, 2002). In other words, it is often assumed that higher levels of career motivation will result in more investment in one's career (such as working longer hours or carrying out extra activities). However, only a few studies have provided empirical evidence for this assumption (Judge et al., 1995; Keuzenkamp, 2009). This study investigates the role of career motivation in explaining the career investment of women physicians. We define career investment as women physicians' willingness to invest time and energy in their work to enhance their chance of career advancement. We distinguish three elements of career investment: i) the number of hours worked; ii) holding a PhD degree or not (or currently conducting PhD research); and iii) whether or not they gathered
extra experiences through performing ancillary activities at work (e.g., sitting on a Patients Committee) (from hereon referred to as ancillary activities). Whitely, Dougherty and Dreher (1991) argue that motivational variables, such as the number of hours worked, work centrality and ambition, are likely to influence career achievement. Career achievement, however, is affected by numerous factors which are not always within the individual’s span of control. We will therefore concentrate on those career decisions that are likely to maximize future career achievements, yet are mainly a result of a personal decision. In our fourth hypothesis, we expect that:

H4a: Women physicians with high levels of career motivation (career centrality, career insight and career ambition) work longer hours than women physicians with lower levels of career motivation.

H4b: Women physicians with higher levels of career motivation (career centrality, career insight and career ambition) are more likely to hold a PhD degree or to be currently conducting PhD research.

H4c: Women physicians with higher levels of career motivation (career centrality, career insight and career ambition) are more likely to perform ancillary activities at work.

A simplified overview of our conceptual framework is depicted in Figure 2.

6.3. Data

Participants
To test our hypotheses, we conducted a web survey in the summer of 2008 entitled “Physician and Career”. The survey was sent to a representative sample of 3,500 women physicians (and assistant physicians). Their year of birth (the sample included those between the ages of 25 and 50 years) and specialty (all specialties) were used as criteria to select physicians from the official database of medical registration commissions in the Netherlands (KNMG), in which all physicians in the Netherlands are registered. Respondents were invited to participate by letter and were asked to visit the website where an online questionnaire was posted. To do this, they used the personal log-in code provided in the letter. After three months and three reminders by mail and e-mail, 1,070 women physicians had completed the survey, constituting a response rate of 32%. This is a fairly good response rate, given that the average response rate for web surveys in the Netherlands varies between 25 percent and 45 percent (De Leeuw & De Heer, 2001). The
Figure 2 Conceptual framework

Frames
- Career frame
- Switching frames
- Care frame
- Non-traditional frames

Offered Gender Equality Arrangements
- Ideal Mother Arrangements
- Ideal Worker Arrangements
- Revising Work Culture Arrangement

Career motivation
- Career centrality
- Career insight
- Career ambition

H1
H2
H3
Career investments
Number of actual working hours
(Currently working on) PhD degree
Conducting work-related side activities
sample that completed the survey was representative of the population of women physicians in the Netherlands as a whole in terms of both age and specialty (Van der Velden, Hingstman, Heiligers, & Hansen, 2008).

The sample included 486 medical specialists and 401 residents. The remaining 183 medical physicians were neither medical specialists nor training to become one, and were thus working as physicians in some other capacity (for insurance companies, for instance). The average number of years of work experience as a physician was 10.27 (SD=6.11).

**Dependent variables**

*Hours worked.* In the analysis we used ‘actual hours worked’ as a continuous dependent variable, which included working hours at the hospital, working at home on research or catching up with e-mails, meetings outside office hours and (extra) training. Respondents were asked not to include commuting time.

*PhD degree.* Whether or not respondents had a PhD degree or whether they were currently conducting PhD research was measured by a dichotomous variable (‘0’ for not having/working on a PhD degree, ‘1’ for having/working on a PhD degree).

*Performing work-related ancillary activities.* Were respondents in fact performing work-related ancillary activities, such as being a member of a committee, a pressure group, an employer’s association or trade union, and/or a (patient) foundation. Performing work-related ancillary activities was measured by a dichotomous variable (‘0’ for not performing work-related side activities, ‘1’ for performing work-related side activities).

*Career motivation.* The career motivation items were based on the Career Motivation Inventory (London, 1997), the Emancipation Monitor (SCP, 2008), and a Proactive Coping Scale (Ouwehand, 2005). Using principal axes factor analysis (PAF, Oblimin rotated), three sub-dimensions were distinguished, namely *career centrality, career insight* and *career ambition*. Career centrality consisted of six items, with a Cronbach’s alpha of .85, and included items such as “I am very focused on my career” and “I get the most satisfaction in life out of my career”. Career insight consisted of three items (Cronbach’s alpha = .81), such as ‘I have formulated clear career goals for myself’ and ‘I have developed a strategy how to obtain my career goals’. The third dimension, career ambition, consisted of four items (Cronbach’s alpha = .78). Examples of these items are ‘I want to obtain a top position in my field’ and ‘I want to obtain a position with a higher salary level’. Items were measured on a five-point Likert scale ranging from 1 for “totally disagree”, to 5 for “totally agree”.

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Independent variables

Frames. As explained in the theoretical framework, we constructed four frames based on respondents’ scores on two scales. The first scale was the ‘Ideal Mother Scale’ (see Pas et al., forthcoming 2011) and the second scale was the ‘Ideal Physician Scale’. The latter scale was specifically designed for this study on the basis of qualitative research into the characteristics of the ideal worker (Kelly et al., 2010; Meriläinen, Tienari, Thomas, & Davies, 2004) and the ideal physician (Price et al., 1971). The scale used in this study was subjected to principal axes factor analysis with oblimin rotation. Where a clear factor structure was confirmed, the items were summed and averaged to create indices for each scale.

The Ideal Mother Scale consisted of eight items relating to views on how to allocate time between children and activities outside the home (e.g., paid work). Examples of these items were “I want to share much time with my child(ren)” and “I find it important to share breakfast and dinner together with my children during the (work) week”. Internal reliability was assessed using Cronbach’s alpha (\( \alpha = .77 \)). Women physicians with no children were asked to respond as if they had children. They were presented with items such as “I believe I would want to share much time with my child(ren)”. The Ideal Physician Scale consisted of eight items concerning one’s views of being an ideal physician. The Cronbach’s alpha for this scale was .78. Examples of these items were “I believe I am a good physician when I do not mind working overtime” and “I believe I am a good physician when I am always available”. The items for both the Ideal Mother Scale and the Ideal Worker Scale were measured on a five-point Likert scale ranging from 1 “totally disagree” to 5 “totally agree”.

On the basis of these two scales, we constructed four frames: career frame, care frame, switching frames and non-traditional frames. To construct the frames, we obtained the mean scores of the respondents on the two scales. For the Ideal Mother Scale the mean score was 3.19; for the Ideal Worker Scale the mean score was 2.92. Women who had a below average score on the Ideal Mother Scale (<3.19) and an above average score on the Ideal Physician Scale (>2.92) were categorized as having a ‘career frame’. Women with a below average score on the Ideal Worker Scale (<2.92) and an above average score on the Ideal Mother Scale (>3.19) were categorized as having a ‘care frame’. Women who had an above average score on the Ideal Worker Scale (>2.92) and an above average score on the Ideal Mother Scale (>3.19) were categorized as women with ‘switching frames’. Finally, women with a below average score on the Ideal Worker Scale (<2.92) and a below average score on the Ideal Mother Scale (<3.19) were categorized as women with ‘non-traditional frames'.
Gender Equality Arrangements offered. On the basis of literature on feminist theory, we subdivided Gender Equality Arrangements into three categories. The first category, Ideal Mother Arrangements, included the following arrangements: job sharing, mothers’ rooms to express milk, ‘mother-contracts’ (the possibility of working during school hours), the possibility of working part-time, doing a part-time training programme, extra maternity, paternity, adoption and care leave (more than the statutory), career breaks and leave-saving possibilities. The variable Ideal Mother Arrangements were used as a continuous variable, with a minimum of zero arrangements and a maximum of eleven arrangements. On average, 4.13 arrangements were offered to women physicians. The second category, Ideal Worker Arrangements, was also a continuous variable, with a minimum of zero and a maximum of ten arrangements. It included the following offered arrangements: onsite childcare, childcare arrangements in other care facilities, childcare at home (nanny/nurse), financial support for childcare, mentoring, coaching, work-life balance training, tenure-track/moving up programmes designed especially for women, women’s networks and sabbatical leaves. The average number of Ideal Worker Arrangements offered was 1.85. The variable Revising Work Culture Arrangements was also constructed as a continuous variable, with a minimum of zero and a maximum of three arrangements. The three arrangements were: flexible start- and end time of working days, the possibility of working from home (teleworking), and having a say in scheduling. The average number of arrangements offered was 1.02.

Our categorization differs from other research in two ways. First, we distinguished between organizations according to whether they – implicitly - considered themselves partly responsible for allowing workers to combine work with other areas of life (Revising Work Culture Arrangements), or whether this was considered to be primarily or solely the responsibility of the individual (Ideal Worker/Ideal Mother Arrangements). Secondly, we split the latter category into Ideal Worker Arrangements and Ideal Mother Arrangements, depending on which normative ideals predominated. For example, by offering extra arrangements to extend statutory leave arrangements, women physicians are permitted to live up to the motherhood ideology in which women with infants stay at home for as long as possible.

Interaction effects
To examine the interaction between frames and arrangement, we include terms that are related to a particular frame and to a particular arrangement. For example, the interaction effect of childcare arrangements on the relationship between a care frame and career identity was obtained using
the term care frame childcare arrangements offered. In total, 9 interaction variables were created (3 type of arrangements x 3 frames).

**Control variables**

The control variables were the respondent’s years of work experience as a physician\(^3\), medical specialty (0=general practitioners; 1=non-surgical specialists; 2=surgical specialty), age, presence of a partner (0=no, 1=yes) and presence of a child/children (0=no, 1=yes).

**6.4. Methods**

Descriptive analyses were conducted to identify the career characteristics (specialty, number of working hours, years of work experience, career motivation, PhD degree and side activities) and personal/household characteristics (respondent’s age, partner, presence of children) of women physicians. T-tests were used to test whether women physicians with a certain frame scored significantly higher or lower than women physicians with other frames.

Linear regression and logistic regression were used to test the direct effects of frames and Gender Equality Arrangements on career motivation and on career investments. Regression analyses were conducted to test the moderating effects of Gender Equality Arrangements on the relationship between frames and career motivation. All the parameters estimated were controlled for years of work experience, specialty, having a partner, having children and respondent’s age. All the regression analyses were conducted after list wise deletion of missing values. The number of cases included in the analyses was N=673.

**6.5. Results**

To gain a better perspective of the characteristics of the women physicians with different frames, we conducted descriptive analyses for each type of frame (see Table 1).

---

\(^3\) Years of work experience as a medical doctor was calculated by the authors by deducting the year in which they received their medical degree certificate from the year in which the survey was conducted (2008). Any periods of maternity or parental leave were thus not included as factors that affected years of work experience.
Table 1 descriptives (means, standard deviations) of four frames

<table>
<thead>
<tr>
<th>Variables</th>
<th>Career frame</th>
<th>Care frame</th>
<th>Switching frames</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Years of work experience</td>
<td>9.2 (5.5)</td>
<td>9.2 (5)</td>
<td>6.9 (4.8)</td>
</tr>
<tr>
<td>Respondent’s age</td>
<td>35.7 (5.9)</td>
<td>35.6 (5.6)</td>
<td>33.4 (5.4)</td>
</tr>
<tr>
<td>Partner (%)</td>
<td>88%</td>
<td>95%</td>
<td>89%</td>
</tr>
<tr>
<td>Children (%)</td>
<td>58%</td>
<td>66%</td>
<td>47%</td>
</tr>
<tr>
<td>Medical specialist (%)</td>
<td>44%</td>
<td>50%</td>
<td>29%</td>
</tr>
<tr>
<td>Residents (%)</td>
<td>56%</td>
<td>50%</td>
<td>71%</td>
</tr>
<tr>
<td>Generalists (%)</td>
<td>41%</td>
<td>54%</td>
<td>45%</td>
</tr>
<tr>
<td>Physicians (%)</td>
<td>48%</td>
<td>43%</td>
<td>41%</td>
</tr>
<tr>
<td>Surgeons (%)</td>
<td>11%</td>
<td>4%</td>
<td>14%</td>
</tr>
<tr>
<td>Career centrality</td>
<td>2.97 (.65)</td>
<td>2.55 (.63)</td>
<td>2.92 (.70)</td>
</tr>
<tr>
<td>Career insight</td>
<td>3.24 (.60)</td>
<td>3.16 (.64)</td>
<td>3.27 (.61)</td>
</tr>
<tr>
<td>Career ambition</td>
<td>3.02 (.67)</td>
<td>2.67 (.71)</td>
<td>2.95 (.70)</td>
</tr>
<tr>
<td>Actual working hours</td>
<td>45.07 (10.7)</td>
<td>40.01 (11.6)</td>
<td>46.49 (12.7)</td>
</tr>
<tr>
<td>Holding a PhD degree/</td>
<td>40%</td>
<td>22%</td>
<td>27%</td>
</tr>
<tr>
<td>conducting PhD research(%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performing work-related side</td>
<td>54%</td>
<td>38%</td>
<td>38%</td>
</tr>
<tr>
<td>activities (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>N=162</td>
<td>N=167</td>
<td>N=152</td>
</tr>
</tbody>
</table>

*** p< 0.001; ** p<0.01; * p<0.05 (one-tailed); n.s. not significant
### Non-traditional frames vs All

<table>
<thead>
<tr>
<th>Non-traditional frames</th>
<th>All</th>
<th>Significant difference between highest versus other categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean (SD)</strong></td>
<td><strong>Mean (SD)</strong></td>
<td></td>
</tr>
<tr>
<td>11.26 (5.5)</td>
<td>9.3 (5.5)</td>
<td>***</td>
</tr>
<tr>
<td>37.9 (6)</td>
<td>35.8 (5.9)</td>
<td>***</td>
</tr>
<tr>
<td>91%</td>
<td>91%</td>
<td>*</td>
</tr>
<tr>
<td>69%</td>
<td>61%</td>
<td>**</td>
</tr>
<tr>
<td>61%</td>
<td>47%</td>
<td>***</td>
</tr>
<tr>
<td>39%</td>
<td>53%</td>
<td>***</td>
</tr>
<tr>
<td>58%</td>
<td>50%</td>
<td>**</td>
</tr>
<tr>
<td>36%</td>
<td>42%</td>
<td>*</td>
</tr>
<tr>
<td>6%</td>
<td>8%</td>
<td>**</td>
</tr>
<tr>
<td>2.75 (.63)</td>
<td>2.79 (.67)</td>
<td>***</td>
</tr>
<tr>
<td>3.17 (.54)</td>
<td>3.21 (.60)</td>
<td>n.s.</td>
</tr>
<tr>
<td>2.86 (.72)</td>
<td>2.88 (.71)</td>
<td>**</td>
</tr>
<tr>
<td>39.71 (11.3)</td>
<td>42.60 (11.9)</td>
<td>***</td>
</tr>
<tr>
<td>24%</td>
<td>28%</td>
<td>***</td>
</tr>
<tr>
<td>45%</td>
<td>44%</td>
<td>**</td>
</tr>
<tr>
<td><strong>N=192</strong></td>
<td><strong>N=673</strong></td>
<td></td>
</tr>
</tbody>
</table>

* N.S. indicates no significant difference.
Perhaps the most striking feature of the variations among women physicians is that those with switching frames tended to be younger (average age 33.4) than women physicians with a career frame or a care frame (35.7 and 35.6) and those with non-traditional frames (37.9) (see Table 1). They therefore also had less work experience (6.9 years average) and 47% of them had children. Most women physicians had a partner (average of 91%), although those with a care frame were the most likely to have a partner (95%).

Table 1 also shows that women physicians with career frames and switching frames had the highest levels of career motivation, although the differences between women physicians with non-traditional frames and women with a care frame are not very large and not always significant. Finally, women physicians with switching frames and women physicians with career frames work longer hours than those with non-traditional frames or a care frame. Women physicians with a career frame had by far the highest chance of holding a PhD degree (40%) and of performing work-related side activities (54%).

Our first linear regression analysis concerned the effect of frames on career motivation. In our first hypothesis (H1), we predicted that women physicians with switching frames would have higher levels of career motivation than women physicians with a care frame, yet lower levels of career motivation than those with a career frame. As the results in Table 2 show, women physicians with switching frames have higher levels of career centrality than women physicians with a care frame (B = -0.217, p<0.001, one-tailed) (see Table 2, Career centrality, step 1), and a slightly lower level of career centrality than women physicians with a career frame (B = 0.119, p<0.05, one-tailed) (see Table 2, column Career centrality, step 1). Regarding career insight, the first step in the regression analysis reveals that women physicians with switching frames do not significantly differ in their level of career insight compared to women physicians who do not have switching frames (see Table 2, column Career insight, step 1). The results also show that women physicians with switching frames have a higher level of career ambition than women physicians with a care frame, yet their career ambition does not differ significantly from women physicians with a career frame (see Table 2, column Career ambition, step 1). Our first hypothesis (H1) was only partly supported by our data. Women physicians with switching frames do not differ in their level of career insight compared to others; nor do they have lower levels of career ambition lower than those with a career frame, as we expected.
Table 2  Standardized and unstandardized regression coefficients of career motivation (career centrality, career insight and career ambition) on frames and offered HR arrangements

<table>
<thead>
<tr>
<th></th>
<th>Career centrality</th>
<th></th>
<th></th>
<th>Career insight</th>
<th></th>
<th></th>
<th>Career ambition</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Step 1</td>
<td>Step 2</td>
<td>Step 1</td>
<td>Step 2</td>
<td>Step 1/2</td>
<td></td>
<td></td>
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<tr>
<td>Frames^</td>
<td></td>
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</tr>
<tr>
<td>Career frame</td>
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<td></td>
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</tr>
<tr>
<td>B</td>
<td>.119*</td>
<td>.079*</td>
<td>.027</td>
<td>.018</td>
<td>.030</td>
<td>.022</td>
<td>.034</td>
</tr>
<tr>
<td>P</td>
<td>.079*</td>
<td>.018</td>
<td>.017</td>
<td>.013</td>
<td>.005</td>
<td>.014</td>
<td>.017</td>
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<td>-</td>
<td>.014</td>
<td>-</td>
<td>.013</td>
<td>-</td>
</tr>
<tr>
<td>Care frame</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>-.217***</td>
<td>-.140***</td>
<td>-.218***</td>
<td>-.140***</td>
<td>-.048</td>
<td>-.034</td>
<td>-.325**</td>
</tr>
<tr>
<td>Frames^</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Offered Gender Equality Arrangements</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Offered Ideal Mother Arr.</td>
<td>-.020</td>
<td>-.046</td>
<td>-.020</td>
<td>-.046</td>
<td>-.007</td>
<td>-.017</td>
<td>-.030</td>
</tr>
<tr>
<td>Offered Ideal Worker Arr.</td>
<td>.030*</td>
<td>.079*</td>
<td>.018</td>
<td>.048</td>
<td>.039**</td>
<td>.112**</td>
<td>.041**</td>
</tr>
<tr>
<td>Offered Revising Work Culture Arr.</td>
<td>.010</td>
<td>.013</td>
<td>.008</td>
<td>.010</td>
<td>.027</td>
<td>.039</td>
<td>.025</td>
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<tr>
<td>Years of work experience</td>
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<td>-.225**</td>
<td>-.026**</td>
<td>-.215**</td>
<td>-.026**</td>
<td>-.235**</td>
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<td>Respondent’s age</td>
<td>.018*</td>
<td>.164*</td>
<td>.018*</td>
<td>.157*</td>
<td>.016</td>
<td>.158</td>
<td>.016</td>
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<tr>
<td>Partner (1=yes)</td>
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<td>-.028</td>
<td>-.062</td>
<td>-.027</td>
<td>-.013</td>
<td>-.006</td>
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<td>Children (1=yes)</td>
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<td>.296***</td>
<td>.391***</td>
<td>.293***</td>
<td>.165***</td>
<td>.135***</td>
<td>.169***</td>
</tr>
<tr>
<td>Surgeons^</td>
<td>.707***</td>
<td>.297***</td>
<td>.709***</td>
<td>.297***</td>
<td>.412***</td>
<td>.189***</td>
<td>.397***</td>
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<td>Interaction effects^</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ideal Worker Arr. * Career frame</td>
<td>-</td>
<td>-</td>
<td>.051*</td>
<td>.089*</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
</tr>
<tr>
<td>Ideal Mother Arr. * Care frame</td>
<td>-</td>
<td>-</td>
<td>n.s.</td>
<td>n.s.</td>
<td>-</td>
<td>-</td>
<td>.088**</td>
</tr>
<tr>
<td>Adj. R Square</td>
<td>.228***</td>
<td>.230***</td>
<td>.074***</td>
<td>.081***</td>
<td>.133***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adj. R Square change (Δ)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.003**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*** p< 0.001; ** p<0.01; * p<0.05 (one-tailed); n.s. not significant; ¥ Switching frames served as a reference category; # For sake of clarity, only significant interaction effects are reported; ^ General practitioners served as reference category.
In our second set of hypotheses, we posited that Ideal Mother Arrangements would have a negative effect on the career motivation of women physicians (career centrality, career insight and career ambition), while Ideal Worker Arrangements and especially Revising Work Culture Arrangements would have a positive effect. We do not find any significant negative effect of Ideal Mother Arrangements on career motivation in women physicians (see Table 2, columns Career centrality, Career insight and Career ambition, step 1). The first part of our second hypothesis (H2a) was therefore not supported by our data. However, the results do reveal that Ideal Worker Arrangements have a positive effect on women physicians’ career motivation (β = .079, p<0.05, one-tailed for Career centrality, step 1; β = .112, p<0.01, one-tailed for Career insight, step 1; and β = .118, p<0.001, one-tailed for Career ambition, step 1). Offered Revising Work Culture Arrangements do not have a significant effect on women physicians’ levels of career centrality and career insight, but they do have a significant positive effect on women physicians’ levels of career ambition (β = .113, p<0.001, one-tailed, step 1). However, Revising Work Culture Arrangements do not have a stronger effect on career ambition among women physicians (β = .113 < β = .118). All in all, part of our second hypothesis (H2b) was supported by our data.

