HOW EARLY-CAREER FEMALE PHYSICIANS EXPERIENCE WORKPLACE MENTAL HEALTH AND LEAVES OF ABSENCE IN ONTARIO

MARA MIHAILESCU

A thesis submitted in partial fulfillment of the requirements for the
Master of Science degree in Health Systems

Telfer School of Management
University of Ottawa

Abstract

The intersection of gender and early-career stage on the mental health of physicians is emerging and evident. This qualitative, interview-based study explores the perspectives of early-career female physicians regarding their mental health in the context of their work, their experiences with taking a leave of absence from work, and promising practices and supports that can support early-career female physicians in the workplace with regards to mental health and leaves of absence. Nine interviews with female physicians in the first ten years of practice in Ontario were conducted and analyzed thematically. A conceptual framework borrowed from the Healthy Professional Worker (HPW) Partnership was employed and revised based on the findings. The findings suggest that increased awareness of the challenges faced by early-career female physicians may contribute to the destigmatization of mental health and leaves of absence and foster supports at work. Policy makers and regulatory bodies should consider developing equitable leave of absence policies for physicians and reframing how seeking mental health care is viewed to contribute to positive culture change.

Acknowledgements

Thank you to everyone who encouraged me throughout my master's and helped me pursue my many passions.

I want to thank Canadian Institutes of Health Research (CIHR) and Telfer School of Management at the University of Ottawa for generously funding this research.

I'd like to thank my supervisors, Dr. Ivy Lynn Bourgeault and Dr. Jennifer Dimoff for their guidance and support throughout my thesis and MSc journey. Your insightful feedback has helped me grow both intellectually and professionally.

Thank you to the members of my thesis committee, Dr. Samia Chreim and Dr. Catherine Tsilfidis, for sharing your expertise and for your thoughtful feedback.

A special thank you to the team members of the Healthy Professional Worker project, particularly those in the Medicine Case, including Dr. Sarah Simkin, Dr. Elena Neiterman, and Dr. Ivy Bourgeault for your continuous mentorship.

Thank you to the physicians who shared their experiences with me and let me share them with everyone else. I look forward to entering the profession and continuing this important work.

To my partner, whom I love dearly, thank you for being my sounding board and helping me achieve all my goals.

Lastly, thank you to my parents and sister who supported me during this time, past and future.

A great journey – now onto the next!

Table of Contents

ABSTRACT ..... **II**

ACKNOWLEDGEMENTS ..... **III**

LIST OF ACRONYMS ..... **VI**

LIST OF TABLES ..... **VI**

LIST OF FIGURES ..... **VI**

CHAPTER 1: INTRODUCTION **1**

Statement of the problem 1
Purpose 2
Research question and objectives 2
Conceptual framework 3
Healthy Professional Worker Contextualized Pathway Model *3*
Thesis organization 4

CHAPTER 2: LITERATURE REVIEW **5**

Theoretical perspectives: Gender intersectionality theories 5
Intersectionality theory *6*
What do we know about mental health at work? 7
What do we know about physician mental health? 7
What do we know about the influence of gender on physician mental health? 7
The intersecting influences of gender and career stage: female physicians in early career 8
Birthing physicians and parental leaves 9
Leaves of absence from work 12
Gaps in our knowledge 16

CHAPTER 3: METHODOLOGY **17**

Data collection 17
Data sources *17*
Data collection *19*
Data management *19*
Data analysis *20*
Ethical considerations 21
Data quality and trustworthiness 21
Reflexivity *23*

CHAPTER 4: RESULTS **24**

Demographic data 24
The gendered experience of mental health of early career female physicians 26
An overview of mental health experiences *26*
Contextual influences of mental health *28*
Coping with mental health issues and seeking care *37*
Disclosure and stigma around mental health *41*
Gendered experiences of leaving work 43
Motivations for taking a leave *43*
Stigmatization of leaves of absence *45*
Lack of redundancy in the system: A cause and consequence *46*
Leave of absence, disrupted *50*
Attrition from medicine *51*
Supporting early-career female physicians: the gap between what exists and what is needed 52