In our third set of hypotheses (H3a;H3b and H3c), we predicted that the effect of women physicians’ frames on career motivation would be both positively and negatively affected (moderated) by Gender Equality Arrangements. In H3a, we posited that Ideal Mother Arrangements would temper the negative effect of a care frame on career motivation; however, this type of arrangement would also negatively affect the positive relationship between a care frame and switching frames and career motivation. As Table 2 shows, we only found that Ideal Mother Arrangements had a significant positive effect (β = .227, p<0.01 one-tailed, see column Career insight, step 2) on the negative relationship between a care frame and career insight (see also Figure 4). This suggests that offering Ideal Mother Arrangements tempers the negative effect that a care frame has on career insight. Our third hypothesis (H3a) is thus hardly supported, because Ideal Mother Arrangements only temper the negative effect that a care frame has on women physicians’ levels of career insight. Offering Ideal Mother Arrangements does not negatively affect the positive relationship between a care frame or switching frames and career motivation.

In H3b, we expected Ideal Worker Arrangements to strengthen the positive effect that a care frame and switching frames have on career motivation; however, we also predicted that it would strengthen the negative
<table>
<thead>
<tr>
<th>Frames</th>
<th># Actual working hours</th>
<th>(Working on) PhD degree</th>
<th>Work-related side activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>(Exp) B</td>
<td>B</td>
</tr>
<tr>
<td>Career frame</td>
<td>-1.596*</td>
<td>.752*</td>
<td>.355</td>
</tr>
<tr>
<td>Non-traditional frames</td>
<td>-2.213**</td>
<td>.289</td>
<td>-0.96</td>
</tr>
<tr>
<td>Care frame</td>
<td>-2.092*</td>
<td>.397</td>
<td>-0.070</td>
</tr>
</tbody>
</table>

**Offered Gender Equality Arrangements**

<table>
<thead>
<tr>
<th>Offered Ideal Mother Arr.</th>
<th>-946***</th>
<th>-124***</th>
<th>.067</th>
<th>1.070</th>
<th>-0.010</th>
<th>.990</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offered Ideal Worker Arr.</td>
<td>.254</td>
<td>0.038</td>
<td>.056</td>
<td>1.058</td>
<td>-0.005</td>
<td>.995</td>
</tr>
<tr>
<td>Offered Revising Work Culture Arr.</td>
<td>-281</td>
<td>-0.020</td>
<td>.374**</td>
<td>1.453**</td>
<td>.145</td>
<td>1.156</td>
</tr>
</tbody>
</table>

**Career motivation**

| Career centrality | 3.432*** | .194*** | .385* | 1.470* | .206 | 1.228 |
| Career insight    | -1.754***| -0.091***| .063  | .939  | -0.258* | .773* |
| Career ambition   | .838     | .051    | .547** | 1.727** | .626*** | 1.871*** |

**Control variables**

| Years of work experience | -.442** | -.210** | .068 | 1.070 | .139*** | 1.149*** |
| Respondent’s age         | .238*   | .120*   | -.047 | .954  | -.028  | .972   |
| Partner (1=yes)          | .627    | .016    | -.184 | .832  | .425   | 1.530  |
| Children (1=yes)         | -.5.896*** | -.2.50*** | -.071 | .931  | -.3.48* | .706* |
| Physicians^              | 9.363*** | .396*** | 2.695*** | 14.811*** | .753*** | 2.124*** |
| Surgeons^                | 13.788*** | .327*** | 3.305*** | 27.242*** | .653* | 1.921* |

\[
\text{Adj. R Square} \quad .519***
\]

\[
\text{Nagelkerke R square} \quad .422***
\]

*** p < 0.001; ** p < 0.01; * p < 0.05 (one-tailed); ¥ Switching frames served as a reference category; ^ General practitioners served as a reference category.
Figure 3 Interaction effect of Ideal Worker Arrangements on relationship between career frame and career centrality

Figure 4 Interaction effect of Ideal Mother Arrangements on relationship between care frame and career insight
effect that a care frame has on career motivation. Table 2 shows that we only found one significant effect of Ideal Worker Arrangements on the positive relationship that a career frame has on career centrality ($\beta = .089, p<0.05$ one-tailed, see column Career centrality, step 2) (see also Figure 3). It appears that women physicians with a career frame have higher levels of career centrality when Ideal Worker Arrangements are offered. We do not find that offering Ideal Worker Arrangements demotivates women physicians with a care frame. Although we find that Ideal Worker Arrangements strengthen the positive relationship between a career frame and career centrality, the second part of our third hypothesis (H3b) is hardly supported.

The last part of our third hypothesis (H3c) predicted that Revising Work Culture Arrangements would strengthen the positive effect of a career frame and switching frames on career motivation, and would also temper the negative effect of a care frame on career motivation. We do not find any significant interaction effects to support hypothesis H3c.

All in all, we can conclude that offering Gender Equality Arrangements affects the relationship between frames and career motivation, but only marginally.

Our fourth and final set of hypotheses involved the supposed positive effect that career motivation has on career investment. In the first part of our fourth hypothesis (H4a), we posited that women physicians with higher levels of career motivation work more hours. As can be seen in Table 3 ('hours actually worked' column), women physicians with higher levels of career centrality do indeed work more hours than those who do not have high levels of career centrality ($\beta = .194, p< 0.001$ one-tailed). However, we find that having higher levels of career insight has a significant and negative effect on the number of hours women physicians work ($\beta = -.091, p< 0.001$ one-tailed). Women physicians with higher levels of career ambition do not work more hours ($\beta = .051, n.s.$). The first part of our fourth hypothesis was therefore only partly confirmed, with only career centrality having a positive effect on the number of hours that women physicians actually work. In the second part of our fourth hypothesis, we predicted that higher levels of career motivation would increase the chance that women physicians would hold or currently be working on a PhD degree. Only women physicians with higher levels of career centrality or with higher levels of career ambition are more likely to hold or work on a PhD degree (See Table 3, column (Working on) PhD Degree: (Exp) $B = 1.470, p<0.05$ one-tailed for career centrality; (Exp) $B = 1.727, p<0.01$ one-tailed for career ambition). The second part of our fourth hypothesis (H4b) was therefore mainly supported by our data. The last part of our fourth hypothesis (H4c) posited that women
physicians with higher levels of career motivation would be more likely to be involved in ancillary work activities. We find that women physicians with higher levels of career insight are less likely to be involved in ancillary activities (\(\text{Exp} B = .773, p<0.05\) one-tailed), whereas women physicians' with higher levels of career ambition are more likely to perform side activities (\(\text{Exp} B = 1.871, p<0.001\) one-tailed). The last part of our fourth hypothesis (H4c) was thus only partly supported.

We also found some other interesting results that had not been hypothesized. For instance, women physicians with switching frames work the most actual hours (see Table 3, 'hours actually worked' column, women physicians with switching frames being the reference group) and are more likely to hold a PhD degree (\(\text{Exp} (B) = 2.122, p<0.05\) one-tailed). In other words, regardless of career motivation, women physicians with switching frames invest the most in their career. Although we controlled for age and years of work experience, the results shown above led us to check whether the respondents were in training to become a physician, which may have accounted for their long working hours and working on a PhD degree. The analysis which included traineeship as a control variable (not reported in Tables) showed the same results.

We also found significant direct effects of Gender Equality Arrangements on the career investment of women physicians. Offering Ideal Mother Arrangements had a negative effect on the number of hours actually worked by women physicians (see Table 3 below, column 'hours actually worked', \(\beta = -.124, p< 0.001\) one-tailed). Offering Ideal Worker Arrangements does not significantly affect the career investment of women physicians. Offering Revising Work Culture Arrangements, on the other hand, increases the likelihood that women physicians' hold or are currently working on a PhD degree (\(\text{Exp} = 1.453, p<0.01\) one-tailed).

With respect to the control variables, we found that surgeons and physicians (whether still in training or not) work more hours and are more likely to hold or be working on a PhD degree compared to generalists. Moreover, the respondent's age has a positive effect on career centrality. Having more years of work experience negatively affects working hours, but positively affects performing extra activities. Finally, having children negatively affects the number of hours worked by women physicians and the likelihood that they would perform work-related ancillary activities.

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4 Being in training highly correlated with age and years of work experience and was therefore not included as a structural control variable in the analyses.
6.6. Conclusion and discussion

This study was designed to investigate a) the effects of women physicians' frames – regarding their role as a caretaker and their role as a professional – and Gender Equality Arrangements on their career motivation; b) whether these arrangements moderate the relationship between women physicians' frames and career motivation; and c) whether the career motivation of women physicians can explain variations in their career investment in terms of actual hours worked, having a PhD degree and performing work-related ancillary activities.

Turning to our first research goal, we can conclude that women physicians' frames – that is, their ways of dealing with conflicting and gendered role expectations – do affect their career motivation. Our results show that women physicians with a care frame, in particular, have lower levels of career centrality and career ambition, and that women physicians with a career frame have higher levels of career centrality. However, a more surprising finding was that women physicians with switching frames did not score lower than women physicians with a career frame in terms of career motivation. This reveals two important aspects. First, our study showed that nowadays women physicians not only 'play house' (internalize gendered motherhood ideals); they 'play doctors' as they also internalize male-dominant ideals regarding being an 'ideal' physician. Including multiple role prescriptions rather than only that of the ideal mother thus provides a much more nuanced and richer picture of what affects women's career motivation and investment.

Secondly, women physicians who want to 'do it all' are not necessarily less motivated compared to those who abandon their motherhood ideals completely and aim to be an ideal physician. On the contrary, women physicians with switching frames in our study worked the longest hours and were the most likely to hold or be working on a PhD degree. These results contrast with the general belief that women physicians with traditional notions of the ideal mother stop investing in their career.

The second contribution of this study is the finding regarding the effectiveness of Gender Equality Arrangements on the career motivation and investment of women physicians. To our surprise, we found that only Ideal Worker Arrangements have a positive effect on the career motivation of women physicians, and these appear to be most suitable for those women physicians who already have a career frame. However, Ideal Worker Arrangements, which offer training, coaching or other forms of individual career support, were not capable of altering the negative effects of a care
frame on career motivation. In other words, they are not capable of ‘fixing’ women (Ely & Meyerson, 2000); they serve principally to support women who already are very career-oriented and who incorporated gendered ideals regarding the ideal physician. Although Ideal Worker Arrangements positively affected the career motivation of women physicians, they did not positively affect their career investment. Despite the empirical evidence of the positive effect of Ideal Worker Arrangements on the career motivation of women physicians, Ideal Worker Arrangements still have the drawback that they suggest women’s career advancement is simply a matter of individual traits and personal choice. Offering Ideal Worker Arrangements alone leaves gendered structures in place and the division between public and private spheres intact. It could be that career motivation mediates the relationship between offering Ideal Worker Arrangements and investing in one’s career. Further longitudinal research is needed to study this in greater depth. Ideal Mother Arrangements affected the career insight of women physicians with a care frame only marginally, and even had a negative effect on women physicians’ working hours. Although Ideal Mother Arrangements may have a positive effect on personal well-being, their effect on career motivation is only marginal and their effect on actual career investment can even be negative. Only Revising Work Culture Arrangements positively affected both the career motivation (career ambition) and investment (having a PhD degree or currently conducting PhD research) of women physicians, and showed no negative effects. Unfortunately, these arrangements were hardly offered by the health care institutions that appeared in our study. To summarize, this study contributes to our understanding of this area by revealing that both Ideal Worker and Ideal Mother Arrangements are in fact interspersed with veiled gendered assumptions about what women need. It also reveals that the effectiveness of these arrangements is only marginal and incapable of countering negative effects of motherhood ideals; and that – at worse – they can even have a negative effect on women’s career investment.

Offering Revising Work Culture Arrangements would appear to be the least gendered HR practice, standing a much better chance in improving women’s career motivation, career investment and hopefully also their career advancement. Since this type of arrangement is currently hardly offered in Dutch hospitals, according to this study (see Chapter 2), further research – perhaps in other industries in which this is more commonly offered - is needed on the possible effects of arrangements such as teleworking and flexible working hours on (women’s) career motivation and investment.

The final part of this study dealt with the relationship between the career motivation and career investment of women physicians. Although the
Chapter 6

relationship between career motivation and career investment is highly susceptible to misinterpretations of causality, some interesting results were found in this study that ask for further investigation. To our surprise, we found a negative relationship between career insight and the hours worked by women physicians and the likelihood that they would be involved in ancillary activities at work. Although we suspect a causal effect, it could also be that thinking about where one is heading results in hesitation to actually do it. Another interesting finding was that women physicians who are more ambitious (aiming for the more senior positions in the medical field) did not work more hours, yet were more likely to hold a PhD degree and to be involved in work-related ancillary activities. This outcome would appear to support for a more holistic approach to women's careers, in which women's ambition is not (only) judged according to the number of hours they work, but also on the basis of other career related activities.

A shortcoming in this study concerns a common struggle experienced by feminist researchers when investigating women's career motivation. As in almost all quantitative studies of women's career motivation and investment, the construct of career motivation – as used in this study - is based on men's career experiences. Women are thus measured by men's standards (Pringle & McCulloch Dixon, 2003). For example, using 'career centrality' could be disputable given that putting one's career central in one's life means that someone else needs to take care of everything else in life. Whereas for men 'career centrality' could have a positive connotation since a driven, ambitious, and goal-oriented man will receive social approval for his behaviour, a woman could have a negative connotation, since she receives much less social approval for her making her career central in her life. However, for women, other, latent meanings and associations are probably made with the centrality of their role as a mother and caretaking responsibilities, since this is so integral to the way a woman contemplates her career. We suggest that further validity tests are needed to test whether career motivation does indeed have a different meaning for men than for women. On the other hand, we cannot overlook that for many highly educated women, such as women physicians, who have invested heavily in their careers in terms of training and obtaining experience, career plays an important part in their life from which they derive pleasure.

Finally, respondents' age seemed to play an important role in this study, as if frames could reflect phases through which all women physicians go. Women physicians seem to start out with switching frames, as the women physicians in our study were the youngest category, wanting to live up to all gendered role prescriptions at the same time. It could be that younger women
physicians, who are on the threshold of becoming a mother and becoming a physician, are the most susceptible to normative role prescriptions and – as a result of that – are more insecure and need social approval from their environment. Later on in life, perhaps once they have had their first child, they discover that doing it all is almost impossible, which results in them prioritizing one role over the other (choosing a career frame or a care frame). Once they have gone through and survived the most intensive years of combining care responsibilities with a demanding job, they become more self-confident and critical of role prescriptions. Longitudinal research should be conducted to investigate the dynamic nature of how highly educated women are affected by gendered role prescriptions.
‘KEEPING MEN SUPERVISORS’ BALLS IN THE AIR’:

How gendered resistance and counter-resistance discourses diminish the career prospects of Dutch women medical specialists

This chapter is currently under review for *Gender, Work & Organization*. 
Abstract

Gender inequality in top academic medical regimes persists, despite the feminization of the medical profession. The normalizing discourse of the ideal specialist – which resembles that of the ideal worker – continues to predominate and is heavily anchored in career planning and upward mobility. Based on three focus groups and two small-group interviews with 20 academic medical specialists (men and women) conducted in 2009 in a Dutch teaching hospital, this study reveals how gender plays an important role in normalizing discourses on the ideal specialist, resistance and counter-resistance discourses. By peeling away the gendered assumptions regarding what women specialists want and need, the gradual and concealed process of the exclusion of women specialists from top medical regimes is uncovered. Due to these gendered discourses, women specialists appear to run the risk of facilitating men specialists in pursuing their individual career goals, doing research, publishing, reaping the grants and – eventually – earning promotion.
"Ever since I have had this woman professor in my department, things have fallen into place for me and I've realized how many balls I was keeping up in the air for all these men supervisors! And that I – very nice of me – was doing most of the patient care!"

Woman medical specialist (FG3:6)

7.1. Introduction

Women medical students are currently in the majority at Dutch universities, and women medical specialists can be found in all specialties (Heiligers & Hingstman, 2000; Van der Velden, Hingstman, Heiligers, & Hansen, 2008). At face value, it appears as if the tables have turned and that women enjoy full inclusion within the medical profession. However, the profession is segregated, with women tending towards specialties such as paediatrics and family practice, and considerably fewer women in more prestigious areas such as surgery (Doorne-Huiskes & Conen, 2007; Pringle, 1998). In addition to this segregation, women medical specialists still seem to be excluded from senior academic medical positions (Van Doorne-Huiskes & Van Beek, 2009). Even with the number of women medical students rising, inequality regimes seem to remain. These inequality regimes are “loosely interrelated practices, processes, actions, and meanings that result in and maintain class, gender, and racial inequalities within particular organizations” (Acker, 2006, p. 443).

The explanations for gender inequality, and possible remedies, fall into two broad categories. The first category of explanations for medical inequality regimes focuses on women themselves. They either do not want to achieve senior positions because they prefer to focus on their caretaking responsibilities at home (e.g., Hakim, 2002; Hamel, Ingelfinger, Phimister, & Solomon, 2006), or they are perceived to simply lack the ambition to achieve these positions (Eagly & Carli, 2007; Van Vianen & Fischer, 2002; Van Vianen & Keizer, 1996). The other category of explanations focuses on the organization and the way that the gendered notion of the ‘ideal worker’ excludes women from career progression (e.g., Acker, 2006; Benschop & Doorewaard, 1998). The ideal worker is what Acker calls the ‘disembodied worker’, which includes qualifications such as working full-time and being continuously available, being work-oriented (i.e., with a high level of career motivation) and work-centred – with someone else to take care of all the other aspects of life (Acker, 1992; Tienari, Quack, & Theobald, 2002).
Gendered practices, such as organizations' implicit preference for ideal workers, are often obscured by dominant textual presentations or leading discourses which characterize organizations in terms of objectified and neutral social relations (Benschop & Doorewaard, 1998). For example, work-life balance is a topic presented as an important value in organizations, supported by the family-friendly arrangements offered and displayed on corporate websites and in corporate policy documents. However, underneath this work-life balance discourse, implicit messages are perpetuating the traditional standards of the ideal worker (Mescher, Benschop, & Doorewaard, 2010). The ideal worker is still anchored in career planning, qualifications for hierarchical positions and work processes (Acker, 1992; Benschop & Doorewaard, 1998; Benschop & Verloo, 2006). The ideal worker norm is gendered in the sense that men and women have to deal with different societal expectations regarding their roles as parents and their roles as employees (Kelly, Ammons, Chermack, & Moen, 2010). Women, and mothers in particular, are less likely to live up to the expectations of the ideal worker and less likely to receive the economic and social rewards associated with being an ideal worker (Kelly et al., 2010).

The increasing number of women entering the medical profession is leading to a greater focus on work-life balance – or rather the lack of it – among medical specialists (Heiligers & Hingstman, 2000; Robinson, 2003). The family-friendly or work-life balance discourse has been suggested by researchers as a form of resistance to the norm of the ideal worker that continues to predominate (Meriläinen, Tienari, Thomas, & Davies, 2004). However, whether this increased focus on work-life balance is a serious attempt to challenge the ideal worker norm remains to be seen (Kelly et al., 2010). In this paper, we are interested in how the ideal worker norm is embedded in the talk of Dutch academic medical specialists (the 'ideal specialist' norm) and how this affects the daily working lives of women medical academic specialists in particular (hereafter referred to as 'specialists'). Building on the work of Karreman and Alvesson (2009) and Meriläinen et al. (2004) on the power of normalizing discourses, resistance and counter-resistance, we are interested in how the dominant and normalizing discourse of the ideal specialist is, on the one hand, implicitly propagated in the language of Dutch academic specialists, and yet, on the other hand, is also resisted and counter-resisted. Moreover, we are especially interested in how gender plays a role in the process of normalizing discourses, resistance and counter-resistance, and how these gendered discourses reproduce inequality regimes in teaching hospitals. In doing so, we are contributing to existing literature in four ways. Firstly, this study reveals that women specialists seem to construct a subtly different
notion of the ideal specialist to the men specialists in the study, in which competitive masculinity (Kerfoot & Knights, 1993) and team-commitment serve as all-determining opposites. This subtle and gendered difference in the perceptions of what constitutes the ideal specialist seems to form an initial and essential basis for the exclusion of these women specialists from the higher echelons of the profession. Secondly, the results reveal that the resistance and counter-resistance discourses are both gendered, and reinforce other dominant discourses (i.e., women's alleged preference for caretaking responsibilities). Thirdly, the study provides new understanding of how resistance discourses can take on different guises – including, for example, the well-meaning and 'constructive' solutions to the negative consequences of the normalizing discourse of the ideal specialist. Finally, we demonstrate that, as a result of these gendered discourses, women specialists' real hesitations and obstacles to reach the higher echelons of the medical profession not only remain concealed, but women specialists also risk implicitly helping their male counterparts live up to the role of the ideal specialist.