Existing supports available *53*
Promising practice recommendations *57*

CHAPTER 5: DISCUSSION & CONCLUSION **66**

GENDERED EXPERIENCES OF MENTAL HEALTH OF EARLY-CAREER FEMALE PHYSICIANS 66
Gender biases *66*
Emotional labour *67*
Motherhood *67*
Peer support, gender representation, and leadership *68*
GENDERED EXPERIENCES WITH LEAVES OF ABSENCE OF EARLY-CAREER FEMALE PHYSICIANS 69
Barriers to leaves of absence leading to presenteeism *69*
Stigmatization *70*
SUPPORTING EARLY-CAREER FEMALE PHYSICIANS AT WORK 70
Debrief sessions as a formal mental health support *70*
Peer supports and mentorship *71*
Increase coverage and redundancy for leaves of absence *72*
Culture change *72*
COVID-19 context *73*
CONCLUSION 74
Contributions and health system implications *74*
Limitations *76*
Future research *76*

REFERENCES **78**

APPENDICES **83**

APPENDIX A: RECRUITMENT MATERIALS 83
APPENDIX B: INTERVIEW GUIDE 84
APPENDIX C: INTERVIEW CONTACT SUMMARY FORM 91
APPENDIX D: CODEBOOK 92
APPENDIX E: CONSENT FORM FOR PARTICIPANT INTERVIEW 98

List of Acronyms

CIHR-SSHRC	Canadian Institutes of Health Research – Social Sciences and Humanities Research Council
CMA	Canadian Medical Association
CPSO	College of Physicians and Surgeons of Ontario
EAP	Employee Assistance Program
HPW	Healthy Professional Worker
OMA	Ontario Medical Association
PHP	Physician Health Program
SEAL	Secure Empirical Analysis Lab

List of Tables

Table 1.	Background descriptions of the most often used gender theories, p. 5
Table 2.	Challenges among early-career female physicians, p. 9
Table 3.	Challenges and supports among physician moms during residency, p. 11
Table 4.	Summary of literature on factors influencing mental health and leaves of absence from work among physicians, p. 13
Table 5.	Summary of literature on barriers and facilitators for leaves of absence among physicians, p. 15
Table 6.	Demographic and work characteristics of participants, p. 25
Table 7.	Summary of mental health experiences of participants, p. 27

List of Figures

Figure 1.	An Intersectional, Contextualized Path Model of Mental Health, Leaves of Absence, and Return to Work Experiences [Adapted to reflect thesis topic], p. 3
Figure 2.	Braun and Clarke's Five Phases of Thematic Analysis and Supplementary Approaches, p. 20

Chapter 1: Introduction

Statement of the problem

Mental health of physicians is emerging as an important issue within the medical profession due to the intrinsic difficult nature of medical work and context in which this work is done, both at a workplace and systemic level. There are several layered intersections that can further impact physician mental health including gender, age, and career stage.

The gender of physicians is an important subfactor that influences the mental health of physicians. Gender is a social construct that defines the roles, behaviours, activities, attributes, values, power, and influence ascribed to women, men and gender diverse individuals in a society.[1,2] Gender as a social construct can be applied to the context of medicine and to physicians working within this context.

One element of gender as a social construct is the inherent inequity between genders. Gender inequity is intrinsic to the health system and strongly influences the mental health of the physician workforce. Traditionally, medicine has been a male dominated profession and the historically recent feminization of medicine has existed within the historical masculine legacies leading to power imbalances. Data from the Canadian Medical Association (CMA) shows that there are more female physicians in the workforce now than ever before.[3] The total percentage of female physicians in 2019 is almost 43% compared to 28.4% in 2000.[3,4] However, women are still less represented in higher-paying specialties such as surgical specialties and are more common in 'female' specialties such as family practice. The current percentage of female physicians in surgical specialties is 30.3% compared to 46.6% in family medicine and general practice.[3] Additionally, women are less represented in leadership and academic positions than men.[5] The impact of the masculine structure in which female physicians work is particularly felt by early-career physicians, however more research is needed to understand this phenomenon.[6]

There are many other gendered influences into the mental health of physicians. It has been found, for example, that female physicians[1] are affected by gender-based workplace stressors, such as discrimination and inequitable treatment, as well as bullying and sexual harassment, which can further impact their mental health and act as a barrier to seeking help.[7,8] Outside of work stressors, female physicians also face additional challenges that can affect their mental health at work, including infertility, pregnancy loss, pregnancy, and birth. In order to effectively

[1] The language surrounding gender will follow conventional approaches in the literature. I will utilize the term 'female' as an adjective and the term 'women' as a noun. As such, physicians who identify as women will be referred to as 'female physicians' throughout the thesis.

address mental health in the medical workplace, we need to understand how gender affects the needs and experiences of physicians, and the outcomes of policies that affect these experiences.[2]

Career stage is another intersection that influences the mental health of physicians. Past literature identifies that early career physicians have the lowest career satisfaction, which can lead to attrition from the workforce soon after their training is complete.[9] This attrition pattern can be partly explained by the mental health experiences of early-career physicians, including increased burnout and poor work-life balance.[9] Early career is also a time when physicians emerge from medical training with various amounts of debt and begin to pay it off, which can have mental health implications.[10,11]

Career stage intersects with both gender and age of physicians. It has been suggested by prior literature that early career physicians who are women are particularly at risk of leaving the profession.[6] The timing of early-career when physicians emerge from training is typically the time and age when women are socialized to have children.

Leaves of absence from work is an important strategy to address mental health issues among physicians. Stigmatization of mental health issues compounded with stigma around female-specific challenges such as pregnancy can impact physicians' ability to reach out for help in the workplace or to take a leave of absence.[12] Stigmatization is a process of denigrating someone or something due to perceived negative differences.[13] It includes the attribution of negative stereotypes when their actions or characteristics are different from societal norms.[13]

There is little literature that takes into consideration the intersection of gender and career stage on physician mental health and leave of absence experiences. I will begin to fill this gap with an exploratory qualitative study, situated in the unique health and social care context of Canada.

Purpose

The purpose of this study is to understand the experiences of early-career female physicians regarding their mental health and how they navigate leaves of absence from work using an exploratory qualitative, interview-based study.

Research question and objectives

This study aims to answer the following research question:

- *What are the experiences of early-career female physicians regarding their mental health and how they navigate leaves of absence from medical work in Canada?*

The specific objectives of this study are:

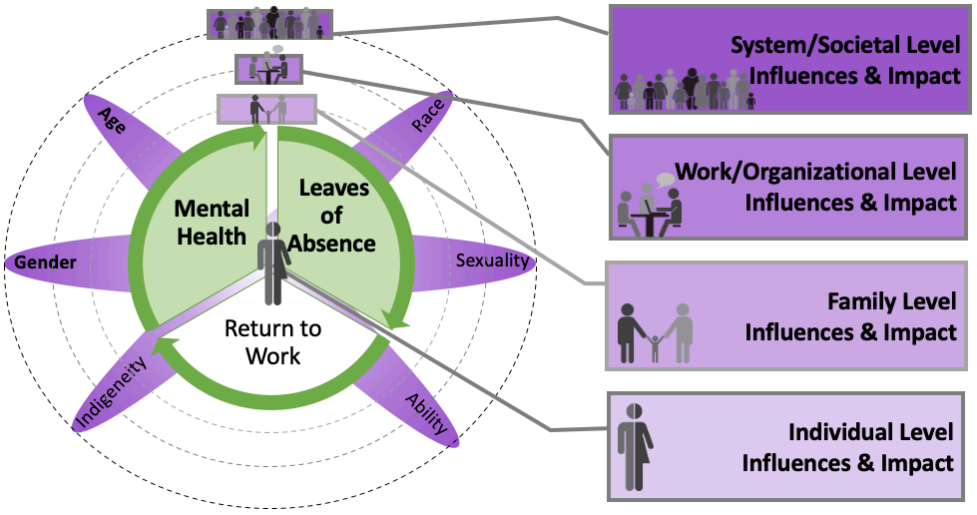
1) To explore the perspectives of early-career female physicians regarding their mental health in the context of their work
2) To explore early-career female physicians' motivations for taking a leave, and the barriers and facilitators that prevent or enable a leave to be taken
3) To understand how early-career female physicians accommodated taking a leave of absence
4) To identify promising practices and supports that can support early-career female physicians in the workplace with regards to mental health and leaves of absence