7.2. Theoretical framework

Our theoretical framework is based on the intersection of three theoretical concepts - gendered practices (gender), power in the form of normalizing discourses, and (counter) resistance. We will first briefly describe our understanding of these three theoretical concepts, and then we will describe how we believe these concepts relate to each other.

Gender

In this study, we are interested in how gender is embedded in normalizing and resisting discourses. We perceive doing gender as a discursive effect that comes into being through discursive practices (Kelan, 2010). It is a dynamic process by which gender is brought into social relationships through interaction – for instance in the workplace (Martin, 2003). Gender is often hidden in institutionalized structures and procedures and is therefore also called the 'gender subtext', since it is difficult to discern from the dominant rhetoric in organizations (Benschop & Doorewaard, 1998). This dominant rhetoric pervades myths of equality and equal opportunity, while organizational practices still categorize between men and women. Both the organization's rhetoric on equality and the gender subtext will condition the lives of employees (Benschop & Doorewaard, 1998; Tienari et al., 2002). To make things more complicated and harder to undo or resist, gendered norms
and rules are changing continuously (Tienari et al., 2002). Because people follow these norms – partly in order to obtain societal approval – gender is perpetuated and reinforced (Benschop & Doorewaard, 1998).

What matters in this study are the processes that produce and reproduce gender inequality in senior academic medical positions and gender segregation between different medical specialities (Pringle, 1998). One concept which is fundamentally gendered is that of the 'ideal worker' (Acker, 1990). This is the notion of the employee who is prepared to work long hours, arranges her/his other responsibilities around paid work and is committed to her/his work (e.g., Bailyn, 2006; Kelly, et al., 2010). Although jobs and hierarchies seem to be abstract categories, they are fundamentally gendered (Tienari et al., 2002). For instance, within the concept of the ideal worker, assumptions are hidden about the dividing line between one's professional life and one's private life, and where men and women draw that line (Gherardi & Poggio, 2001; Tienari, et al., 2002). This separation also involves women staying at home to take care of everything else in their (and their husband's) lives (Acker, 1992).

Power: the normalizing discourse of the ideal specialist

The dominant norm of the ideal worker has often been discussed in relation to managers and professionals or knowledge workers, such as consultants (e.g., Karreman & Alvesson, 2009; Kelly et al., 2010). In fact, the ideal worker has become such a dominant discourse that it starts to seem like common sense (Meriläinen et al., 2004). In this study, we see discourses as historically and culturally variable ways of specifying knowledge and truth (Meriläinen et al., 2004). Discourses are made up of language or statements together, which arrange and naturalize the social word in a specific way and thus inform and affect social practices (Alvesson & Karreman, 2000; Foucault, 1980). A dominant discourse is one that wields power, since "the normalizing effects of discourses determine who and what is 'normal', standard and acceptable" and what is considered to be 'truth' (Meriläinen et al., 2004, p. 544). Normalizing discourses not only transmit and produce power; they also reinforce, undermine and expose power (Meriläinen et al., 2004). Power is an integral part of social reality which enables subjects to act in a particular way (Karreman & Alvesson, 2009). In the footsteps of other researchers (e.g., Alvesson & Willmott, 2002; Meriläinen, et al., 2004; Thomas & Davies, 2005), we thus use a Foucauldian-influenced approach to conceptualize the normalizing discourse regarding what – according to men and women specialists – would constitute the 'ideal' specialist.
One example of such a powerful, normalizing discourse is that of 'competitive masculinity' (Kerfoot & Knights, 1993). This refers to the way in which organizations appropriate certain dominant notions of masculinity, such as self-assertiveness and being work oriented (Collinson & Hearn, 1994; Meriläinen, et al., 2004). Kerfoot and Knights (1993) derived the concept of 'competitive masculinity' from what Seidler (1989) calls contemporary masculinity – a way of relating to the world in which everything becomes an object of and for control. This control sustains a hierarchy imbued with instrumentalism, careerism and the language of 'success', competition, decisive action and risk taking (Kerfoot & Knights, 1993). Competitive masculinity can result in individuals feeling 'driven' for no discernible reason other than because this is simply what it means and to subscribe and live up to a certain ideal. The display of vulnerability – such as compassion for others or emotional sensitivity – undermines that ideal (Kerfoot & Knights, 1993).

Despite the altruistic characteristics that might be expected to typify physicians and which are present in the core tasks of practicing medicine, the academic specialist is also embedded in an academic environment that has been described as masculine and in which masculine subjects (whether men and women) struggle to further themselves within this highly competitive institution (Van Doorne-Huiskes & Van Beek, 2009).

**Resistance and counter-resistance**

Closely related to the normalizing discourse and the power that is intrinsic within it, is the concept of resistance. We define resistance as any response of those over whom power is exercised, which includes the articulation of alternative interpretations (Karreman & Alvesson, 2009). In fact, the definition of resistance has been broadened to include the more routinized, informal and often inconspicuous forms of resistance in everyday practice (Thomas & Davies, 2005). Resistance is a “constant process of adaptation, subversion and reinscription of dominant discourses” (Thomas & Davies, 2005; p. 687). Expressing a notion of the ideal specialist that differs from what is articulated in the normalizing discourse can thus also be viewed as resistance. Individuals – whether alone or together, consciously or unconsciously – reflect on themselves and their performance and sometimes recognize contradictions and tensions between what others say and do and what they themselves feel is the right thing to do. These contradictions and tensions can either find expression in the form of overt resistance (i.e., striking), or by creating an alternative discourse in which the dominant normalizing discourse is criticized and resisted.
However, since the normalizing discourse is dominant in everyday practice, individuals are forced to accommodate it, which again causes feelings of contradiction and tension. To overcome this inconvenience, individuals subtly shift their definitions and understandings in order to reassure themselves that there is no contradiction between what they think and what they do and to ensure social approval (Lindenberg & Frey, 1993; Thomas & Davies, 2005). These subtle shifts in meanings are what Karreman and Alvesson (2009) introduce as counter-resistance, which refers to the fact that “resistance can in itself be resisted” (Karreman & Alvesson, 2009; p. 1120). For example, an employee can resist the normalizing discourse of the ideal worker during a coffee break with a colleague by stating that being available to the organization full time is unrealistic and even a form of exploitation. However, the employee knows that after the coffee break, the same heavy work load will be waiting for her and she will end up working overtime 'voluntarily' to get through it all. In order to bring her talk into line with her behaviour, she 'counter-resists' by stating that she loves her work and therefore does not mind the overtime that she routinely has to work.

Background: the academic specialist

The career path of an (academic) specialist is notoriously demanding (Peschel & Peschel, 1986) and varies between specialties and between countries. In the Netherlands, the academic medical hierarchy is categorized as follows, although not all specialists have to go through each step in this career ladder: physician (MD), assistant specialist (resident), assistant clinical researcher, (medical) specialist, academic specialist, professor/specialist, professor/head of department. The duration of residency varies for each specialty, with an average duration of 5.4 years. Surgical specialties and internal medicine have a six-year residency; specialties such as paediatrics and radiology are characterized by a residency period of five years; and supporting specialties such as nuclear medicine or psychiatry have an average residency period of four years (Van der Velden & Hingstman, 2003).

After becoming a specialist, most academic specialists are responsible for three tasks, namely: patient care, research and teaching medical students and assistant specialists. An unofficial fourth task is taking on managerial work (Van der Wee, 2000).

Teaching hospitals in the Netherlands are facing challenges in the future with new financial structures, increased competition, more emphasis on quality of care and performance, and increased demand for specialized health care with greater transparency and more patient-friendly organizations. Teaching hospitals are often the subject of debate and scrutiny.
in the media when bad health-care processes and medical failures are exposed (Van Doorne-Huiskes & Conen, 2007; Schut & Van de Ven, 2005). Moreover, teaching hospitals have to operate in a highly competitive academic environment, where grants and funding are scarce. Teaching hospitals’ work environments have often been compared to one of athletes practising top-level sport (Van Doorne-Huiskes & Van Beek, 2009).

7.3. Methodology and reflexivity

Case study and focus groups

The empirical basis of this study stems from a case study of a Dutch teaching hospital. The material consists of transcripts from three focus groups and two small-group interviews in which a total of 20 academic specialists participated (see Table 1).

The teaching hospital has around 9,000 employees – including 520 academic specialists - and educates around 3,000 medical students. The organization is characterized by a low number of female specialists in the medical top positions. To improve gender equality in more senior positions, the board of the medical staff initiated a working group called DAFAS (Diversity Advancement Network of Female Academic Specialists). The first author was asked to conduct a small-scale quantitative analysis regarding the family-friendliness of the work culture and women’s ambitions in the hospital. The survey was distributed in May 2009 and the report was offered to the chairwoman of DAFAS early in July 2009. It was mutually decided that the results of the survey would be distributed and discussed in small focus groups with a minimum of two and a maximum of seven participants. We deliberately choose to use small focus groups to promote a feeling of empowerment among the participants and allow enough time for all group members to participate in the discussions (Eriksson & Kovalainen, 2008). The aim of using small focus groups was to enable us to study the dynamics of how opinions are formed, and how subjects are discussed and expressed in a social situation (Wilkinson, 1998). All specialists in the hospital were invited to participate in one of the focus groups in an e-mail from the chairwoman of DAFAS. Participants could register for the focus groups by choosing their preferred date and time by replying to the invitation. The first author (BP) collected the enrolments. All participants were allocated to their ‘first preference’ focus group, initially not knowing who the other participants would be. There two all-women groups, one all-men group and two mixed-gender groups. This categorization developed as a result of
specialists’ preferences for dates and times and was not enforced by the researchers. Some focus groups were intended to have more participants (the all-men group and the second mixed-gender group), but some specialists could not attend the meeting due to emergencies. Although this resulted in small groups of three and two participants, the focus group structure was still used during the interview.

The topic list for the focus group was semi-structured and included subjects that were dealt with in the survey, such as the family-friendliness of the work culture (i.e. support for working part-time, absence of career hindrance), the ‘ideal’ specialist (i.e., long working hours, academic output, patient care), HR initiatives to address gendered inequality in senior positions (i.e., providing extra grants for promoting women, offering a management development course specialized for women, DAFAS meetings,
diversity training for all heads of departments) and (self-perceived) career ambition. The results of the quantitative study performed in this hospital revealed that there was an inconsistency between certain outcomes. On the one hand, respondents reported working long hours as a matter of routine, while on the other hand they reported not believing that this was necessary in order to be an ‘ideal specialist’. They also believed that the work environment was family-friendly, yet they also expected to be hindered in their career if they actually made use of these family-friendly arrangements. The interviewer decided to use these observations in the quantitative data as input for the focus group discussions, and to ask focus group members to reflect on these outcomes.

On average, each focus group lasted for about ninety minutes. The focus groups were chaired by the first author (BP), who was assisted by a student or colleague. The interviewer specifically explained the thinking behind using the technique of a focus group, which was mainly to observe and register their conversation regarding discussion topics, in which they were allowed to react to one another with similar or different experiences and ask each other questions. The quotes in this paper are translations of the original Dutch excerpts. Participants in the focus groups and small-group interviews are, for sake of anonymity, referred in the excerpts with codes such as male specialist, FG1:4. FG1 refers to ‘focus group 1’, ‘4’ refers to participant number 4. SG refers to a small-group interview.

**Analyses**

The material was primarily analysed using a form of critical discourse analysis (Fairclough, 1992, 2003), in which the aim is to address the issues of social power by elites, institutions or groups that result in social inequality, including that of gender inequality (Van Dijk, 1995). Firstly, two authors (BP and HD) coded the data (separately) using the categories: the ‘ideal’ specialist, the family-friendly work culture (or lack of it), gender, and gendered beliefs regarding women’s ambitions. During this phase, the issues of the normalizing discourse together with subtle expressions of resistance emerged as an important theme from the data. In the second stage, we selected the excerpts that most clearly articulated notions of the ‘ideal’ specialist or resisting the ‘ideal’ specialist norm. We made a more detailed analysis of these sections to investigate social practices in relation to issues of power and control. In this second stage, we first analysed which ideal specialist norms played a role in the hospital and then looked specifically for differences, ambiguities and communalities in these norms. The respondents’ reactions and explanations for the inconsistencies in the quantitative data
'Keeping men supervisors’ balls in the air'

were very helpful, as they appeared to contain the first signs of resistance and counter-resistance discourses.

7.4. Results

In the following section, we will introduce three themes, which will enable us to reveal how gender and power relate to each other in the normalizing discourse of the ideal specialist, the (counter) resistance discourse and how these discourses preserve inequality regimes. The first theme is that of team-commitment versus competitive masculinity; the second theme is women’s alleged ‘dip’, and the third theme is that of blaming the women.

Team-commitment versus competitive masculinity

The normalizing discourse of the ideal specialist in the conversation among specialists reveals some typical characteristics of the ideal worker: he or she is always available, dedicated and perceives of his or her work as a hobby. In one extreme example, a pregnant woman specialist, who already had three miscarriages, reports how her (mainly men) colleagues responded to her final – successful – pregnancy.

Interviewer: And how do colleagues deal with that [her pregnancy, BP]?
Woman specialist (FG2:1): Well, they are not amused.
Interviewer: How does that show?
Woman specialist (FG2:1): Well, they don't say anything. No.
Interviewer: What do you believe they should say, then?
Woman specialist (FG2:1): Well, it would be nice if... especially considering the past, if they had said “Congratulations” for example, you know. Well, they don't say that. Or “good for you”. Not from my direct colleagues, but the nurses did say these things.

When pressed further, this woman specialist admits that it “would have been nice if... especially considering the past”. In expressing her disappointment, she seems weakly to resist the ideal of the specialist that is always available and whose private life (or that of colleagues) is of minor importance compared to work. Another woman specialist in the focus group is amazed by the reaction of the men colleagues, and says:

Woman specialist (FG2:2): They cannot separate your happiness from the burden it will be to them? [amazed, with condemnation]
Woman specialist (FG2:1): But I can understand that. Imagine you are sixty and
you don't have to work shifts any more. And then two weeks after you've announced
that, suddenly I show up saying “well listen up, I can't do shifts anymore either,
could you step in for me every now and then during the work week.” I can
understand that.

In reaction to the amazement of the second woman specialist, the first
woman specialist defends the behaviour of her colleagues that have not
congratulated her on her successful pregnancy by saying “but I can
understand that” (twice). She even explains why she feels sorry for her (man)
senior colleague who now – due to her pregnancy and being unable to do
shifts – has to run more shifts. By doing so, she counter-resists her initial
resistance.

Feeling guilty about burdening colleagues with extra work appeared to
go beyond being unavailable for the organization or colleagues due to
physical absence. For example, another woman specialist (FG2:3) explains
that she is trying to finish her dissertation, but that she can never manage
to reserve time in her schedule to do this and that she does not feel supported
by her supervisor and colleagues. Some other participants recognize this
and claim to have similar experiences. The interviewer asks the woman
what would happen if she simply did not show up and stayed at home or in
the library to work on her research. She replies “Yes, you are right, perhaps I
should be more persistent in sticking to my plan, but there is just so much work to do
that I actually also feel guilty towards my colleagues for landing them with that extra
workload”. Again, this gendered ideal specialist norm, according to which you
do not burden colleagues, dominates this conversation. Moreover, she coun­
ter-resists her initial criticism (resistance) of her unsupportive colleagues
and supervisors by blaming herself for not being self-assertive (‘perhaps I
should be more consistent in sticking to my plans’). This woman struggles to
be both a good colleague while at the same time expressing competitive
masculinity (Kerfoot & Knights, 1998; Meriläinen, et al., 2004), being
self-assertive (sticking to her plans) and having enough self-discipline.

As the conversation continues, another woman specialist (FG2:4) explains
that when she started out as a specialist, she was promised that she could
begin some PhD research. But then things went differently. She became
involved with doing managerial tasks for the department, which she
appeared to be good at and which was perceived by others as “convenient”,
and it took her about three-and-a-half years to get permission to start her
PhD research. She then continues:

Woman specialist (FG2:4): ...and then, well, yes, I think... yes I think that men are
better at that.
Interviewer: At what?
Woman specialist (FG2:4): At clearly setting their goals and at sticking to their goals. Yes, that's what I think.
Woman specialist (FG2:1): ...every now and then thinking more about their own interests instead of the common interest. Actually they're better at that. And eventually their own interest also serves the common interest.

The two excerpts above reveal how these women specialists use gendered stereotypes to counter-resist their initial, yet weak, resistance discourse. Men are perceived to be “better” and “more clever” in “thinking about their own interests instead of the common interest”. One of them even states that the men's individual interests also benefit the whole group (“eventually their own interest also serves the common interest”). It appears as if pursuing an individual career interest rather than serving common interests is thus acceptable for men, while for women it is considered as not behaving as a good colleague.

Only women specialists in this study mentioned group interests explicitly, which we will henceforth refer to as ‘team-commitment’. Remarkably, none of the men participants – although there were only seven - explicitly or implicitly mentioned a feeling of not wanting to burden colleagues with work they felt was basically their responsibility. The only concern one man specialist (SG5:1) felt about carrying out his research alongside patient care, were the complaints he expected to get from his wife at home (“when I say at home “yes, well, you know it is quite important that I get my PhD”... the home front of course foresees that this will be yet another sacrifice she has to make, so no, the idea does not really get an enthusiastic reception from her”).

The ‘dip’

There were no outward manifestations of resistance discourses among specialists. There was no strike or whistle blowing about routinely having to work overtime, even though some participants acknowledged they had every right to do so. However, it seems as if small cracks are starting to appear in the norm of the ideal specialist.

Our next excerpt is distracted from men and women specialists’ conversations regarding the dominant norm of the ideal specialist, the difficulty that women specialists seem to encounter in living up to this norm, and how that may explain the gendered inequality at the top of their institution. The participants seem to be aware that offering the opportunity to work part-time does not liberate women specialists from participating in a highly competitive academic working environment in which not being able to
continuously deliver scientific output is "deadly" for your career (woman specialist, professor, FG3:5). So far, they seem to be aware of and openly resist the dominance of the normalizing discourse of the ideal specialist, who is fully work-oriented. But then the conversation continues as follows:

Man specialist, head of department (FG3:4): It's a first step [offering the opportunity to work part-time, BP], but there are many other things that... just like [OTHER PARTICIPANT] said, when they get pregnant, then comes the dip. That's the point I guess.

Woman specialist, professor (FG3:5): Yes, well and then... of course it is a natural dip. And I believe that it should be possible. That at a certain moment a woman's attention, and also that of a young father, presumably, is temporarily elsewhere. And that does not matter, but to pick up after that...

Man specialist, head of department (FG3:4): Yes, that is an important problem I think.

The woman specialist seems to choose her words carefully in order not to run into gendered assumptions regarding women's sole responsibility for caretaking by stating "...and also that of a young father, presumably". Both specialists agree on the problem being the 'dip', during which attention... is temporarily elsewhere. The remainder of the conversation reveals the specific meaning of the 'dip':

Woman specialist, professor (FG3:5): And especially getting to the top means [generating] scientific output. And that used to be done late in the evening, but when you have children that becomes difficult, and then your output goes down. What I’m looking for is, how can you create a work environment for such a person in which you can at least continue to stimulate this scientific interest, you know.

Again, both the man and woman specialist use gender-sensitive phrases such as ‘when you have children’ and ‘such a person’. People without children apparently do not have this ‘problem’ since work is done 'late in the evening'. The beginning of their discussion, regarding the hidden subtext of the ideal specialist who is always available and how that aggrieves specialists with children, reveals signs of resistance. However, their resistance to the dominant discourse – which makes an academic career with having children impracticable – moves over into questioning (women) specialists’ scientific interest by stating “...can at least continue to stimulate this scientific interest, you know”. This reveals the hidden meaning of ‘the dip’: a decline in scientific interest.

What is striking is that none of the women participants in our focus
groups (13 in total) reported having had a difficult time combining caretaking responsibilities with work. Only one woman specialist (SG5:2) stated that she felt she should or would like to spend more time with her daughter. However, most women specialists reported working overtime routinely and had a partner that was either working part-time, working from home (e.g., entrepreneur) or unemployed, thus reversing the usual gender role prescription of the male bread-winner model.

Blaming the women

In an all-women focus group, women specialists share their thoughts and experiences about how men and women colleagues deal with leaving work for caretaking responsibilities, and how that is gendered.