Conceptual framework

Healthy Professional Worker Contextualized Pathway Model

This independent study is embedded within the larger Medicine Case for the CIHR-SSHRC Healthy Professional Worker (HPW) Partnership, a pan-Canadian study of the mental health, leave of absence and return to work experiences of a range of professionals. In this study, I carve out a portion of the larger HPW project specific to early-career female physicians. The overarching framework for this study borrows from the Intersectional, Contextualized Path Model of Mental Health, Leaves of Absence, and Return to Work Experiences from the larger HPW partnership (Figure 1).

Figure 1. An Intersectional, Contextualized Path Model of Mental Health, Leaves of Absence, and Return to Work Experiences [Adapted to reflect thesis topic]



The pathway between mental health, leaves of absence, and return to work is situated in the center. Mental health issues may lead someone to take a leave of absence, which may be followed by their return to work. In turn, the leave of absence and return to work experience

may have a positive or negative influence on the individual's mental health. The model outlines that mental health, leaves of absence, and return to work are situated in the context of the individual, family, work, organization, system, and society – all of which can influence these experiences and are a source of stressors.

At the center, individual level characteristics such as gender, age, sexuality, and identity can influence these experiences. Factors at the familial level include roles such as partner, breadwinner, parent, or carer. Having children or being the primary caregiver to a friend or family member also influences this pathway. Profession and career stage are work and organization level influences and include the context in which one works and the content of that work. For example, physicians can work in a variety of contexts including independent practice, group practice, academic practice, and have various fee structures. The content of one's work is often related to their specialty and includes concepts such as emotional labour, defined in healthcare as suppressing one's true feelings to make others feel cared for and safe.[14] At the system and societal level, the societal roles and expectations and the systemic culture of one's profession influence the mental health and leave of absence pathway. This also includes factors such as working in the public or private sector and the systemic supports that are available. In addition, there are intersectional factors that cut across the mental health, leave of absence, and return to work pathway, which also intersect with the contextual influences at each level.

I used this broader, existing model as a guide and teased it apart for my target population of early-career female physicians. For my thesis, I specifically focus on the intersection of female gender and the influence of early career stage on mental health and leaves of absence. I do not explore nor investigate the other intersections of the framework or the return to work experiences following a leave, though they are part of the larger path model.

Thesis organization

This thesis is divided into five chapters. In this introductory chapter, I discuss the rationale for the study and the guiding research questions and conceptual framework. In Chapter 2, I discuss what is currently known about early career and female physicians with respect to their mental health and how these factors intersect. I also discuss what is known from the academic literature on leaves of absence in medicine, including barriers and facilitators to taking leaves. In Chapter 3, I describe the methodology used to conduct this study and my personal standpoint vis-a-vis this topic. In Chapter 4, I present the results of my research through the perspectives of participants across three major themes and several subthemes. Lastly, in Chapter 5, I discuss the major findings in relation to the extant literature, the implications of this research on health systems, study limitations, and provide next steps for further inquiry.

Chapter 2: Literature Review

Theoretical perspectives: Gender intersectionality theories

Before diving into the literature on mental health of physicians, I explore the literature on gender and intersectionality theory as it provides insights that guide this work. In their scoping review, Hammarström and Hensing[15] identify the most commonly used gender theories in public health research and how they are used, which are described in Table 1.

Table 1. Background descriptions of the most often used gender theories [Adapted from Hammarström and Hensing[15]]

Poststructuralist theory	A crucial concept in the development of gender research has been 'doing gender' or 'constructions of gender', which in a basic sense means creating social and behavioral differences (that do not exist) between men and women.[2] Poststructuralist theory has developed as a critique of such an essentialist approach, that is, the tendency to regard differences between men and women as constant and unchangeable.[3]
Relational theories of gender	According to Raewyn Connell, the "relational theory usually understands gender as multidimensional: embracing at the same time economic relations, power relations, affective relations and symbolic relations; and operating simultaneously at intrapersonal, interpersonal, institutional and society-wide levels."[4] Connell defines gender order as the structure of gender relations in a given society at a given time.[4]
Gender construction theories	Theories about gender constructions were developed by Raewyn Connell and others from feminist theories of patriarchy and debates over the role of men in transforming patriarchy.[5] Connell defines hegemonic masculinity as the "pattern of practice (i.e., things done, not just a set of role expectations or an identity) that allowed men's dominance over women to continue."[5]
Intersectionality	Intersectionality is based on the underlying assumption of heterogeneity within the groups of 'men' and 'women' and recognizes that individuals are defined by multiple, intersecting dimensions.[6] This approach was developed as a critique against the dichotomous way of dividing gender into 'men' and 'women', without analyzing differences within the group of men and within the group of women.

[2] West C, Zimmerman DH. Doing gender. Gend Soc. 1987;1:125–51
[3] Alsop R, Fitzsimons A, Lennon K. Theorizing gender. Cambridge: Polity; 2002
[4] Connell R. Gender, health and theory: conceptualizing the issue, in local and world perspective. Soc Sci Med. 2012;74:1675–83
[5] Connell R. Masculinities. Berkeley: University of California Press; 2005.
[6] Hammarström A, Johansson K, Annandale E, et al. Central gender theoretical concepts in health research: the state of the art. J Epidemiol Community Health. 2014 Feb;68(2):185–90.

Intersectionality theory

Intersectionality was introduced by Crenshaw in 1989 and aimed to understand how multiple marginalizations of race and gender influence the experiences of African-American women.[17] Intersectionality recognizes that these intersectional experiences are greater than the sum of their individual parts.[17] Intersectionality includes identities such as gender, race, class, sexuality, citizenship, and age. Romero[17] describes these intersections as a Rubik's cube, with each color on the faces of the cube representing an identity, and these identities shifting and mixing with each other. Particular intersections may be more pronounced in certain settings and identities may carry more or less power and privilege in different settings or systems.[17]

This concept of intersectionality has changed how gender is discussed and how social identities and social positions can create privilege or oppression among individuals or groups.[17,18]

Shields[18] explains that employing an intersectionality perspective in research includes an agenda for positive social change and informing policy, particularly around issues that influence people's lived experiences. Similarly, Romero[17] describes that processes and policies may also be studied using an intersectional approach because they can create inequalities between groups.

This paper draws upon concepts from the gender theory literature, such as feminine and masculine structures, gender norms, gender relations, and gender roles and role expectations. Medicine is a profession that was historically gendered masculine and structural legacies of this are prevalent in the contemporary era.[16] This lead to beliefs about gender becoming embedded in the professional work. Given the feminization of health care professions, including medicine, the gender divisions of labour are being challenged. [16] In comparison, nursing has been a traditionally female dominated profession. [16] Between these two profession, there are varied gendered expectations of female nurses and female physicians based on the gendered structures in which they work. [16] These include one's gender roles and the gender norms present in the profession. In fact, women began their work in health care in supportive roles to males and were required to portray typical 'female' qualities such as being gentle and patient.[16] These legacies and expectations continue to be present today and shape the experiences of female physicians.

For this study, I focus on the intersection of gender and career stage, but allowed participant to explore other identities important to them as they influence their mental health and contribute to these structures of privilege and oppression in medicine.

What do we know about mental health at work?

For this study, I borrow the definition of mental health issues from the HPW partnership. Mental health issues are defined as both short-term mental health problems that temporarily limit one's ability to function, as well as more persistent and severe medical health disorders that require medical intervention. These include mental or psychological stress or distress, burnout, anxiety, depression, other mood disorders, substance use or dependence, post-traumatic stress disorder, or serious thoughts of suicide at some point in their training or career.