Woman specialist (FG2:1): ... There is a kind of pressure. And if a guy then says “hey, I have to go home to take care of a sick child” then everyone says “You’re such a great guy, how good of you”. And if a woman says “I have to go home because...” then... and I think that... that it partly has to do with women as well. Because women who do not have children yet then look at you thinking “there she goes again”. And that is rather... yes, I do feel that.

Woman specialist (FG2:4): What women do to each other is even worse than [what] men [do to women]. Because men are not aware of doing it. Well, at least they are partly unaware of it, that is.

Woman specialist (FG2:3): You know, what I notice. That is a little like what you meant with those women who are each other’s worst enemies. I believe we have to be aware of what we say and do ourselves regarding that.

The three women specialists are aware of gender practices and even admit that it is not only men who have gendered opinions about caretaking responsibilities versus – implicitly – work-orientation, but that women also have gendered beliefs regarding how men and women should behave (“I think that it partly has to do with the women as well”). At first, these women resist the normalizing discourse in which men are the ideal specialists and women are more care-oriented. But then the conversation shifts slightly from collective resistance to counter-resistance in which women in particular are held responsible for gender discrimination in the normalizing discourse. Women in general are not only accused of even being worse than men (“What women do to each other is even worse than [what] men [do to women]”), but also accused of sending out the wrong signals and not sticking together (“we have to be aware of what we say and do ourselves regarding that”). As the conversation continues, the blame continues to be dealt out.
Woman specialist (FG2:5): *I sometimes have difficulty with the fact that it is always the mother who sacrifices herself in that respect. And then I think “well, you also have a husband, why can't he jump in every now and then?” But apparently I cannot say that, that would be very bad. I believe that is also a cultural thing. The woman sacrificing herself, and of course the mother is perhaps quicker to respond to caretaking responsibilities.*

This woman specialist blames other women (mothers) for their lack of assertiveness in asking their husband to take care of family responsibilities and being too willing to sacrifice themselves (“the woman sacrificing herself”). She ascribes this to the Dutch motherhood ideology, in which women are mainly responsible for children. She resists this normalizing discourse on women being the best caretakers, which is, according to her, not done (“Apparently I cannot say that, that would be very bad”). However, by using this argument she counter-resists her resistance to the normalizing discourse of the ideal specialist as someone who has someone else at home to take care of everything else. In short, women are frequently and wrongfully frowned upon if they leave work for caretaking responsibilities (resistance), but then again women are often too ready to resign themselves to this situation due to the motherhood ideology (counter-resistance).

Later in the conversation, a woman specialist, who first states that there is not enough sympathy for working mothers, even accuses younger women physicians for not being ambitious enough. As she explains how she was invited to talk to medical students about her specialty, she expresses how she was annoyed by women asking her “whether her specialty could be combined with having children – ‘Can you do the residency in three days per week?’” (woman specialist, FG2:1). She then tells the other participants that she answered this question by stating that she personally believes it is absurd to expect to become a good specialist on a three-day residency. She then says that she presented these students an Excel sheet that showed “what we have at home, who's supposed to pick up whom, when and where, who has shifts, and so on. We really have an Excel sheet, with a big picture of my beautiful son!”

These remarks illustrate how this woman specialist falls back on gendered assumptions regarding women’s lack of ambition, which for her showed through in the question about whether residency could be done part-time. In doing so, she counters her initial resistance to the ideal specialist norm who is available full-time. Consequently, she even corroborates the normalizing discourse by presenting an Excel sheet in how life at home should arrange itself around work.

Finally, all these examples of ‘blaming the women’ reveal how gender is
embedded in the normalizing discourse of the ideal specialist who is assertive and work-oriented.

**Gendered (counter) resistance and inequality regimes**

The teaching hospital provides extra grants for appointing female principal investigators (PIs) and professors. These grants, intended to encourage women specialists into top medical positions, are an organizational method of resisting the dominant discourses of the ideal specialist which lead to inequality regimes (DAFAS, 2009). However, the participants in our focus groups seemed to view these arrangements in a different light, stating that they only served to stress that women should become the 'ideal specialist' along the lines of the normalized discourse, but that the arrangements fail to provide the support that women really need. As the participants in this mixed-gender focus group agree, not publishing due to the 'dip' will mean that women do not secure any grants, because they have not published enough. This will eventually result in in a vicious circle. One woman specialist explains how a woman professor was recently appointed to her department, which - together with her attending a course in leadership techniques for women specialists - made her more aware of women physicians being at a disadvantage compared to their men counterparts in organizations. She shares her revelation with the others in the mixed-gender focus group as follows:

Woman specialist (FG3:6): *Ever since I have had this woman professor in my department, things have fallen into place for me and I've realized how many balls I was keeping up in the air for all these male supervisors! And that I - very nice of me - was doing most of the patient care!*

Later in the same focus group, both (man and woman) heads of department acknowledge that women tend to fall into the trap of doing 'patient care' due to their 'dip', neglecting or losing their academic interests, and thereby 'helping men colleagues who did have the time to publish and get those grants' (man specialist, head of department, FG3:4). There is, however, a subtle difference in the reasons attributed to doing more patient care: whereas the woman specialist in the excerpt refers to it as 'keeping men supervisors' balls in the air' (implying that she is basically doing them a favour as part of her commitment to the team and is being 'very nice' to others), the man head of department attributes it to his women colleagues experiencing a 'dip'.

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Chapter 7

7.5. Conclusion and discussion

The first and main contribution of this explorative study is that it reveals how gender is not only integral to the normalizing discourse of the ideal academic specialist, but also how it is used as a basis for resisting and counter-resisting this normalizing discourse. Its second contribution, which is related to the first, is that by focusing on the role of gender, the ambiguous nature of resistance and counter-resistance discourses has been revealed. In total, we have observed three themes in the conversations of academic medical specialists which illustrate these two contributions. The first theme was that of competitive masculinity versus team-commitment. Some researchers have already identified the ‘ideal worker norm’ in the talk of professionals – for example among consultants who create their own ‘ideal consultant’ norm (Karreman & Alvesson, 2009; Meriläinen, et al., 2004) or among bank employees (Tienari, Quack & Theobald, 2002). These studies illustrated the masculine ideal of competence in which the opposite ‘feminine’ behaviour is that of being more private, invisible and submissive (e.g., Meriläinen et al., 2004; Katila and Meriläinen, 2002). Our analysis of the ‘ideal specialist’ has uncovered another opposite to competitive masculinity – that of team-commitment. The obvious opposite of ‘assertiveness’ in this study and in the context of medical specialists is being sensitive concerning other people’s interests – not only those of patients but also those of colleagues. However, the medical context seems to be characterized by a double bind as women physicians are often expected to have a ‘natural’ preference for patient care (Verdonk et al., 2007). One of many possible reasons for the inequality regime in this particular Dutch teaching hospital would seem to be how women specialists interpret the notion of the ideal specialist as one who is not only constantly available for patients, but also highly committed to her team. The ideal specialist, according to most women specialists in this study, does not burden other colleagues with extra work, not even to achieve individualistic goals such as completing PhD research. None of the men specialists explicitly expressed any concerns about this, whereas several women specialists told of their struggle to combine the two aspects of their work, which are constructed as mutually contradictory and exclusive. We would like to stress that we do not seek to imply that the men specialists in this study were not considerate about their colleagues in terms of sharing the work load. The point of our argument relates to the apparent differences between the men and women specialists in how they relate to the ideal specialist norm. Competitive masculinity, in which assertive, individualistic and goal-oriented behaviour are important aspects, seemed to be more acceptable
among the men specialists in the study, and less so among the women specialists. The dominance of the normalizing discourse in particular emerged as women specialists in this study were believed to lack assertiveness and had trouble completing their PhD research as a result.

The second theme was that of the ‘dip’. Women specialists in particular were assumed to have not only practical difficulty in combining care-taking responsibilities with a medical career, but also to have a natural ‘dip’ in their level of scientific interest after the birth of their children. However, as our analysis revealed, the women in our focus groups did not mention a ‘dip’ in scientific interest at all, and most of them appeared to have worked out a reversed ‘breadwinner’ model, with husbands either working part-time or not at all. Only one woman specialist stated that she would rather spend more time with her child, but so did three men specialists. The main concern among the women physicians in this study seemed to be whether they would burden colleagues with extra work in patient care and how they should combine their patient care work with pursuing individual career goals. Other researchers have already pointed out the possibility of one and the same discourse serving as a normalizing discourse in one context and as a resource for resistance in the other (Meriläinen et al., 2004). We have illustrated how one and the same discourse, such as women specialists’ alleged ‘dip’, can come in different forms at the same time and in the same context. While the ‘dip’ discourse is meant to express resistance against the normalizing discourse of the ideal specialist, it simultaneously serves as a normalizing discourse for women’s alleged preference for caretaking responsibilities.

In the third theme, blaming the women, a similar process is apparent around counter-resistance. Although most women specialists in this study agreed that women specialists are disadvantaged by the ‘ideal specialist’ norm, women who do not yet have children were particularly singled out for blame because they lack sympathy for the working mothers among the women specialists. In addition, some women specialists in this study held women (in general) themselves responsible for perpetuating a cultural motherhood ideology by not being assertive enough with their husbands. On one occasion, young women physicians were even assumed by a woman specialist to lack ambition, or at least lack willingness to make sacrifices at home, because they asked whether a medical career in a certain specialty could be combined with having children. The ‘blame-the-women’ discourse serves to counter-resist the resistance to the ideal specialist norm; yet at the same time, it illustrates and strengthens another normalizing discourse, namely that of women not being self-assertive, home-oriented and not ambitious enough. Further research on how discourses go from being
dominant and normalizing to resisting and counter-resisting could shed light on why it is so hard to resist resistance (Karreman & Alvesson, 2009).

The third contribution of this study lies in the way we reveal how resistance discourse is not necessarily one of explicit (verbalized) criticism, protest or opposition. In our mixed-gender focus groups, both men and women specialists expressed their resistance to the ideal specialist norm by providing ‘constructive’ criticism about how to create gender-sensitive career paths for both men and women. Although these ideas were interspersed with gendered assumptions on what women specialists might need, it also showed that resistance discourse does not always have to be negative in tone. Perhaps the fact that it was a mixed-gender group made participants more cautious of gender-sensitive wording and led to seek solutions for a ‘mutual problem’. In fact, the men specialists in this study also expressed resistance to the ideal specialist norm by stating that they wanted more time for their children and that men specialists were also assumed to experience a ‘dip’ in scientific interest due to childbirth. An important shortcoming of this study was the relatively small sizes of two focus groups. Further research on the influence of the size and composition of a focus group is needed and could provide more insight into how that could affect organizations’ attempts to deal with issues of gender diversity.

The fourth and final contribution of this study is our insight into how resistance and counter-resistance discourses were able in themselves to perpetuate, or even create, inequality regimes in this Dutch teaching hospital. This process has the shape of a two-stage rocket. Firstly, by assuming that women specialists experience a ‘dip’ in scientific interest due to their childcare responsibilities and by using this as a resource for resistance, women specialists are not only perceived as ‘the others’ and thus marginalized; their real reasons for not conducting scientific research remain concealed. Consequently, women specialists’ real needs, such as adequate measures to improve transparency over who is doing what in a team of specialists and confronting those who cut corners when providing patient care, remain hidden and are thus not implemented. Secondly, by perhaps concentrating excessively on one’s role as a good colleague due to gendered role prescriptions and carrying out the greater share of patient care, women specialists risk missing out on time to devote to research, publicity and winning grants. Moreover, unless women specialists are able to see through this gendered criss-cross of discourses with their gender-neutral appearances and dangerous career pitfalls, they run the risk of facilitating the (men) specialists that already enjoy an advantaged and powerful position.
8

CAREER = CAREER?

CONCLUSION AND DISCUSSION
8.1. Introduction

Individual employees and health care institutions invest heavily in combining caretaking responsibilities with work (e.g., Van Doorne-Huiskes, Peper, & Den Dulk, 2005; Pouwels, 2011). However, demanding household responsibilities and demanding work environments do not naturally result in constant high levels of career motivation, inexhaustible career investment and automatic career advancement. It would appear that the pressing question is, therefore: how can having caretaking responsibilities at home (Care) together with (+) a demanding profession and work environment (for example, the Emergency Room) result in prosperous careers for women physicians?

The first aim of this study was to provide insight into the effects of both individual and organizational aspects on career motivation and career investment among women physicians in particular. From an individual perspective, (women) physicians’ having children and their views on the ‘ideal’ mother and the ‘ideal’ physician were studied in terms of their effect on career motivation and investment. From an organizational perspective, I focused on the effects of family-friendly HR arrangements and family-friendly work-home cultures on the career motivation and investment of (women) physicians.

The second aim of this study was to shed more light on whether – and if so how – individual and organizational aspects interact to affect women physicians’ career motivation, their career investments, and ultimately, their career advancement. For example, women physicians could have certain views of the ‘ideal’ mother which could affect their career motivation, but health care organizations’ family-friendly HR arrangements and work-home cultures may strengthen or diminish these direct effects. Moreover, I wanted to reveal how societal discourses on certain notions – such as parenthood or the motherhood ideology, but also the normalizing discourse on the ideal physician, which makes itself heard the loudest within organizational cultures – can influence the career progression of women academic specialists.

The aims of this study were attained by empirically testing hypotheses and answering the research questions. I will summarize and discuss the most salient findings and conclusions regarding the research questions here. More detailed conclusions can be found in the individual chapters concerned. First, the effects of individual aspects on career motivation and investment among (women) physicians will be discussed, after which I will elaborate on this study’s findings regarding the effects of organizational aspects. This will serve the first aim of this study.
The second section reflects on how individual and (perceived) organizational aspects interact, and how this interaction in itself influences the relationship between on the one hand individual and organizational aspects and on the other (women) physicians' career motivation, their career investment and, consequently, their career advancement. This will work towards the second aim of this study.

Subsequently, the study's limitations and contributions will be discussed, followed by the practical implications for (women) physicians and (HR) policy makers and managers working in health care institutions. This chapter will be rounded off with a general conclusion in which I will return to the general aim of this study.

8.2. Individual aspects

The majority of the respondents in all datasets had children under the age of 12, still attending kindergarten and/or elementary school. Combining this demanding household characteristic with a medical career seems particularly hard for women physicians, since the majority of them have a partner who works more than 36 hours per week. Their male colleagues, on the contrary, usually have partners who work in part-time jobs (< 36 hours per week) [question 1]. However, it seems that the partners of women physicians do adjust their working hours to those of their spouses more than other Dutch men (SCP, 2008). This seems to be in line with the findings from a recent study on interdependencies within families, life events such as child birth and time allocation decisions (Pouwels, 2011). As the results of the study suggest, 'time-greedy' organizations contribute to a more equal division of paid and unpaid work between parents.

The general and scientific debate often falls back on women's caretaking responsibilities and societal motherhood ideologies to explain women's alleged lack of career motivation (e.g., Hakim, 2002; Van Engen, Dikkers, Vinkenburg, & De Rooy, 2009; Van Vianen & Keizer, 1996) and, consequently, their career investment (Hamel, Ingelfinger, Phimister, & Solomon, 2006). The following section discusses this study's findings with regard to the effects of these individual aspects on career motivation and investment.

**Having children, views of the 'ideal' mother and career motivation**

Do having children and women physicians' views of the 'ideal' mother affect their career motivation? The results reveal that women physicians without children have more traditional views of the 'ideal' mother than
women physicians with children (*question 2a*). Secondly, women physicians with more traditional views of the ‘ideal’ mother have lower levels of career motivation than those with less traditional views (*question 2b*). Thirdly, the findings show that having children does not explain women physicians’ levels of career motivation, whereas their views of the ‘ideal’ mother does explain variances in career motivation (*question 2c*). This finding was partly confirmed by another study in this dissertation, which also revealed that women academic specialists with children have higher levels of career motivation than those without children. Moreover, men academic specialists with a child of under 4 years old have lower levels of career centrality than those without children (*question 2d*). In addition, wanting to be a role model for their children positively affected women physicians’ career motivation. This effect was stronger than the negative effect of holding traditional views regarding time allocation.

To summarize, the first contribution of this study to the scientific and general debate on the individual aspects of career motivation is therefore that *having children is not a predictor of women physicians’ levels of career motivation but is a predictor for men physicians with young children*. Also, especially women physicians without children tend to hold a more traditional view of the ‘ideal’ mother.

**Career motivation and career investments**

Most women physicians work part-time - between 28 and 36 contracted hours per week. However, they still work between 7 and 14 hours overtime as a matter of routine, resulting in an average fulltime working week (*question 1*). Although most respondents were satisfied with their current number of working hours, the results also reveal that it is mostly men physicians who would like to work fewer contracted hours, while it is mostly women physicians who would like to work more contracted hours (*question 1*). The call for a better work-life balance (i.e., working fewer hours) seems to be shifting from women physicians toward men physicians.

It is often implicitly or explicitly assumed that working hours reflect career motivation (Judge, Cable, Boudreau, & Bretz, 1995), although this is contested by other researchers (Keuzenkamp, 2009; Peters, Bleijenbergh, Pas & Gremmen, 2010) who state that women’s career motivation should be more broadly defined than only their decisions on labour participation. I showed that women physicians with high levels of *career centrality* work longer hours and are more likely to hold a PhD degree. Women physicians with higher levels of *career insight* work fewer hours and are less likely to perform ancillary activities. Women physicians’ with higher levels of *career ambition* do not work more hours than those who are not ambitious, yet they are more likely
to hold a PhD degree and to be engaged in ancillary activities (question 3a, 3b and 3c).

The second contribution of this study in terms of the individual aspects is thus that working hours can only be explained by women physicians' career centrality, while women physicians who would like to obtain a top position are more likely to obtain a PhD degree and/or to be engaged in work-related ancillary activities. Career insight – setting career goals – affects women physicians' career investment negatively.

Dealing with gendered role prescriptions: framing

Women physicians not only have to deal with gendered role prescriptions regarding being a 'good' mother, they are also confronted with gendered role prescriptions regarding the 'ideal' physician. These two societal ideals are very difficult to reconcile, with the ideal mother working only three days a week outside the home (SCP, 2008) and the ideal physician being available all the time (Acker, 1990; Price et al., 1971). The internalization of these conflicting role prescriptions can result in different coping mechanisms with different underlying frames. For example, a woman physician may prefer one traditional role prescription over another, resulting in either a care frame or a career frame. Women physicians can also decide to try to live up to both traditional ideals (switching frames) or to reject them both (non-traditional frames). This study has revealed that women physicians with switching frames have higher levels of career centrality than women physicians with a care frame; and a slightly lower level of career centrality compared to women physicians with a career frame. However, women physicians with switching frames do not differ in their level of career insight compared to the others; nor is their level of career ambition lower than that of those with a career frame (question 4). Women physicians who want to 'do it all' are just as career motivated as those who deny or reject gendered role prescriptions. Although not hypothesized, I also found that women physicians with switching frames work more hours than those without switching frames.

The third contribution regarding individual aspects is that women physicians with switching frames (thus also having a more traditional view of the 'ideal' mother) are as career motivated as those having a career frame, and work more hours than women physicians without switching frames. The views of women physicians regarding the 'ideal' physician should thus be included in research models that aim to explain women physicians' levels of career motivation and investment. As shown by this study, focusing exclusively on the alleged career-threatening role of being a mother provides a gendered and distorted picture.
8.3. Organizational aspects

The other side of the debate focuses more on organizational aspects that can affect women physicians’ career motivation and investment. As stated in the Introduction of this Chapter, medical working environments are characterized by their demanding nature and contemporary health care institutions seem to be well aware that employees with caretaking responsibilities expect some sort of compensation from the organizations in which they work.

Family-friendly arrangements

Health care institutions – like other organizations – have to adjust to their environments, including the changing make-up of their employees (e.g., Boon, Paauwe, Boselie, & Den Hartog, 2009). Physicians and academic specialists in this study do seem to perceive their organizations as family-friendly in terms of the possibility of working part-time, having a part-time residency, having a say in scheduling and having the opportunity to take care leave for a sick child or relative. However, other types of arrangements such as flexible working, childcare, extra leave and career coaching are perceived to be less common (question 1). With the exception of part-time working, the actual use of these arrangements was also relatively low (question 1).

This study also shows that those health care organizations which are finding more women entering certain medical specialties are perceived to provide more Reduced Participation Arrangements (RPAs) - such as the possibility to work part-time, offering part-time residency - and Full Participation Arrangements (FPAs) - such as working from home (teleworking) and having a say in rostering - than those who mostly accommodate medical specialisms that are less feminized. Furthermore, the presence of Collective Labour Agreements (CLAs) also had a significant positive effect on the number of RPAs and FPAs offered (question 5a).

However, since health care institutions adjust to the changing characteristics of their work forces, they also run into a strategic dilemma in terms of rising relative labour costs (Montgomery, 1988). As the results of the study described in Chapter 5 reveal, offering RPAs has a significant negative effect on women physicians’ contracted working hours. However, offering FPAs has a significant positive effect on women physicians’ contracted working hours (question 5b). Moreover, women physicians’ who make use of RPAs work fewer contracted working hours, while FPAs have no effect on their contracted working hours (question 5c). Since the use of FPAs does not reduce women
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It can therefore be concluded that offering FPAs is more profitable in terms of an organizational labour-cost-containment strategy. These insights shed new light on the effectiveness of family-friendly arrangements on the contracted working hours of women physicians, showing that offering (and the participating in) FPAs has fewer adverse effects than offering chiefly part-time arrangements. Unfortunately, most health care institutions were perceived as offering mainly RPAs arrangements.