Mental health is essential to achieving general health, has the potential to influence many aspects of one's life – professional, personal, and familial – and can have detrimental effects when there is no intervention. A review of the literature identified the causes and consequences of mental health concerns, interventions that can be used to address them, and the barriers to seeking and providing care, specific to the case for physicians.[19]

What do we know about physician mental health?

Physicians are vulnerable to poor mental health due to the nature of their work, including heavy workload, time constraints, difficult patient encounters, lack of autonomy, and poor work-life integration.[20,21] The National Survey on Physician Health conducted by the CMA in 2018 identified the prevalence of burnout among physicians to be at 30%, depression at 34%, and lifetime suicidal ideation at 18%.[20] Early-career physicians are also more likely to report higher burnout and lower resilience than their colleagues.[20]

What do we know about the influence of gender on physician mental health?

In the same CMA National Survey on Physician Health, the gendered breakdown of prevalence of burnout, depression, and lifetime suicidal ideation was higher for women compared to men.[20] Specifically, women had 23% increase in odds of experiencing burnout, 32% increased odds of experiencing depression, and 31% increased odds of engaging in suicidal ideation during their life.[20] Additionally, significantly more women reported low resiliency than men.[20]

Female physicians are affected by similar work stressors as physicians of other genders; however, the literature identifies additional stressors specific to female physicians. Robinson[22] and Byerly[23] identify several stressors specific to female physicians including discrimination, minority status in subspecialties, under-representation in leadership and research, and pay inequalities based on gender. Women physicians tend to have fewer role models which diminishes support systems and increases stress.[22] Robinson[22] identifies role strain between professional life and one's role as a mother or wife and challenges related to being in a dual-career couple such as sharing household tasks and deciding whose career comes first as

stresses for female physicians. Lastly, Robinson[22] discusses the stressors of pregnancy and motherhood including timing the pregnancy, length of maternity leaves, and the implications on career trajectory.

There are also unconscious and unrecognized gender biases beyond sexism and discrimination which are endemic to the medical profession.[23] These biases include the expectation that women are team players, modest, empathetic, and helpful and result in female physicians being overburdened from additional tasks.[23] These biases influence women's experiences and contribute to burnout or other mental health issues.

The intersecting influences of gender and career stage: female physicians in early career

Early career stage can be a challenging time for physicians because of the transition from training to practice and the contextual and policy-related changes associated with this transition. During residency, physician residents are employees of an academic institution and part of provincial unions, which comes with a clear and defined contract. In Canada, this contract dictates your salary, call stipends, maximum duty hours, academic requirements, and employee benefits.[24] In addition, there are clear policies around vacation, professional leave, pregnancy, and parental leave.[24] After graduation from training, practicing physicians are no longer associated with the institution, no longer part of the union, and typically work in a variety of environments. This leads to a diverse variety of practice patterns, funding structures, and work environments which lead to varying access to leave policies, health benefits, and work schedules.

A recent paper in First Five Years, a quarterly series in *Canadian Family Physician*, explores some of the challenges faced by female family physicians in early-career, which they define as the first five years of practice.[10] Bogler et al.[10] outlines systemic and individual challenges that intersect gender and career stage which are summarized in Table 2. These challenges parallel those faced by female physicians across all stages of training and practice, however, they are amplified during early career.

Systemically, female physicians in early career face implicit gender biases from patients and colleagues, such as being less likely to be introduced as the doctor.[10] They also face overt harassment, including sexual harassment, and experience pay inequalities compared to their male counterparts.[10] There are fewer women in leadership positions, which contributes to poor support for female physicians through career transitions and obstacles for career advancement, especially in early career.[10] Bogler et al.[10] also identifies the lack of comprehensive leave policies for parental, caregiving or medical reasons, and states that early-career physicians are disproportionally affected.

At the individual level, gender norms create challenges for female physicians in early career to balance home life, childcare, and caregiving responsibilities with professional responsibilities.[10] Imposter syndrome, defined as the "inability to believe that one's success is deserved or has been legitimately achieved as a result of one's own efforts of skills," is most prevalent among women and in early-career physicians.[10] This is particularly seen in women with intersecting forms of social positions, including race and sexual orientation.[10]

These challenges can influence the mental health of female physicians, but those relationships are yet to be explored in the literature, particularly during early career.