Organizations offer family-friendly or gender equality arrangements to establish all kinds of desired HR outcomes, such as maintaining women physicians’ working hours, improving employees’ work-life balance or creating gender equality in senior positions (Lewis, 2001; Mescher, Benschop, & Doorewaard, 2010). This study contributes by bundling family-friendly arrangements in terms of the implicit support they provide to gendered role prescriptions such as that of the ‘ideal’ mother (i.e., working part-time) and the ‘ideal’ worker (i.e., making use of childcare facilities or being enrolled in extra career development programmes). Certain family-friendly arrangements can be categorized as Revising Work Culture Arrangements, because they implicitly increase flexibility within the organization (i.e., teleworking, flexible start and end of working hours). The question that I wanted to answer in this study was whether perhaps implicit signals or gendered subtexts underlie these arrangements and affect women physicians’ career motivation and investment. The results in Chapter 6 reveal that Ideal Mother Arrangements, such as part-time working or extra leave arrangements, have no effect on women physicians’ levels of career motivation (question 6a). However, the provision of Ideal Worker Arrangements affects physicians’ career motivation positively. Revising Work Culture Arrangements have a significant positive – although not stronger – effect on women physicians’ levels of career ambition (question 6b).

On the basis of these results, it can be concluded that the most commonly offered family-friendly arrangements, such as part-time working, do not contribute to increasing women physicians’ career motivation, nor does it benefit the organization’s cost-containment strategy. Moreover, if career motivation and career investment among women physicians is to be increased, offering extra career support (such as coaching and mentoring) seems to be more effective. However, if health care organizations want to encourage women physicians’ ambition to obtain a senior position, they should revise their work culture and introduce greater flexibility.
Supportive work-home cultures

Turning to perceptions of the supportiveness of the work-home cultures, women physicians and women academic specialists perceive the work-home cultures in their organizations as less supportive than their male peers (question 1). However, both men and women physicians agree that working part-time can jeopardize career advancement (question 1).

Some researchers (e.g., Dikkers et al., 2007) have found no significant relationship between parental status and perceptions of the supportiveness of the work-home culture. This study reveals contradicting results, showing that women physicians with a youngest child in elementary school believe that their work environment offers more support for their career than women physicians without children. However, for women physicians whose youngest child is a pre-schooler and those whose youngest child is in secondary school, no significant differences were found in perceptions of the supportiveness of the organizational work-home culture compared to their childless counterparts (question 7a). Women physicians with children do not differ in their levels of career motivation from those without children. The results in this dissertation reveal that these equal levels of career motivation among mothers and non-mothers in this study are not due to differences in perceptions regarding the supportiveness of the work-home culture (question 7b).

As for the effect of a supportive work-home culture on women physicians' career motivation, I found that support for the work-life balance has no significant effect on any of the dimension of career motivation. However, women physicians who perceive their organization's work-home culture as supportive in terms of their career goals, also report higher levels of career motivation than women physicians who do not feel supported in this way. Contrary to what I expected, the results showed that women physicians who do not expect to be hindered in their career progression as a result of working part-time, also report lower levels of career motivation. In other words, those who do feel hindered in their careers have higher levels of career motivation. Regarding differences between men and women in the effects of a supportive work-home culture on career motivation, the results revealed that women benefit mainly from support in achieving their career goals, whereas men become more motivated when they feel supported in improving their work-life balance (question 7c). These outcomes confirm earlier suggestions that there may be gendered assumptions behind the provision of family-friendly arrangements.

Finally, I studied the effects of a supportive work-home culture on women physicians’ contracted working hours. The results showed that women
physicians who feel supported in achieving or maintaining a good work-life balance work fewer hours than those who do not feel supported in this area. Women physicians who believe that using family-friendly arrangements will hold them back in their careers work fewer hours than those who do not perceive this to be the case. However, women physicians who feel supported in achieving their career goals work more hours than women physicians who do not feel supported in this area (question 7d).

Overall, the most important findings reveal that support for the work-life balance has no significant effect on any of the dimension of women physicians' career motivation, whereas support in terms of their career goals does. Men physicians, however, do become more motivated when they feel supported in improving their work-life balance. Finally, only support for career goals, instead of support for work-life balance, seems to increase the number of contracted hours that women physicians work.

8.4. Interaction: individual notions and organizations intentions

Work-home cultures interacting with family-friendly arrangements

This section will address the second aim of this dissertation, namely to provide more insight in how individual and (perceived) organizational aspects interact in affecting career motivation and investment among women physicians. As discussed more in detail in Chapter 5 and 6, it appears that offering support for career goals tempers the negative effects that RPAs have on women physicians' contracted working hours, as did perceived absence of career hindrance (question 8a and 8b). I also found that of those women physicians who use FPAs, those who feel supported in achieving their career goals work more hours than those who do not feel supported in achieving their career goals. More specifically, the use of FPAs causes women physicians to work fewer hours, except where the use of FPAs coincides with the perception that there is support for their career development, in which case the use of FPAs has a positive effect on contracted working hours. Furthermore, I found that support for improving the work-life balance has a negative effect on the relationship between the take-up of FPAs and contracted working hours. Of those women physicians who use FPAs, those who feel supported in improving or maintaining their work-life balance work fewer hours than those who do not feel supported in this (question 8a and 8b).

To summarize, offering support for career goals tempers the negative effects that RPAs (part-time working) have on women physicians' contracted working hours, and strengthens the positive effect that the use of FPAs (i.e., working from home) has on
women physicians' working hours. I thus conclude that career support can provide a ‘healthy’ counterweight in balancing employees’ search for work-life balance with the labour-cost-containment strategy of health care institutions.

**Frames interacting with family-friendly arrangements**

As described earlier, women physicians have to perform ‘cognitive aerobatics’ in order to cope with the contradictory role expectations regarding the ‘ideal’ mother and the ‘ideal’ physician. From an HR perspective, the question is whether organizations actually support these women physicians in their struggles, or whether organizations – as a result of the gendered subtext underlying family-friendly arrangements – only make things worse. The results reveal that Ideal Mother Arrangements only improve the career insight of women physicians with a care frame. However, the provision of Ideal Mother Arrangements does not distract women physicians with a career frame or switching frames from their career motivation (question 9a). Ideal Worker Arrangements appear to have a similar selective effect, as they only positively affected women physicians’ career centrality when they have a career frame. These arrangements neither temper nor strengthen the negative effects of having a care frame on career motivation (question 9b). Revising Work Culture Arrangements do not affect the relationship between women physicians’ frames and their career motivation (question 9c).

These findings reveal that family-friendly or gender equality arrangements cannot alter the effects of internalized societal and organizational role prescriptions. On the contrary, they seem only to serve those women physicians who have internalized either one of the dominant, gendered role prescriptions.

**The underlying subtle influences of gendered normalizing discourses**

The final research question (10) dealt with whether and how gender is interwoven in the normalizing discourse of the ideal academic specialist, but also whether and how gender is used as a basis for resisting and counter-resisting the normalizing discourse. Moreover, I wondered if and how these gendered discourses could – unintentionally – perpetuate inequality regimes in a Dutch teaching hospital. In doing so, this study revealed the ambiguous nature of resistance and counter-resistance discourses. In total, three themes in academic medical specialists’ talk were extracted that illustrate how gender is rooted in normalizing, resisting and counter-resisting discourses. The first theme was that of competitive masculinity versus team commitment in which the discourse on the ‘ideal specialist’ was full of masculine characteristics such as being competitive and having self-efficacy, while also
revealing the marginalized opposite of competitive masculinity, namely that of team commitment. For example, while it was perceived as logical for men specialists to pursue individual career goals such as obtaining a PhD degree, women specialists seemed to struggle with the gendered role prescription for women specialists, in which women do not burden colleagues with extra work – not even when they want to conduct PhD research. The dominance of the normalizing discourse emerged particularly when women specialists in this study stated that they were not assertive enough when ensuring that they have enough time to complete their PhD research. The second theme was that of the 'dip', in which women specialists in particular are assumed to have not only practical problems with combining care taking responsibilities with a medical career, but also to have a natural 'dip' – a temporary lack of interest - once children are born. However, the women in the focus groups did not mention a 'dip' in scientific interest at all and most of them appeared to have developed a 'reverse-breadwinner' model, in which their partner either worked part-time or not at all. In the third theme, blaming the women, a similar process evolved through counter-resistance. Although most women specialists in this study were unequivocal about the disadvantages they experienced due to the 'ideal specialist' norm, they particularly blamed other women who do not (yet) have children and lack sympathy for the working mothers among the women specialists. In addition, some women specialists in this study held women (in general) responsible for perpetuating the cultural motherhood ideology by not being assertive enough toward their husbands.

These three gendered themes in normalizing, resisting and counter-resisting discourses illustrate the subtle processes by which inequality regimes are perpetuated. This process has the shape of a two-stage rocket. First, by assuming that women specialists experience a 'dip' in scientific interests due to their childcare responsibilities or by 'blaming women' and using this as a resource for (counter) resistance, women specialists are perceived not only as 'the others' and thus marginalized, but their real reasons for not conducting scientific research – such as their fear of overloading their colleagues with patient care - remain concealed. Second, by believing that one must above all be a 'good' colleague, which can result in performing the majority of patient care, women physicians run the risk of missing out on time needed to carry out research, publish work and secure grants – and subsequently also miss out on promotion. Meanwhile, their male counterparts seem to be less hindered by this normalizing discourse of the 'ideal' specialist – at least in this respect – and perhaps benefit implicitly from women's gendered role prescriptions because they facilitate men to conduct research.
8.5. Limitations and suggestions for further research

The limitations of this study presented themselves at the level of theoretical and pragmatic issues, but also at the methodological level. Theoretically, it would be interesting to compare men and women physicians or to investigate how particularly men physicians deal with conflicting societal expectations. However, as the societal and scientific debate focuses specifically on reduced labour participation rates among women due to their caretaking responsibilities, and their consequence absence from senior medical positions, I decided to focus on women physicians. Nevertheless, as the results revealed, it seems that future studies should focus on men and the – perhaps changing – role prescriptions that they face.

A similar limitation is my decision to focus on medical professionals, rather than comparing highly educated women from a range of sectors within the same study. However, limiting this study to one profession increased the reliability of the relationships that were found between variables, as it eliminated the possibility of interference from variations in the professional context. Despite this, a similar research model could be interesting to investigate in other feminizing professions, such as law (Bolton & Muzio, 2007).

Another factor in this dissertation, which I personally experienced as an important limitation, is that I used a career motivation instrument which incorporates the normalizing discourse of the ideal worker. This shortcoming concerns a common struggle experienced by feminist researchers seeking to investigate women’s career motivation. As in almost all quantitative studies on women’s career motivation and investment, the construct of career motivation is based on men’s career experiences (Pringle & McCulloch Dixon, 2003). For example, the use of ‘career centrality’ could be challenged on the grounds that making one’s career central to one’s life requires that someone else takes care of all the other aspects of one’s life. Whereas for men ‘career centrality’ could have a positive singular connotation since a driven, ambitious, and goal-oriented man will receive social approval for his behaviour, it could have much more equivocal connotations for a woman, since it is socially much less acceptable for women to put their careers above all other aspects of their life. Women, then, not only score lower on career motivation inventories than men, but they probably also associate other, latent meanings such as the centrality of their roles as mothers and their caretaking responsibilities, since these are so entangled in the way women view their careers. I therefore suggest that further validity tests are needed to ascertain whether career motivation does indeed have a different meaning.
for men and women. On the other hand, we should not overlook the fact that for many highly educated women such as women physicians, who have invested heavily in their career through training and obtaining experience, career plays an important part in their life, and that women derive pleasure in that too.

Turning to the effects of family-friendly HR arrangements, I would suggest that investigating how family-friendly arrangements interact with other HR practices, such as career tracks and promotion systems, could be a fruitful line of research. So long as full-time employees continue to stand a better chance of promotion, support from employers for the work-life balance of their staff will be a mixed blessing, undermining the possible positive HR outcomes of family-friendly arrangements. Accordingly, I believe that future research should try to include the perceptions of multiple stakeholders (such as supervisors and HR managers) in multilevel research models. This would shed light on how others perceive the effectiveness of family-friendly HR practices, and how different perceptions and discourses regarding their effectiveness in turn affect HR practices and outcomes.

The study also had some methodological limitations. For example, it is based on self-reports and carries the risk of self-selection bias. However, the variances that were found in – for example – perceived supportiveness of work-home cultures and levels of career motivation suggest a low risk of self-selection bias. Another risk that is worth mentioning is that of a non-responders bias. To minimize the chance of a serious non-responder bias, I cross-checked the respondents’ career, household and perceived organizational characteristics – insofar as was possible – with data available on the medical Dutch population. Nevertheless, since not much data are available on – for example – perceived work-home cultures and the family-friendly arrangements offered by health care institutions, the chance of a non-responders bias cannot be ruled out completely.

Since a cross-sectional study is unable to register changes over time or to further analyse directions of causality, longitudinal research is also needed. For example, respondents’ ages seemed to play an important role in determining women physicians’ frames, as if frames might be a reflection of the respondents’ phases of life. The relationship between career motivation and career investment is particularly susceptible to a causality-effect, with previous career investment leading to higher levels of career motivation to begin with.
8.6. Contributions

The main contribution of this dissertation is that it provides insight into how (gendered) individual aspects together and in interaction with (gendered) organizational aspects affect and alter career motivation, career investment, and possible career advancements. The journal ‘Human Relations’ recently published a special issue on interdisciplinary approaches to contemporary career studies, in which the guest editors Khapova and Arthur (2010) call for more interdisciplinary studies on careers, since the overspecialization of scientists in a certain subject area within a certain scientific discipline can deprive us from an ‘holistic vista’ (p. 9). This research responds to their appeal for a more interdisciplinary approach by including both the social context as the agents, yet mainly focuses on the relationship between them (Giddens, 1984), using different perspectives, methods and types of data to explore the topics at hand. This also enables the study to contribute to several scientific fields, such as career studies, gender studies and the HRM field.

Career studies

Although in Dutch organizational and societal practices, there is consensus over the meaning of ‘ambition’ (Peters et al., 2010), and despite many constructs in career literature that closely resemble ‘ambition’, such as career aspirations (e.g., Rainy & Borders, 1997), career motivation (London, 1983, 1993, 1997; Lopes, 2006; Noe, Noe, & Bachhuber, 1990), and career orientation (e.g., Pulkkinnen, Ohranena, & Tolvanena, 1999), all these constructs interpret career – and what it means for individuals and organizations – slightly differently (Dikkers, Van Engen, & Vinkenburg, 2010). The three-dimensional construct of career motivation, as used in this study, is based on a combination of instruments developed by other researchers (London, 1983, 1993; Lopes, 2006; Noe et al., 1990; SCP, 2008). This enables the inclusion of the various aspects that are involved in career motivation such as centrality, insight and desire for upward mobility. Furthermore, this multifaceted construct of career motivation was tested on highly educated professionals working in a medical setting, which had not previously been investigated. Another contribution to career studies is that most studies on women professionals’ careers only look into gender differences, in which gender is dichotomized to a 0-1 variable, with women labelled as ‘0’ (e.g., Taylor, Lambert, & Goldacre, 2009). Although this dichotomization of a variable seems to be a pragmatic, statistical procedure, it subtly illustrates how men are regarded as the dominant norm, and women
as the marginalized 'other'. I did not, therefore, compare women's scores on career motivation with that of men, since that would have not have been comparing like with like. I aimed specifically at a broader interpretation of career 'success' or 'achievement' by not looking at seniority or higher salary levels, but by looking at types of career investment that benefit women's intellectual knowledge (PhD degree) and their chance of upward mobility, and also how women contribute to society with this knowledge (work-related ancillary activities). The findings provide support for a broader approach toward defining women's career achievements.

Gender studies

This dissertation also contributed to sociological studies, in particular gender studies. The principal contribution of this study in this field is that it reveals how gender is not only interwoven into normalizing discourse of the 'ideal' academic specialist, but also used as a basis for resisting and counter-resisting this normalizing discourse. Although other researchers have already pointed out the possibility of one and the same discourse serving as a normalizing discourse in one context and as a resource for resistance in the other (e.g., Meriläinen, Tienari, Thomas, & Davies, 2004), I have illustrated how one and the same discourse, such as women specialists' alleged 'dip', can take different forms at the same time and in the same context. While the 'dip' discourse is meant to express resistance against the normalizing discourse of the ideal specialist, it is simultaneously a normalizing discourse regarding women's alleged preference for caretaking responsibilities. Meanwhile, other normalizing discourses undermine what are in essence hopeful resisting discourses, and can even bolster counter-resistance discourses, perversely helping to perpetuate inequality regimes.

Another contribution of this dissertation to sociological and gender studies is its investigation of the effects of societal gendered role expectations on career motivation and investment, particularly in women. In sociological studies, women's roles as mothers and the possible effects on their rates of labour market participation are often reflected by the inclusion of variables such as whether she has children and the age of the youngest child (e.g., Vlasblom & Schippers, 2006). However, societal role expectations associated with being a mother are not then included in the scope of most research. To my knowledge, only a few studies (e.g., Marks & Houston, 2002; Van Engen et al., 2009) investigate the effects of motherhood ideology on women's careers. I suspect this has much to do with dominant gendered practices, which evidently also affect scientific knowledge. This could also explain why women physicians' struggle with other gendered role expectations, such as
that of the 'ideal' worker, has not often been included in studies on women's careers. This study has included both the internalized views of the 'ideal' mother and that of the 'ideal' worker/physician, and as such, I have emasculated myths regarding women's decreasing career motivation after childbirth. I have shown that this is more dependent on their views of an 'ideal' mother, and that even if these views are somewhat traditional, they views stand a good chance of being balanced by traditional views of the 'ideal' physician. Moreover, the results suggest that perhaps men physicians' are more 'susceptible' to changing priorities when it comes to being a father and a physician.

By investigating the effects of societal gendered role prescriptions, I have provided gender researchers, whose studies are more qualitatively oriented (Spierings, 2010), with more quantitative examples of how gendered practices affect women professionals' lives and careers. Moreover, quantitative research methods can reveal patterns and the extent of differences (Harding, 1997; Spierings, 2010). This study provides gender researchers with some insight into the impact or strength of certain societal, gendered factors that in daily life are often assumed to influence women's careers.

Organizational HRM studies

SHRM researchers nowadays stress the importance of including the individual level of analysis (Paauwe, 2009; Wright & Nishii, 2004) when studying HRM (and organizational) performance, in which HR practices serve as communication mechanisms that signal to employees that they should adopt a certain form of behaviour (Wright & Nishii, 2004). It is through HR practices, also known as high-performance work practices (Huselid, 1995), that employees’ knowledge, skills and abilities are increased which in turn improves organizational performance (Combs et al., 2006). By combining insight from Organizational Behaviour (BO) literature on the effects of family-friendly arrangements on the individual level with insights from SHRM literature, this study contributes in three ways.

Firstly, studies into family-friendly arrangements have so far focused on the uptake rates of these arrangements provided by organizations (e.g., Dikkers et al., 2007), and on whether the use of these provisions correlates with outcomes for the individual employee, such as reduced work-life conflict (e.g., Saltzstein, Ting, & Saltzstein, 2001), increased job attraction (Honeycutt & Rosen, 1997) or parents’ career success (Dikkers et al., 2010). However, whether organizational performances do indeed improve due to family-friendly arrangements has barely been studied until now (Giardinia & Kabst, 2008). On the other hand, SHRM research also involves certain
limitations, such as an overrepresentation of traditional HRM practices and the exclusion of more recent developments such as family-friendly arrangements (Boselie, Dietz, & Boon, 2005; Kaarsemaker & Poutsma, 2006). By offering these arrangements, organizations expect to improve performance and productivity at work. In this dissertation, I have provided a more nuanced understanding by showing that certain family-friendly arrangements do indeed have positive HR outcomes, but other family-friendly arrangements do not improve HR outcomes, and can even be detrimental to the organization's other (cost-containment) strategies.

Secondly, SHRM researchers generally agree that HR practices are at least loosely related to the performance of firms (Boselie, Dietz, & Boon, 2005; Wright & Boswell, 2002; Guest, 2011). As stated earlier, employees' perceptions of HR practices ('perceived HRM practices') should be included in the analyses to explain further how HR activities affect organizational performance (Guest, 2011). I included physicians' perceptions regarding the supportiveness of the work-home culture and how this influences the effectiveness of the used family-friendly arrangements provided. I was thus able to show that a supportive work-home culture plays an essential role in both strengthening the positive effects of certain family-friendly arrangements on working hours, but also in moderating the negative effects of other family-friendly arrangements.

A final contribution to this field is that organizations' HR policies relating to family-friendly or gender equality arrangements can be viewed more critically. HR arrangements are always developed by people, who are inevitably and unconsciously affected by gendered practices. This results in family-friendly arrangements with a 'subtext' (Benschop & Doorewaard, 1998) that carries gendered assumptions and ideals which can, in turn, reinforce gendered practices. By categorizing family-friendly arrangements along the lines of gendered role expectations and hidden gendered subtexts, I have shown that these arrangements are especially effective for women physicians who subscribe to these gendered ideals. Moreover, some arrangements designed mainly to improve the better work-life balance contribute only marginally or not at all to women physicians' career motivation and investment. As such, it can be argued that these arrangements are only serving to perpetuate or reinforce the status quo.
8.7. Policy implications

The following sections will discuss the implications for both sides of the spectrum, both individuals as physicians (men and women) – including in their roles as supervisors or colleagues – and policy makers and managers in healthcare organizations.

Individual level

Without wanting to suggest that we should seek to ‘fix’ women, which is always the risk of issuing advice directed at women, I will start by discussing how the findings of this dissertation can benefit individual (women) physicians. First, parenthood enriches both women’s and men’s lives, and not only at home but also in terms of their career motivation. The media attention given to the tension between having children and a demanding career tends to overshadow the positive influence of having children on one’s career. More importantly, I hope this dissertation provides individuals with the insight that work-life conflict is much more than a ‘house of cards’ in which child care, household and career responsibilities are organized. Societal ideals relating to what constitutes a good mother, for example, are often taken for granted, internalized by women and men without reflection, and automatically projected upon others and thus reinforced. Both parents and non-parents working in the medical setting could focus more on their personal views and those of others when it comes to what constitutes a good parent, according to personal standards – rather than automatically and implicitly assuming that all women share the same views regarding motherhood.

Secondly, this study has shown that support for career goals benefits women physicians’ career motivation in particular, whereas men physicians benefit more from support for work-life balance. This suggests that women should perhaps actively seek career support, while men could more actively seek more support in achieving a better work-life balance. This will not only serve to maintain career motivation, but also alter gendered stereotypes on what men and women physicians want and need in order to remain motivated in their career. In the current discourse on work-life balance, supervisors tend to forget – and should thus become more aware – that women physicians with children are also highly qualified professionals whose career motivation (or work-life balance in case of men) needs to be addressed and nurtured.

Finally, this study has revealed that women in particular can adopt a more team-oriented attitude at work and experience feelings of guilt when pursuing personal career success. Before blaming themselves, women, but
particularly their supervisors, could try to investigate whether there is scope for improvement when it comes to dividing the work load - not only regarding the more prestigious tasks such as conducting research, but also patient care.

Organizational level

The main contribution of this study for policymakers is that it reveals that they should become more aware of the gendered subtexts on which well-intended family-friendly or equality arrangements are based. Family-friendly arrangements are only marginally effective in retaining or increasing women physicians' career motivation, and can have be counter-productive in terms of women's career investment. Furthermore, family-friendly arrangements are less efficient when the perceived work-home culture does not shift accordingly. Family-friendly arrangements should be provided only after careful consideration of how they can be combined with other HR arrangements, such as tenure tracks, promotion systems and selection and recruitment procedures.

Most policies still focus – and have done so for the last decades – on 'fixing' women, sending them to assertiveness training, work-life balance or strategic leadership courses. Besides the risk of sending out the message that there is something about women that needs to be 'fixed', after all these years gender inequality regimes in Dutch health care institutions persist. This strengthens my belief that family-friendly arrangements seem to be what soap is in the medical practice. Washing your hands will not cure the patient (offering family-friendly arrangements will perhaps not improve physicians' productivity), but of course not washing your hands can make matters a whole lot worse (not offering family-friendly arrangements can – in the long run – demotivate staff and result in lower productivity). I am under the impression that health care institutions still view family-friendly arrangements as a remedy to gendered inequality, rather than as simple good practice for all employees.

Organizations need to think out of the box, and critically investigate how their work processes can become more efficient, for example, and not only in terms of cost-containment strategies, but also in terms of bringing an end to the exhausting way in which physicians are expected to serve their employers and society, working an average of eight hours of overtime as a matter of routine. With the ever increasing demand for health care services which is swallowing ever more of society's resources, this has become a strategic HR theme that can no longer be ignored. The differences in the perceived supportiveness for work-life balance, flexibility and collegiality that were
found in this study within similar types of specialties, with no appreciable difference in the complexity of the work processes involved, convinced me that it is hardly a matter of rigid work processes, but much more a question of a social system in which people are doubtful about experimenting with new, unorthodox ways of working (Achterbergh & Vriens, 2010). Critical questions about the alleged reduction in the quality of patient care when handing over patients (working in shifts) can no longer be disguised by blaming physicians who work part-time. Rather than pushing women physicians into the mould of their more competitive masculine colleagues, supervisors should become more experienced in managing professionals in highly competitive work environments in order to share out the less ‘prestigious’ work more equitably between men and women physicians.

8.8. Conclusion

The title of this dissertation poses a question: does having caretaking responsibilities at home (Care) together with (+) a demanding profession and work environment (for example, the Emergency Room) result in prosperous careers for women physicians? Before I can answer this question, let me summarize how both streams of the debates seem to rest on gendered assumptions regarding what women physicians, in particular, want and need in order to succeed in their careers.

Regarding the individual aspects, the following myths have been debunked. First, having children positively affects women but negatively affects men physicians’ career motivation. Second, although traditional views of the ‘ideal’ mother can indeed explain why certain women physicians have lower levels of career motivation and investment, women physicians without children hold the most traditional views regarding motherhood. Third, women physicians’ traditional views of the ‘ideal’ physician often counter their traditional views regarding motherhood, resulting in a more nuanced understanding and higher levels of career motivation and investment by women physicians.

At the other end of the spectrum, similar assumptions appear to dominate. Offering family-friendly arrangements mostly affects women physicians’ career motivation and investment when they comply with gendered role prescriptions. Moreover, these arrangements do not always interact well with organizational (cost-containment) strategies, nor do they counter traditional societal ideals regarding the ‘ideal’ mother and the ‘ideal’ physician. The results of this study reveal that there is still much to
gain by critically analysing work processes and competitive, masculine work cultures in health care institutions, in which even resisting discourses appear to be capable of perpetuating gender inequality regimes. And contrary to what is often expected, support from colleagues and supervisors in obtaining and maintaining a good work-life balance seems to be becoming a 'men's issue', while especially women physicians would benefit from greater support for their career goals.

Care + ER = Career? The answer to this question, in my opinion, is a resounding yes. However, instead of focusing excessively on the alleged negative effects of professional women's caretaking responsibilities, equal attention should be paid to negative effects of gendered, dominant and hidden norms in the work environment. Only then can organizations and society benefit from women physicians' potential contribution in the 'ER'.
Epilogue

Conducting a multi-disciplinary and multi-method study on how women (physicians) deal with contradictory gendered role expectations regarding the ‘ideal’ mother and the ‘ideal’ worker, family-friendly arrangements and (un)supportive work-home cultures, and how these factors affect their career motivation and investment was an intensive task for at least three reasons.

First, although researchers stress the importance of looking over the fences of their own discipline, those fences can be quite high. For example, much creativity was needed to combine and enter the field of gender studies with quantitative research methods, in which ‘generalizations’ are often – and sometimes rightfully – scrutinized. Similarly, it was not always easy to incorporate a critical gender perspective with mainstream career and HRM research, in which sometimes the only way to get published is to minimize my ‘feminist rebelliousness’ and label women physicians as ‘1’, instead of ‘0’.

Secondly, I can assure you that becoming a scientific expert on work-life balance issues is no guarantee that your own work-life balance will improve immediately. On the contrary, every now and then along the way, I wished I had not learned about gendered role prescriptions and the way power is caught up in gendered, everyday practices – as did my partner Hans.

Finally, I am a woman, mother, partner, researcher, colleague, daughter, subordinate, friend, and so on. At the intersection of all these roles and their associated societal expectations lies the realization that there is no such thing as ‘objective’ research. I now feel saturated with all the different points of view on women’s career advancement that I have come across during the past four years. It is because of all these insights that I have been able to trust myself to conduct this research thoroughly and with an open mind – as much as can be expected of a woman, mother, partner, researcher, colleague, daughter, subordinate, friend, and so on.
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Summary

Individual employees and health care institutions invest heavily in combining caretaking responsibilities with work (e.g., Van Doorne-Huiskes, Peper, & Den Dulk, 2005). However, demanding household responsibilities and a demanding work environment do not naturally result in constant high levels of career motivation, inexhaustible career investments and automatic career advancement. The pressing question is therefore: How can having caretaking responsibilities at home (Care) together with (+) a demanding profession and work environment (for example, the Emergency Room) result in (=) prosperous careers for women physicians?

The first aim of this study was to provide insight into the effects of both individual and organizational aspects on career motivation and career investment among women physicians in particular. From an individual perspective, (women) physicians' having children and their views regarding the 'ideal' mother and the 'ideal' physician were studied in terms of their effect on career motivation and career investment. From an organizational perspective, I focused on the effects of family-friendly HR arrangements and family-friendly work-home cultures on the career motivation and investment of (particularly) women physicians.

The second aim of this study was to shed more light on whether – and if so how – individual and organizational (gendered) aspects interact to affect women physicians' career motivation, their career investments, and ultimately, their career advancement. For example, women physicians could have certain views of the 'ideal' mother which could affect their career motivation, but health care organizations' family-friendly HR arrangements and work-home cultures may strengthen or diminish these direct effects. Moreover, I wanted to reveal how societal discourses on certain notions – such as parenthood or the motherhood ideology, but also the normalizing discourse on the ideal physician, which makes itself heard the loudest within organizational cultures – can influence the career progression of women academic specialists.

Individual aspects

The majority of the respondents in this study had children under the age of 12, still attending kindergarten and/or elementary school. Combining this demanding household characteristic with a medical career seems particularly hard for women physicians, since the majority of them have a
partner who works more than 36 hours per week. Their male colleagues usually have partners who work in small part-time jobs. However, it seems that the partners of women physicians do adjust their working hours to those of their spouses more than other Dutch men (SCP, 2008).

**Having children, views of the ‘ideal’ mother and career motivation**

The general and scientific debate often rely on women's caretaking responsibilities and societal motherhood ideologies to explain women's alleged lack of career motivations. But does having children and women physicians' views of the ‘ideal’ mother indeed affect their career motivation? This study's results reveal that women physicians with children have less traditional views of the ‘ideal’ mother than women physicians without children. Secondly, women physicians with more traditional views of the ‘ideal’ mother have lower levels of career motivation than those with less traditional views. Thirdly, the findings show that having children does not explain levels of career motivation, whereas women physicians' views of the ‘ideal’ mother do explain variances in career motivation. In addition, wanting to be a role model for their children positively affected women physicians' career motivation, and this effect was stronger than the negative effect of holding traditional views regarding time allocation. In one particular case study, women academic specialists with children had higher levels of career motivation than those without children. Moreover, men academic specialists with a child under 4 years old have lower levels of career centrality than those without children.

To summarize, the first contribution of this study to the scientific and general debate on the individual aspects of career motivation is therefore that having children is not a predictor of women physicians' levels of career motivation but is a predictor for men physicians with young children. Also, especially women physicians without children tend to hold a more traditional view of the ‘ideal’ mother.

**Career motivation and career investment**

Most women physicians work part-time – between 28 and 36 contracted hours per week. However, they still work between 7 and 14 hours overtime as a matter of routine, resulting in the average fulltime workweek. Interesting are the results in this dissertation that reveal that although most respondents were satisfied with their current number of working hours, it is mostly men physicians who would like to work fewer contracted hours, while it is mostly women physicians who would like to work more contracted hours. The call for a better work-life balance (i.e., working fewer hours) seems to be shifting from women physicians toward men physicians.
It is often implicitly or explicitly assumed that working hours reflect career motivation (e.g., Judge, Cable, Boudreau, & Bretz, 1995), although this is contested by other researchers (Keuzenkamp, 2009; Peters, Bleijenbergh, Pas & Gremmen, 2010) who state that career motivation should be more broadly defined than only women's decisions on labour participation. This study more reveals the specific nature of the relationship between career motivation and career investment of women physicians. Women physicians with high levels of career centrality indeed work longer hours and are more likely to hold a PhD degree. However, women physicians with higher levels of career insight work less hours and are less likely to perform work-related ancillary activities. Finally, women physicians' with higher levels of career ambition do not work more hours than those who are less ambitious, yet they are more likely to hold a PhD degree and to perform work-related ancillary activities.

The second contribution of this study in terms of the individual aspects is thus that working hours can be explained by women physicians' career centrality, while women physicians who would like to obtain a top position (career ambition) are more likely to obtain a PhD degree and/or to be engaged in work-related ancillary activities. Career insight – setting career goals – affects women physicians' career investment negatively.

**Dealing with gendered role prescriptions: framing**

Women physicians not only have to deal with gendered role prescriptions regarding being a 'good' mother, they are also confronted with gendered role prescriptions regarding the 'ideal' physician. These two societal ideals are very difficult to reconcile, with the ideal mother working only three days a week outside the home (SCP, 2008) and the ideal physician being available all the time (Acker, 1990; Price et al., 1971). The internalization of these conflicting role prescriptions can result in different coping mechanisms with different underlying frames. For example, a woman physician may prefer one traditional role prescription over another, resulting in having either a care frame or a career frame. Women physicians can also decide to try to live up to both traditional ideals (switching frames) or to reject them both (non-traditional frames). This study has revealed that women physicians with switching frames have higher levels of career centrality than women physicians with a care frame; and a slightly lower level of career centrality compared to women physicians with a career frame – but only when controlled for the presence of family-friendly arrangements. However, women physicians with switching frames did not differ in their level of career insight compared to others; nor is their level of career
ambition lower than that of those with a career frame. Women physicians who want to ‘do it all’ are just as career motivated as those who deny or reject gendered role prescriptions. Besides, women physicians with switching frames worked more hours than those without switching frames.

The third contribution regarding individual aspects is that women physicians with switching frames (thus also having a more traditional view of the ‘ideal’ mother) are as career motivated as those having a career frame, and work more hours than women physicians without switching frames. The views of women physicians regarding the ‘ideal’ physician should thus be included in research models that aim to explain women physicians’ levels of career motivation and investment.

Organizational aspects

The other side of the debate focuses more on organizational aspects that can affect women physicians’ career motivation and investment. Medical work environments are characterized by their demanding nature and contemporary health care institutions seem to be well aware that employees with caretaking responsibilities expect some sort of compensation from the organizations in which they work. Nonetheless, the effectiveness of these ‘compensations’ (family-friendly arrangements) in terms of HR outcomes (i.e., women physicians’ career motivation and investment) have not yet been studied.

Family-friendly arrangements

Health care institutions – like other organizations – have to adjust to their environments, including the changing make-up of their (future) employees. Healthcare institutions do seem to anticipate as physicians and academic specialists in this study perceived their organizations as family-friendly in terms of the possibility to work part-time, having a part-time residency, having a say in scheduling and to having the opportunity to take care leaves for a sick child or relative. However, other type of arrangements such as flexible working, childcare facilities, extra leave and career support (i.e., coaching) are perceived to be less common. With the exception of part-time working, the actual use of these arrangements was also relatively low.

The results of this study show that those health care organizations which are finding more women entering certain medical specialties are perceived to provide more Reduced Participation Arrangements (RPAs) and Full Participation Arrangements (FPAs) than those who mostly accommodate
medical specialisms that are less feminized. Furthermore, the presence of Collective Labour Agreements (CLAs) also had a significant positive effect on the number of RPAs and FPAs offered. However, since health care institutions adjust to the changing characteristics of their workforces, they also run into a strategic dilemma in terms of rising relative labour costs (Montgomery, 1988). Offering RPAs has a significant negative effect on women physicians’ contracted working hours; whereas offering FPAs has a significant positive effect on women physicians’ contracted working hours. Moreover, women physicians who make use of RPAs indeed work fewer contracted working hours, while the use of FPAs have no effect on their contracted working hours. Since the use of FPAs does not reduce women physicians’ working hours, it can therefore be concluded that offering FPAs is more profitable in terms of an organizational labour-cost-containment strategy. These insights shed new light on the effectiveness of family-friendly arrangements on the contracted working hours of women physicians, showing that offering (and the participating in) FPAs has fewer adverse effects than offering chiefly part-time arrangements. Unfortunately, most health care institutions were perceived as offering mainly reduced-participation arrangements (RPAs).

Family-friendly arrangements are often bundled according to their precise nature (e.g., flexible facilities versus childcare facilities) or according to statistical analysis (i.e., principal axing factor analysis). Organizations offer family-friendly or gender equality arrangements to establish all kinds of desired HR outcomes, such as maintaining women physicians’ working hours, improving employees’ work-life balance or creating gender equality in senior positions. The present study contributes by bundling family-friendly arrangements in terms of the implicit support they provide to gendered role prescriptions such as that of the ‘ideal’ mother (i.e., working part-time) and the ‘ideal’ worker (i.e., making use of childcare facilities or being enrolled in extra career development programmes). Certain family-friendly arrangements can be categorized as Revising Work Culture Arrangements, because they implicitly increase flexibility within the organization (i.e., teleworking, flexible start and end of working hours, having a say in rostering). The question that I wanted to answer in this study was whether perhaps implicit signals or gendered subtexts underlie these arrangements and affect the career motivation and investment of women physicians. The results reveal that Ideal Mother Arrangements, such as part-time working or extra leave arrangements, have no significant effect on women physicians’ levels of career motivation. However, the provision of Ideal Worker Arrangements affect the career motivation of women physicians positively. Revising Work Culture Arrangements have a significant positive – although
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not stronger - effect on women physicians' levels of career ambition.

On the basis of these results, it can be concluded that the most commonly offered family-friendly arrangements, such as part-time working, do not contribute to increasing women physicians' career motivation and career investments, nor do they benefit the organization's cost-containment strategy. Moreover, if career motivation among women physicians is to be increased, offering extra career support (such as coaching and mentoring) seems to be more effective. However, if health care organizations want to encourage women physicians' ambition to obtain a senior position and their career investments, they should revise their work culture and introduce greater flexibility.

Supportive work-home cultures

Turning to the perceptions of the supportiveness of the work-home cultures, women physicians and women academic specialists perceive the work-home cultures in their organizations as less supportive than their male peers. However, both men and women physicians agree that working part-time can jeopardize career advancement.

Some researchers (e.g., Dikkers et al., 2007) have found no significant relationship between parental status and perceptions of the supportiveness of the work-home culture. This study reveals contradicting results, showing that women physicians with a youngest child in elementary school believe that their work environment offers more support for their career than women physicians without children. However, for women physicians whose youngest child is a pre-schooler and those whose youngest child is in secondary school, no significant differences were found in perceptions of the supportiveness of the organizational work-home culture compared to their childless counterparts.

As for the effect of a supportive work-home culture on women physicians' career motivation, I found that support for work-life balance has no significant effect on any dimension of career motivation. However, women physicians who perceive their organization's work-home culture as supportive in terms of achieving their career goals, also report higher levels of career motivation compared to women physicians who do not feel supported in this way. Contrary to what I expected, the results show that women physicians who do not expect to be hindered in their career progression as a result of working part-time, also report lower levels of career motivation. In other words, those who do feel hindered in their careers have higher levels of career motivation. Regarding differences between men and women in the effects of a supportive work-home culture on career motivation, the results reveal that women benefit mainly from support in achieving
their career goals, whereas men become more career motivated when they feel supported to obtain a work-life balance. These outcomes confirm earlier suggestions that there may be gendered assumptions behind the provision of family-friendly arrangements.

Finally, I studied the effects of a supportive work-home culture on women physicians' contracted working hours. The results showed that women physicians who feel supported in achieving or maintaining a good work-life balance work fewer hours than those who do not feel supported in this area. Women physicians who believe that using family-friendly arrangements will hold them back in their career all the same work fewer hours than those who do not perceive this to be the case.

However, women physicians who feel supported in seeking to achieve their career goals work more hours than women physicians who feel less supported in this area. I therefore conclude that support for career goals, in particular, seems to increase the number of contracted hours that women physicians work.

Overall, the most important findings reveal that support for the work-life balance has no significant effect on any of the dimension of women physicians' career motivation, whereas support in terms of their career goals does. Men physicians, however, who feel supported in improving their work-life balance do have higher levels of career motivation than those who feel less supported in this area. Finally, only support for career goals, instead of support for work-life balance, seems to increase the number of contracted hours that women physicians work.

Interaction: individual notions and organizations intentions

The second aim of this dissertation was to provide more insight in how individual and (perceived) organizational aspects interact in affecting career motivation and investment among women physicians. It appears that offering support for career goals tempers the negative effect that RPAs have on women physicians' contracted working hours, as did perceived absence of career hindrance. I also found that of those women physicians who use FPAs, those who feel supported in achieving their career goals work more hours than those who do not feel supported in achieving their career goals. Furthermore, I found that support for improving work-life balance has a negative effect on the relationship between the take-up of FPAs and contracted working hours. Of those women physicians who use FPAs, those who feel supported in improving or maintaining their work-life balance
work fewer hours than those who do not feel supported in this.

To summarize, offering support for career goals tempers the negative effects that RPAs (part-time working) have on women physicians' contracted working hours, and strengthens the positive effect that the use of FPAs (i.e., working from home) has on women physicians' working hours. I thus conclude that career support can provide a 'healthy' solution in balancing employees' search for work-life balance on the one hand, and the labour-cost-containment strategy of health care institutions on the other.

Frames interacting with family-friendly arrangements

As described earlier, women physicians have to perform 'cognitive aerobatics' in order to deal with contradicting role expectations regarding the 'ideal' mother and the 'ideal' physician. From an HR perspective, the question is whether organizations actually support these women physicians with their struggles, or if organizations – as a result of the gendered subtext underlying family-friendly arrangements – only make things worse. The results reveal that Ideal Mother Arrangements only improves career insight of women physicians with a care frame. Fortunately, the provision of Ideal Mother Arrangements does not distract women physicians with a career frame or switching frames from their career motivation. Ideal Worker Arrangements appear to have a similar selective effect, as they only positively affect women physicians' career centrality when they have a career frame. These arrangements neither temper nor strengthen negative effects of having a care frame on career motivation. Revising Work Culture Arrangements do not affect the relationship between women physicians' frames and their career motivation.

The contribution of this study is that its results reveal that family-friendly or Gender Equality Arrangements cannot alter the effects of internalized societal and organizational gendered role prescriptions. Almost to the contrary, they seem to only serve those women physicians who internalized either one of the dominant, gendered role prescriptions, instead of those who want to live up to both ideals.

The underlying subtle influences of gendered normalizing discourses

The final research question dealt with whether and how gender is interwoven in the normalizing discourse of the 'ideal' academic specialist, but also whether and how gender is used as a basis for resisting and counter-resisting the normalizing discourse. Moreover, I wondered if and how these gendered discourses could – unintentionally – perpetuate inequality regimes in a Dutch teaching hospital. In doing so, this study reveals the ambiguous nature of resistance and counter-resistance discourses. In total, three themes in academic medical specialists' talk were extracted that illustrate how
Summary

gender is rooted in normalizing, resisting and counter-resisting discourses. The first theme was that of *competitive masculinity versus team commitment* in which the discourse on the 'ideal specialist' was full of masculine characteristics such as being competitive and having self-efficacy, while also revealing the marginalized opposite of competitive masculinity, namely that of team commitment. For example, while it was perceived as logical for men specialists to pursue individual career goals such as obtaining a PhD degree, women specialists seemed to struggle with the gendered role prescription for women specialists, in which the 'ideal' physician does not burden colleagues with extra work - not even when they want to conduct PhD research. The dominance of the normalizing discourse emerged particularly when women specialists in this study perceived themselves as not assertive enough when ensuring that they have enough time to complete their PhD research. The second theme was that of the 'dip', in which women specialists in particular are assumed to have not only practical problems with combining care taking responsibilities with a medical career, but also to have a natural 'dip' in scientific interests once children are born. In talking about this 'dip', both men and women specialists subtly replace the first meaning (practical problems with combining caretaking responsibilities with career) with the second (lack of scientific interest). However, the women in the focus groups did not mention a 'dip' in scientific interests at all and most of them appeared to have developed a reversed 'breadwinner' model, in which their partner either worked part-time or not at all. In the third theme, *blaming the women*, a similar process evolved through counter-resistance. Although most women specialists in this study were unequivocal about the disadvantages women specialists experienced due to the 'ideal specialist' norm, they particularly blamed other women who do not have children (yet) that they lack sympathy for the working mothers among the women specialists. In addition, some women specialists in this study held women (in general) responsible for perpetuating a cultural motherhood ideology by not being assertive enough toward their husbands regarding taking care of family matters.

These three gendered themes in normalizing, resisting and counter-resisting discourses illustrate the subtle processes by which inequality regimes in health care institutions are perpetuated. This process has the shape of a two-stage rocket. First, by assuming that women specialists experience a 'dip' in scientific interests due to their childcare responsibilities or by 'blaming women' and using this as a resource for (counter) resistance, women specialists are perceived not only as 'the others' and thus marginalized, but their underlying, gendered reasons – such as fearing not behave as the 'good'
colleague - for not conducting scientific research remain concealed. Secondly, by especially women specialists struggling with gendered role prescriptions regarding being this ‘good’ colleague, which can result in performing the majority of patient care, women physicians run the risk of missing out on time needed to carry out research, publish work and secure grants – and consequently also miss out on promotion. Meanwhile, their male counterparts seem to be less hindered by this normalizing discourse of the ‘ideal’ specialist – at least in this respect – and perhaps benefit implicitly from women’s gendered role prescriptions because they facilitate men to conduct research.

**Conclusion**

The title of this dissertation poses a question: does having caretaking responsibilities at home (Care) together with (+) a demanding profession and work environment (for example, the Emergency Room) result in successful careers for women physicians? Before I can answer this question, let me summarize how both streams of the debates seem to rest on gendered assumptions regarding what women physicians, in particular, want and need in order to succeed in their careers.

Regarding the individual aspects, the following myths have been debunked. Firstly, having children positively affects women but negatively affects men physicians’ career motivation. Secondly, although traditional views of the ‘ideal’ mother can indeed explain why certain women physicians have lower levels of career motivation and investment, women physicians without children hold the most traditional views regarding motherhood. Thirdly, as this study showed, women physicians’ views on the ‘ideal’ physician should be included in research that concerns women physicians’ career motivation and career investment. Focusing excessively on caretaking responsibilities and views on motherhood in research and general debates regarding professional women’s career motivation does not do justice to women physicians’ struggles with living up to gendered role prescriptions. What’s more, it highly stigmatizes: as if women’s role is still mainly in the private domain, regardless of the many hours they put in to their work.

At the other end of the spectrum, similar assumptions appear to dominate. Offering family-friendly arrangements mostly affects women physicians’ career motivation and investment when they comply with gendered role prescriptions. Moreover, these arrangements do not always interact well with organizational (cost-containment) strategies, nor do they counter traditional societal ideals regarding the ‘ideal’ mother and the
‘ideal’ physician. The results of this study reveal that there is still much to gain by critically analysing work processes and competitive, masculine work cultures in health care institutions, in which even resisting discourses appear to be capable of perpetuating gender inequality regimes. And contrary to what is often expected, support from colleagues and supervisors in obtaining and maintaining a good work-life balance seems to be becoming a ‘men’s issue’, while especially women physicians would benefit from greater support for their career goals.

**Care + ER = Career?** The answer to this question, in my opinion, is a resounding yes, provided that the general and scientific debates, studies and organizational interventions keep an eye out for the influence of gendered role prescriptions that affect both sides of the plus sign. Instead of focusing excessively on the alleged negative effects of professional women’s caretaking responsibilities, equal attention should be paid to negative effects of gendered, dominant and hidden norms in the work environment. Only then can organizations and society benefit from women physicians’ potential contribution in the ‘ER’.
Samenvatting

Werknemers en zorginstellingen investeren beiden veel in het gecombineerd krijgen van werk en privé. Echter, zorgtaken thuis en veleisende werkomgevingen leiden niet zonder slag of stoot tot niet-aflatende carrièremotivatie, onuitputtelijke loopbaaninvesteringen en zeker niet tot automatische promoties naar hogere functies. De prangende vraag is dan ook: hoe kunnen zorgtaken thuis (Care) samen met (+) een veleisend beroep en werkomgeving (bijvoorbeeld een Emergency Room) resulteren in (=) veelbelovende carrières (careers) voor vrouwelijke artsen?

De eerste doelstelling van dit proefschrift behelst het verschaffen van meer inzicht in de effecten van zowel individuele als organisatorische aspecten op de carrière- en loopbaanmotivatie van (vooral) vrouwelijke artsen. Vanuit een individueel perspectief bezien, spitst dit onderzoek zich toe op de effecten van moederschap, moederschapsopvattingen en opvattingen aangaande de 'ideale' arts (werknemer) op carrière- en loopbaanmotivatie van (vooral) vrouwelijke artsen. Vanuit een organisatorisch perspectief kijkt dit onderzoek naar het effect van familie-vriendelijke arbeidsvoorwaarden en werkprivé culturen op de carrière- en loopbaanmotivatie van (vooral) vrouwelijke artsen.

Het tweede doel van dit proefschrift is om meer licht te werpen op de vraag of – en zo ja, hoe – individuele en organisatorische aspecten interacteren en of deze interacties op hun beurt een effect hebben op carrière- en loopbaanmotivatie van (vooral) vrouwelijke artsen. Zo kunnen vrouwelijke artsen bijvoorbeeld een traditioneel ideaalbeeld hebben ten aanzien van 'goed' moederschap dat kan resulteren in een lagere carrière- motivatie, maar organisationele aspecten zoals de werkprivé cultuur kunnen dit negatieve effect van een (geinternaliseerd) traditioneel moederschapideaal op carrière- motivatie afzwakken. Daarnaast wil ik laten zien hoe bepaalde gendered sociale discoursen ten aanzien van moederschap kunnen beïnvloeden de carrièreprogressie van vrouwelijke medisch specialisten.

Individuele aspecten

De meeste respondenten hadden ten tijde van dit onderzoek kinderen jonger dan 12 jaar, dus nog in de lagere school leeftijd of zelfs jonger. Het combineren van deze (nog) intensieve zorgtaken thuis met een medische carrière lijkt vooral moeilijk voor vrouwelijke artsen, daar de meerderheid van hen een partner heeft die meer dan 36 uur per week werkt. Hun
mannelijke collega's hebben daarentegen meestal partners die in kleine part-time banen werken. Echter, het lijkt er op dat de partners van vrouwelijke artsen hun werkuren wel aanpassen, daar ze iets minder uren werken dan het gemiddeld aantal werkuren van de Nederlandse man (SCP, 2008).

Moederschap, moederschapopvattingen en carrièremotivatie

Het maatschappelijk en wetenschappelijk debat richt zich meestal op de zorgverantwoordelijkheden van vrouwen thuis en een traditionele Nederlandse moederschapsideologie om de vermeende afwezigheid van 'ambitie' en relatief lage arbeidsparticipatie van Nederlandse vrouwen te verklaren. Maar klopt het dat moederschap de persoonlijke moederschapopvattingen van vrouwelijke artsen een negatief effect hebben op carrièremotivatie, zoals vaak wordt verondersteld? Uit de resultaten van deze studie blijkt dat vrouwelijke artsen met kinderen een minder traditionele opvattingen ten aanzien van 'goed' moederschap hebben dan (nog) kinderloze vrouwelijke artsen. Ook blijkt dat moederschap an zich geen verklaring biedt voor de mate van carrièremotivatie van vrouwelijke artsen. Wel laat dit onderzoek zien dat vrouwelijke artsen met traditionele moederschapopvattingen inderdaad minder carrièremotivatie hebben. Bovendien blijkt dat wanneer vrouwelijke artsen het belangrijk vinden een rolmodel als werkende moeder te zijn, dit een positief effect heeft op hun carrièremotivatie. Dit positieve effect is bovendien sterker dan het (eventuele) negatieve effect van het hebben van meer traditionele opvattingen rondom tijdsverdeling tussen werk en zorgtaken thuis. In een tweede case study in dit onderzoek bleek zelfs dat vrouwelijke medisch specialisten met kinderen meer carrièremotivatie hadden dan vrouwelijke specialisten zonder kinderen. Bovendien bleek dat mannelijke medisch specialisten met een jongste kind jonger dan 4 jaar hun carrière minder belangrijk vonden dan hun mannelijke collega's zonder kinderen.

Samenvattend kan dus gesteld worden dat de eerste bijdrage van deze studie aan het maatschappelijk en wetenschappelijk debat wat betreft de individuele aspecten laat zien dat moederschap geen voorspeller is van de carrièremotivatie van vrouwelijke artsen, maar wel voor mannelijke artsen met jonge kinderen. Daarnaast zijn het dus vooral de vrouwelijke artsen zonder kinderen die meer traditionele opvattingen hebben over moederschap.

Carrièremotivatie en loopbaaninvesteringen

De meeste vrouwelijke artsen in deze studie werkten parttime, tussen de 28 en 36 contractuele werkuren per week. Echter, hun structurele overuren variërd tussen de 7 en 14 uur per week, wat betekent dat ze eigenlijk toch
een gemiddeld fulltime werkweek hebben. Vooral interessant is dat in dit onderzoek bleek dat hoewel de meeste vrouwelijke artsen al part-time werken en tevreden waren met hun huidige aantal werkuren, het vooral mannelijke artsen waren die aangaven graag minder uren te werken. Het waren vooral vrouwelijke artsen die aangaven meer contractuele uren te willen werken. De roep om een betere werkprivé balans lijkt zich hier wat te verschuiven van vrouwelijke naar mannelijke artsen.

Vaak wordt impliciet en/of expliciet verondersteld dat het aantal gewerkte uren per week een afspiegeling is van de mate van carrièremotivatie (Judge et al., 1995), ook al wordt dit door sommige wetenschappers sterk bekritiseerd door te stellen dat carrièremotivatie breder gezien moet worden dan alleen het aantal uren dat vrouwen werken (Peters et al., 2010). Deze studie legt de relatie tussen carrièremotivatie en loopbaaninvesteringen specifieker bloot. Vrouwelijke artsen met een hoge mate van carrière-centraliteit (carrière erg belangrijk vinden in het leven) werken inderdaad meer uren en hebben een grotere kans een promotieonderzoek afgerond te hebben (of mee bezig te zijn) dan vrouwelijke artsen die een lagere mate van carrière-centraliteit hadden. Echter, vrouwelijke artsen die meer carrière-inzicht hadden (dus concretere carrièredoelen stelden voor zichzelf), werkten minder uren en hadden een kleinere kans om werkgerelateerde nevenactiviteiten te verrichten dan vrouwelijke artsen die minder carrière-inzicht hadden. Tot slot bleek dat vrouwelijke artsen die ambities hadden om een hogere of topfunctie te bekleden in de toekomst, ook een grotere kans hadden gepromoveerd te zijn (PhD) en werkgerelateerde nevenactiviteiten te verrichten. Deze ambitieuze vrouwelijke artsen werkten echter niet meer uren dan zij die niet zo ambitieus waren, zoals vaak wordt gedacht.

De tweede bijdrage van dit onderzoek is dat het aantal gewerkte uren wel kan worden verklaard door carrière-centraliteit van vrouwelijke artsen, maar niet door de mate van hun carrière-ambitie. Het plannen en stellen van specifieke carrièredoelen leek in dit onderzoek juist een negatief effect op de loopbaaninvesteringen van vrouwelijke artsen te hebben. Carrière-ambitie van vrouwelijke artsen lijkt zich vooral te uiten in het hebben verkregen van een extra graad (PhD) en/of het hebben van werkgerelateerde nevenactiviteiten.

Omgaan met gendered rolopvattingen: framing

Vrouwelijke artsen hebben niet alleen te maken met gendered (seksespecifieke) rolopvattingen ten aanzien van hun rol als moeder; ze worden ook geconfronteerd met gendered professionele rolverwachtingen ten aanzien van het zijn van een ‘goede’ arts. Deze twee ideaalbeelden zijn lastig, zo niet onmogelijk, te verenigen, daar de (traditionele) ‘ideale’ moeder
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slechts 3 dagen per week buitenshuis werkt en de ‘ideale’ arts altijd beschikbaar en aanwezig is. De internalisering van deze conflicterende rolopvattingen kan resulteren in verschillende ‘copingsmechanismen’ en onderliggende frames. Zo kan een vrouwelijke arts bijvoorbeeld het ene ideaalbeeld prioriteren boven het andere, zoals het geval wanneer ze een ‘career-frame’ of ‘care-frame’ heeft. Vrouwelijke artsen kunnen ook besluiten om aan beide traditionele invullingen van de ideaalbeelden te voldoen (‘switching frames’) of om beide gendered rolopvattingen te negeren of te verwerpen (‘non-traditional frames’). In dit onderzoek bleken vrouwen die ‘switching frames’ hebben een hogere score te hebben op carrière-centraliteit dan vrouwen met een ‘care frame’; maar een iets minder hoge score te hebben dan vrouwen met een career frame. Vrouwelijke artsen met ‘switching frames’ hadden geen significante lagere score ten aanzien van carrière-inzicht of carrière-ambitie dan vrouwen met een ‘career frame’. We kunnen dus concluderen dat vrouwelijke artsen die aan alle tegengestelde, gendered rolverwachtingen willen voldoen, niet onderdoen voor vrouwelijke artsen die bepaald ideaatbeeld prioriteren, dan wel die alle rolverwachtingen in de wind slaan. Vrouwen met ‘switching frames’ werkten in deze studie trouwens ook het meeste aantal uren per week.

Het derde inzicht voortkomend uit dit onderzoek, is dat vrouwelijke artsen met ‘switching frames’ (dus ook het willen voldoen aan een traditionelere opvatting ten aanzien van goed moederschap) net zo gemotiveerd zijn ten aanzien van hun carrière als vrouwen met een ‘career frame’ en zelfs het meeste aantal uren werken. Het geinternaliseerde ideaalbeeld van het zijn van een goede arts hoort dus thuis in onderzoeksmodellen die trachten carrièremotivatie van vrouwelijke artsen te verklaren.

Organisatiele aspecten

Andere stromingen in het debat richten zich meer op de organisatiele aspecten die de carrièremotivatie en arbeidsparticipatie van vrouwelijke artsen kunnen beïnvloeden. De medische werkomgeving zijn – in sommige opzichten van nature – veleisend en zorginstellingen lijken zich vandaag de dag welbewust dat werknemers met zorgtaken thuis een bepaalde mate van compensatie op dat gebied verwachten. Echter, de effectiviteit van deze compenserende, familie-vriendelijke arrangementen in termen van HR opbrengsten zoals carrièremotivatie en loopbaaninvesteringen zijn nog nauwelijks onderzocht.
Familie-vriendelijke arrangementen

Zorginstellingen – net als veel andere organisaties – moeten zich aanpassen aan hun omgeving, en zullen dus ook rekening moeten houden met eventuele veranderende eigenschappen van hun (toekomstige) werknemers. Respondenten in dit onderzoek gaven aan dat ze hun organisatie als familie-vriendelijk beschouwden als het ging om het aanbod van de mogelijkheden om part-time te werken, part-time de (medische) opleiding te volgen, het hebben van inspraak op de roosterindeling en de mogelijkheid om verlof op te nemen voor een ziek gezins- of familielid. Andere familie-vriendelijke arrangementen, zoals flexibele begin- en eindtijden, thuiswerken, kinderopvang faciliteiten, extra verlof en carrièreondersteunende arrangementen zoals het hebben van een coach of mentor, werden volgens de respondenten minder vaak aangeboden.

De resultaten van dit onderzoek laten zien dat organisaties waar vrouwen werken in een gefeminiseerd specialisme (> 50% van de huidige medisch specialisten is vrouw) meer participatie-remmende (zoals bijvoorbeeld part-time werken en duobanen) en participatie-stimulerende arrangementen (zoals bijvoorbeeld coaching en thuiswerken) bieden dan organisaties waar vrouwen in niet-geïndustrialiseerde specialisaties werken. Ook de aanwezigheid van collectieve arbeidsvoorwaarden (CAOs) hebben een significant positief effect op het aantal geboden familie-vriendelijke arrangementen. Maar met het bieden van deze arrangementen in respons op de veranderende werknemerskenmerken, krijgen zorginstellingen ook te maken met een strategisch dilemma. Waar zorginstellingen enerzijds willen tegemoet komen aan parttime of flexibiliteitwensen van hun personeel, hebben ze anderzijds zoveel mogelijk arbeidsparticipatie van zo min mogelijk arbeidskrachten nodig om het hoofd te bieden aan de toenemende vraag naar zorg en de al naar gelang de kosten. Uit onderhavige studie blijkt dat het bieden van participatie-verlaging arrangementen zoals part-time werken hebben een negatief effect op het aantal uren dat vrouwelijke artsen werken; terwijl het bieden van participatie-stimulerende arrangementen zoals thuiswerken geen significant negatief effect hebben op het aantal uren dat vrouwelijke artsen werken. Dit onderzoek laat dus zien dat het bieden van participatie-stimulerende arrangementen meer in lijn is met de kostenverlaging organisatiestrategie van zorginstellingen. Helaas bleek uit dit onderzoek ook dat dergelijke arrangementen nog niet veel worden aangeboden.

Familie-vriendelijke arrangementen worden in wetenschappelijk onderzoek vaak gebundeld aan de hand van hun karakteristieken (bijvoorbeeld alle kinderopvangregelingen bij elkaar genomen) of op basis van statistische analyses (principal axing factor analysis). Organisaties
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bieden familie-vriendelijke, of diversiteitsarrangementen om allerlei verschillende HR uitkomsten te genereren, zoals het behouden van het aantal werkende vrouwelijke artsen, het behouden van het aantal uren dat vrouwelijke artsen werken, het helpen verbeteren van het verkrijgen van een betere werk privé balans en/of het verkrijgen van meer diversiteit in toppuncties. In dit onderzoek zijn de arrangementen gebundeld op basis van hun impliciete ondersteuning aan gendered rolopvattingen zoals die van de traditionele 'ideale' moeder (door part-time werken aan te bieden) of van de 'ideale' arts (door het bieden van kinderopvang of het bieden van management-development trainingen tijdens en naast het werk). Weer andere arrangementen, zoals het hebben van inspraak in een roosterindeling of de mogelijkheid om thuis te werken, zijn minder eenduidig toe te kennen aan een specifieke gendered rolopvattingen en doen vooral een beroep op de flexibiliteit van de organisatie, in plaats van de flexibiliteit van het individu. Deze arrangementen zijn om die reden in dit onderzoek onderverdeeld als 'Revising Work Culture Arrangements', daar ze vooral vragen om een aanpassing van de werkcultuur van de organisatie. In dit onderzoek is getracht te onderzoeken of een categorisering op basis van 'gendered subtext' (onderliggende betekenisstructuur) van familie-vriendelijke arrangementen het effect op de carrière motivatie en loopbaaninvestering van vrouwelijke artsen verklaard kon worden. De resultaten laten zien dat 'Ideale Moeder Arrangementen' geen significant effect hebben op de carrière motivatie van vrouwelijke artsen en een negatief effect op loopbaaninvesteringen zoals het aantal gewerkte uren per week. 'Ideale Arts Arrangementen' daarentegen hebben een positief effect op de carrière motivatie van vrouwelijke artsen, maar geen significant effect op loopbaaninvesteringen van vrouwelijke artsen. 'Revising Work Culture Arrangements' hadden zowel een positief effect op de carrière-ambitie van vrouwelijke artsen, als op loopbaaninvesteringen van vrouwelijke artsen.

Op basis van deze resultaten kan geconcludeerd worden dat de meest gebruikelijke arrangementen die worden geboden, zoals de mogelijkheid om part-time te werken, niet bijdragen aan de carrière motivatie van vrouwelijke artsen, dan wel hun loopbaaninvesteringen. Bovendien dragen ze niet bij aan kostenbeperkingsstrategieen, zoals de meeste zorginstellingen die op dit moment hebben. Om zowel de carrière motivatie als de loopbaaninvesteringen van vrouwelijke artsen te stimuleren, lijken 'Revising Work Culture Arrangements' de meest optimale keuze te zijn voor zorginstellingen.
Familie-vriendelijke werkprivé culturen

Wat betreft de gepercipieerde werkprivé cultuur, blijkt uit dit onderzoek dat vrouwelijke artsen en medisch specialisten over het algemeen de werkprivé cultuur in hun organisatie als significant minder familie-vriendelijk ervaren dan hun mannelijke collega’s. Zowel mannelijke als vrouwelijke medisch specialisten geven aan dat part-time werken hun loopbaan in gevaar kan brengen.

Ander onderzoek heeft uitgewezen dat er geen significante relatie bestaat tussen het hebben van kinderen en de opvattingen over de familie-vriendelijkheid van de werkprivé cultuur. Dit onderzoek heeft echter andere resultaten opgeleverd, waarin blijkt dat vrouwen met een jongste kind onder de 5 jaar de werkprivé cultuur in hun werkomgeving juist als familie-vriendelijker ervaren dan vrouwelijke artsen zonder kinderen. Er werden geen significante verschillen gevonden in percepties aangaande de werkprivé cultuur wanneer het jongste kind ouder was dan 5 jaar.

Voor wat betreft het effect van een familie-vriendelijke werkprivé cultuur op de carrièremotivatie van vrouwelijke artsen, bleek in dit onderzoek dat geboden steun voor werkprivé balans geen significant effect had op de carrièremotivatie van vrouwelijke artsen, maar wel een significant positief effect had op de carrièremotivatie van mannelijke artsen. Wel had ervaren steun van collega’s en leidinggevenden voor het behalen van carrièredoelen een positief effect op de carrièremotivatie van vrouwelijke artsen, en niet op die van mannelijke artsen. Deze resultaten sterken de gedachte dat er wellicht gendered veronderstellingen en percepties zitten achter een familie-vriendelijke werkcultuur. De verwachting tegen carrièrebarrières aan te lopen als gevolg van parttime werken, had overigens zowel voor mannelijke als vrouwelijke artsen een negatief effect op hun carrièremotivatie.

Tot slot is er in dit onderzoek aandacht besteed aan het mogelijke effect van de werkprivé cultuur in organisaties op de arbeidsparticipatie van vrouwelijke artsen (aantal gewerkte contractuele uren). Vrouwelijke artsen die zich gesteund voelen in het behalen of behouden van een goede werkprivé balans werken minder uren dan vrouwelijke artsen die zich minder gesteund voelen op dat terrein. Vrouwelijke artsen die vermoeden gehinderd te worden in hun loopbaan als gevolg van part-time werken, werken desalniettemin toch minder uren dan vrouwelijke artsen die dit niet of minder verwachten. Echter, vrouwelijke artsen die zich gesteund voelen door collega’s en leidinggevenden in het behalen van hun carrièredoelen werken meer uren dan vrouwelijke artsen die zich in dit opzicht minder gesteund voelen.
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De belangrijkste bevindingen in dit onderzoek zijn dat het bieden van steun in termen van het verkrijgen van werkprivé balans geen significant effect hebben op de carrièreemotivatie van vrouwelijke artsen, maar wel een positief effect hebben op dat van mannelijke artsen. Steun voor het behalen van carrièredoelen heeft wel een positief effect op de carrièreemotivatie en arbeidsparticipatie van vrouwelijke artsen.

Interactie: individuele opvattingen en organisationele intenties

De tweede doelstelling van dit onderzoek was om meer inzicht te verschaffen in hoe individuele en (gepercipieerde) organisationele aspecten interacteren en hoe deze interactie carrièreemotivatie en loopbaaninvesteringen van vrouwelijke artsen beïnvloedt. Uit dit onderzoek blijkt dat het bieden van steun door collega's en leidinggevenden voor het behalen van carrièredoelen een temperend effect hebben op het negatieve effect dat participatie-verlagende arrangementen (bijvoorbeeld parttime werken) hebben op het aantal uren dat vrouwelijke artsen werken. Ook blijkt dat vrouwelijke artsen die gebruik maken van participatie-stimulerende arrangementen (bijvoorbeeld thuiswerken) niet minder uren werken dan de vrouwelijke artsen die hier geen gebruik van maken, tenzij ze zich ook gesteund voelen in het behouden of een goede werkprivé balans. In dat geval neemt het aantal werkuren bij het gebruik van participatie-stimulerende arrangementen juist af. Voelen ze zich echter vooral gesteund in het behalen van carrièredoelen terwijl ze ook gebruik maken van participatie-stimulerende arrangementen, dan werken ze juist meer uren dan vrouwelijke artsen die zich niet gesteund voelen.

Kort gezegd kan gesteld worden dat het bieden van steun voor het behalen van carrièredoelen de negatieve effecten van parttime werken verminderen, en het bovendien zorgt dat gebruik van participatie-stimulerende arrangementen zoals thuiswerken een positief effect hebben op het aantal contractuele uren van vrouwelijke artsen. Het bieden van steun voor het behalen van carrièredoelen vanuit de werkomgeving aan vrouwelijke artsen die parttime werken, biedt dus een gezonde tegenhanger in het vinden van een balans tussen de werkprivé balans van vrouwelijke artsen enerzijds; en de kostenbesparingsstrategie van zorginstellingen anderzijds.

De interactie van frames en familie-vriendelijke arrangementen

Zoals eerder gezegd, moeten vrouwelijke artsen cognitieve acrobatiek hanteren om aan alle rolverwachtingen te voldoen. Vanuit een HR perspectief, is een belangrijke vraag of het HR beleid in staat is om vrouwelijke artsen te
ondersteunen met deze worstelingen, of dat het HR beleid – als gevolg van gendered subtext in familie-vriendelijke arrangementen – zaken juist (onbedoeld) versterken. De resultaten laten zien dat Ideale Moeder Arrangementen (zoals parttime werken) alleen het carrière-inzicht versterken van vrouwelijke artsen met een ‘care frame’. Gelukkig heeft het bieden van Ideale Moeder Arrangementen geen negatief effect op de positieve relatie tussen ‘career frame’ of ‘switching frames’ en carrièremotivatie, zoals in de hypotheses werd gevreesd. Ideale Arts Arrangementen blijken eenzelfde interactie effect te hebben, daar ze alleen een positief effect hebben op de carrière-centraliteit van vrouwelijke artsen met een ‘career frame’. ‘Revising Work Culture Arrangements’ hebben geen significant modererend effect op de relatie tussen frames en carrièremotivatie. De arrangementen temperen of versterken de effecten van geïnternaliseerde frames op carrièremotivatie van vrouwelijke artsen dus niet, tenzij de ‘gendered subtext’ van de arrangementen overeenkomt met een geëxcludeerde rolverwachting van de vrouwelijke arts.

De bijdrage van deze studie is dat de resultaten laten zien dat familie-vriendelijke of diversiteitsarrangementen niet in staat zijn de eventuele negatieve effecten van geïnternaliseerde rolverwachtingen op de carrièremotivatie van vrouwelijke artsen tegen te gaan. Sterker nog, ze lijken zelfs alleen vrouwelijke artsen te ondersteunen die een van de twee gendered rolverwachtingen prioriteren, in plaats van die vrouwelijke artsen die proberen het op alle fronten ‘goed’ te doen.

Onderliggende subtiele effecten van gendered normaliserende discoursen

De laatste onderzoeks vraag van dit proefschrift had betrekking op de vraag hoe gender is verweven in het dominante, normaliserende discourse van de ‘ideale’ arts - in casu de medisch specialist - dat van weerstandsdiscourse en counter-weerstandsdiscourse (het verwerpen van weerstandsdiscoursen). Daarnaast is onderzocht hoe deze gendered discoursen – onbedoeld – kunnen bijdragen aan het in stand houden van genderongelijkheid in academisch-medische topfuncties. Dit exploratieve onderdeel van dit promotieonderzoek laat de ambigue eigenschappen zien van vooral weerstandsdiscoursen ‘en counter-discoursen’. In totaal zijn drie thema’s gedestilleerd op basis van gesprekken tussen medisch specialisten die illustreren hoe gender is geworteld in normaliserende, weerstands- en counter-weerstandsdiscoursen. Het eerste thema was dat van competitieve masculiniteit versus collegialiteit. Hoewel het voor mannelijke medisch specialisten redelijk geaccepteerd werd dat hij individuele carrière doelen - zoals het doen van (promotie)onderzoek - naaigde, worstelden vrouwelijke specialisten met gendered rolverwachtingen, waarbij vooral
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vrouwelijke artsen geacht worden het team-belang voorop te stellen. Zo voelden sommige vrouwelijke artsen zich erg bezwaard om voor persoonlijke carrièredoelen te gaan staan, omdat ze bang waren daarmee niet collegiaal te zijn naar hun collega’s, die dan met meer patiëntenzorg opgezadeld zouden worden. Het tweede thema dat in de ‘weerstand’ gesprekken naar voren kwam was dat van de ‘dip’. Hierin werd vooral van vrouwelijke artsen verondersteld dat ze gedurende hun carrière, hoogstwaarschijnlijk vooral nadat er kinderen geboren zijn, moeite hebben met het gecombineerd krijgen van een veeleisende baan en zorgtaken thuis. De ‘dip’ leek in eerste instantie vooral betrekking te hebben op het tijdsgbrek en fysieke onmogelijkheid van het combineren van carrière en kinderen. Maar de ‘dip’ had ook een andere onderliggende betekenis, waarbij werd getwijfeld aan de wetenschappelijke interesse van vrouwelijke specialisten gedurende die periode in hun carrière. Het hebben van wetenschappelijk interesse en het vermogen om tegenstrijdige rolverwachtingen te combineren werden dus – zowel door mannen als vrouwen, leidinggevenden en niet-leidinggevenden - door elkaar heen gebruikt. De vrouwelijke specialisten in (andere) ongemene focusgroepen hebben zich echter niet geuit over het ervaren van een dip in hun carrière en ook de vermeende afnemende interesse voor wetenschappelijk onderzoek kwam niet ter sprake. In tegendeel, het merendeel van de geïnterviewde vrouwelijke specialisten was hoofd kostwinner en had een partner die parttime of helemaal niet werkte, wat zou kunnen illustreren dat deze vrouwen juist niet zoveel last hadden van de veronderstelde combinatie-problematiek. Het derde thema betrof het fenomeen van ‘vrouwen verwijten’, dat vooral de counterweerstandsdiscourse illustreerde. Hoewel de meeste geïnterviewden vrouwen in de focusgroepen zich duidelijk bewust waren van de nadelen die vrouwen ondervinden als gevolg van de ‘ideale arts’ norm, verwijten deze vrouwen vooral vrouwen het in stand houden van deze dominante norm. Zo werd vooral andere vrouwen zonder kinderen verweten te weinig sympathie te tonen voor hen die wel kinderen hadden. Sommige vrouwelijke specialisten hielden andere vrouwelijke collega’s verantwoordelijk voor het in stand houden van de traditionele moederschapideologie, omdat ze niet assertief genoeg zouden zijn naar hun mannen die ook hun steentje konden bijdragen in de zorg voor kinderen.

Deze drie gendered thema’s in normaliserende, weerstands- en counterweerstandsdiscoursen illustreren de subtiele processen waarmee gender ongelijkheid in stand wordt gehouden. Het proces zou kunnen worden gezien als een tweetrapsraket. Allereerst worden ondanks het praten over de ‘dip’ waarbij gepoogd wordt aandacht te creëren voor de moeilijke positie van vrouwen, vrouwelijke specialisten nog steeds gezien en gedefinieerd als
'de anderen' en blijft de dominante norm ongeschonden. Andere, onderliggende gendered oorzaken, zoals de angst niet collegiaal gevonden te worden wanneer een vrouwelijke arts (promotie)onderzoek prioriteert, blijven verborgen. Ten tweede, als gevolg van deze verborgen gendered oorzaken, lopen vrouwelijke specialisten de kans dat ze tijd te kort komen om onderzoek te doen, (op basis daarvan) te publiceren en (op basis daarvan) subsidies te verwerven, om zo – uiteindelijk – voor hogere functies in aanmerking te komen. Intussen hebben hun mannelijke collega's wat dit aangaat minder last van de dominante, normaliserende norm van de 'ideale arts' en bestaat het risico dat mannelijke specialisten onbewust en onbedoeld profiteren van de worsteling met gendered rolverwachtingen van hun vrouwelijke collega's, die – door het doen van patiëntenzorg – hen daarmee indirect faciliteren in het doen van onderzoek.

Conclusie

De titel van dit proefschrift stelt een vraag: kan het hebben van zorgtaken thuis (Care) in combinatie met (+) een veeleisend beroep en werkomgeving (bijvoorbeeld de Emergency Room, ER) resulteren (=) in veelbelovende carrières (careers) van vrouwelijke artsen? Voordat ik deze vraag zal beantwoorden, vat ik kort samen hoe beide stromingen in het maatschappelijk en wetenschappelijk debat rusten op gendered veronderstellingen ten aanzien van wat (vooral) vrouwelijke artsen willen en nodig hebben om te kunnen slagen in hun carrières.

Wat betreft de individuele aspecten, worden in dit proefschrift de volgende mythes ontkracht. Ten eerste, heeft het hebben van kinderen geen negatieve of zelfs een positief effect op de carrièremotivatie van vrouwelijke artsen; maar een negatief effect op dat van mannelijk artsen met jonge kinderen. Ten tweede klopt het dat traditionele opvattingen ten aanzien van moederschap een negatief effect hebben op de carrièremotivatie van vrouwelijke artsen, maar het zijn vooral de vrouwelijke artsen zonder kinderen die traditionelere moederschapopvattingen hebben. Ten derde is het belangrijk dat in het onderzoeken van carrièremotivatie van vrouwelijke artsen ook hun rolopvattingen over het zijn van een 'goede' arts moeten worden meegenomen. Het eenzijdig belichten van de mogelijk carrièrebedreigende functie van moederschapopvattingen in onderzoek en het maatschappelijk debat doet geen recht aan de worsteling van vrouwelijke artsen met tegenstrijdige rolverwachtingen. Bovendien werkt het stigmatiserend: alsof vrouwen nog steeds vooral een rol in het privé-domein hebben.
Samenvatting

Ten aanzien van het andere eind van het spectrum, die van de rol die organisationele aspecten spelen, lijken soortgelijke gendered opvattingen te domineren. Allereerst blijkt dat het bieden van familie-vriendelijke HR arrangementen vooral die vrouwen helpt die zich voegen naar slechts één van de traditionele ideaalbeelden. Het helpt dus niet de vrouwen die proberen aan beide ideaalbeelden te voldoen of die de rolverwachtingen negeren of zelfs bekritiseren. Ten tweede blijken familie-vriendelijke arrangementen niet in staat om onwenselijke effecten van geïnternaliseerde rolopvattingen van vrouwelijke artsen op hun carrièreomvorming tegen te gaan. Ten derde blijkt dat de meest geboden familie-vriendelijke arrangementen, zoals parttime werken, een ongewenst effect hebben op de arbeidsparticipatie van vrouwelijke artsen. Flexibele arrangementen, zoals flexibele begin- en eindtijden en thuiswerken, hebben — mits ondersteund met de nodige aandacht voor carrièredoelen vanuit de werkomgeving — een positief effect op de arbeidsparticipatie van vrouwelijke artsen en zijn dus veel meer in lijn met de huidige kostenverlagingstrategieën van zorginstellingen. Zo hebben parttime werkende vrouwelijke artsen die zich gesteund voelen door collega's en leidinggevende in het behalen van hun carrièredoelen grotere parttime banen dan vrouwen die zich hierin minder gesteund voelen. Ten vierde is in dit onderzoek naar voren gekomen dat — wanneer het gaat om het verhogen van carrièreomvorming — vrouwelijke artsen baat hebben bij steun voor het behalen van carrière doelen en mannelijke artsen juist bij het ervaren van steun voor werkprivacy balans. Tot slot laat dit onderzoek zien dat het nog steeds zinvol is om werkprocessen en competitieve, masculiene werkculturen in zorginstellingen kritisch te bestuderen, om zo te laten zien hoe zelfs weerstandsdiscoursen zich niet kunnen onttrekken aan gendered rolopvattingen en zo onbedoeld bijdragen aan voortdurende gender ongelijkheid in medische topfuncties.

Care + ER = Career? Wat mij betreft is het antwoord hierop een volmondig ‘ja’, mits het maatschappelijk debat, wetenschappelijk onderzoek en organisatie-interventies oog houden voor gendered rolopvattingen die aan beide kanten van het plusteken een belangrijke rol spelen. In plaats van het overbelichten van de mogelijke negatieve effecten van ‘Care’, zou net zoveel aandacht mogen bestaan voor negatieve effecten van gendered, dominante en verborgen normen in de ‘ER’. Alleen zo kan de potentiële waarde van vrouwelijke artsen ten volle worden benut.
Samenvatting
Author's biography

Berber Pas was born on the 23rd of September 1973 in Delft, The Netherlands. She obtained her Master's degree in Communication Science in 1999 at the Faculty of Social and Behavioural Sciences at the University of Amsterdam. During this period, she also studied at the Haas School of Business, University of California Berkeley (Marketing and Management in Technological Environments) and obtained a certificate in Project Management at the UC Berkeley Extension Program.

After her study, she first worked at the Anton Dreesmann Institute for Entrepreneurship at the University of Amsterdam, Faculty of Economics, on a project called "Accounting for Knowledge". Later on, she worked as a management consultant at Twynstra Gudde in Amersfoort for five years, during which she was involved in several projects regarding HRM, Knowledge and Change Management. She then became a policy advisor and manager at the Koninklijke Landelijke Politiediensten (KLPD, Dutch National Police Force) for two years. In 2007, she decided to leave 'practice' and enter the scientific arena. She started her PhD research on the effects of caretaking responsibilities and work-home cultures on women physicians' career motivation and career investment at the School of Management, Radboud University of Nijmegen. During this period, she was also affiliated with the Institute for Gender Studies at the same university and with the institute for Gender Studies in Medicine at the UMC st Radboud in Nijmegen. While working on her dissertation, she has published in several national and international peer-reviewed journals, among which the Dutch Journal for Medicine (NTvG, 2008), the Dutch Journal of Gender Studies (2010), Work, Employment and Society (2011), and the Human Resource Management Journal (2011). She often presents her work at international (medical and management) conferences, such as WONCA Europe, European Group of Organization Studies (EGOS), Community, Work and Family (CWF), HRM Network Conference and the European Academy of Management (EURAM). She has served as a reviewer for these conferences on several occasions. In addition, she is frequently invited as speaker or panel discussant regarding women's career advancement (e.g., yearly congress of the Royal Dutch Veterinary Society, Dutch Association of Women Physicians).

In 2010, she was granted the 'Frye Stipendium' which is awarded to promising female researchers to further their scientific career. She has been invited as a visiting researcher by Professor Bob Hernandez, - Department of Health Service Administration, University of Alabama in Birmingham - for the upcoming year. She currently works at the Nijmegen School of Management as an assistant professor in the department of Organizational Development & Design. She and her partner Hans Lobach have two daughters.