Table 2. Challenges among early-career female physicians [Adapted from Bogler et al.][10]

Systemic	**Individual**
• Implicit gender biases • Overt harassment • Gender-based pay inequities • Lack of women in leadership positions and support through career transitions and advancement • Lack of comprehensive family-, caregiving-, and medical-leave policies	• Balance of home, childcare, and caregiving responsibilities with professional responsibilities • Imposter syndrome, which is most prevalent in women and early-career physicians • Intersecting forms of social positions

Birthing physicians and parental leaves

For many, early career is a time to start families, especially if this was deferred during training. While there is some literature on motherhood and maternity leaves during residency, there is little published literature on these topics during early career. What little literature there is tends to be dominated by these experiences and policies in the American context. There is little known about female physicians who are mothers and maternity leaves in the Canadian context of universal health care and availability of parental leave. The intersection of pregnancy and maternity leave experiences with mental health during early career has not yet been explicitly explored in the literature.

The literature on residents explores the link between pregnancy and motherhood and mental health of resident physicians. Studies identified several stressors and challenges surrounding pregnancy, taking maternity leave, and returning to work during residency, which are explored in Table 3. Internal challenges at the individual level included feelings of fear or guilt around asking for and taking time off, feeling guilty for being away from their families, and fearing a

decline in skills or knowledge following a leave which affects one's confidence upon returning to work.[25,26] Walsh[27] explains that female residents place high expectations on themselves which causes severe stress.[27] Challenges at the work and training level include work demands such as work redistribution, long hours and unpredictable work demands, and residency program demands such as studying for licensing examinations and losing your cohort of residents if taking longer term leave.[25–27] Unsupportive attitudes of colleagues, supervisors, or program directors and social isolation from work supports were added stressors. Significant stressors for new mothers were work-life balance and sleep deprivation which influences their ability to work and study.[25–27] Systemic stressors included a lack of program specific policies for taking parental leaves and difficulties in accessing childcare upon return to work.[25–27]

Supports for female physicians who are mothers are required at both the personal and familial level as well as the work and organizational level in order to mitigate stress. Personal and familial supports include having support from one's partner and family to help with childcare, finding reliable childcare outside of work, and having a partner who could also take time off work.[25,26] At work, informal supports include supportive colleagues and program directors, mentorship opportunities, and bonding with other resident parents. More formally, the provision of on-site childcare and increased flexibility in rotation schedule were identified as supportive.[25,26]

Parenthood as a whole is explored in the literature for both female and male physicians who have children and take a parental leave. Willoughby et al.[25] surveyed both female and male residents regarding parental leave in Canada. They found the mean length of parental leave was nine months for female physicians and six weeks for male physicians.[25] Both female and male physicians felt stigmatized for taking longer parental leaves or improving their work-life balance through accommodations when returning to work.[25] Both female and male residents experienced similar challenges including feeling guilty for being away from their family, long and unpredictable work hours, sleep deprivation, and finding time to study.[25] Female physicians had an added stressor of breastfeeding and accommodating pumping at work.[25] Male residents reported feeling pressured to work long hours following return to work to appear dedicated to their training.[25] A study on female and male family medicine residents also found that the effects of parenthood influence career trajectory differently in that three quarters of male parents finish residency in two years but fewer than half of female parents do.[28]

Table 3. Challenges and supports among physician mothers during residency

Challenges	
Personal and internal	• High expectation placed on themselves[27] • Fear and guilt[25,26] • Confidence around returning to work[25,26] • Decline in skills and knowledge[25,26]
Work and training	• Work demands (work redistribution, long hours, unpredictable work demands)[25–27] • Residency program demands (licensing examinations, cohort challenges)[25,26] • Work life balance[25,26] • Sleep deprivation[25–27] • Attitudes of colleagues and supervisors[25,27] • Social isolation[26]
Systemic and societal	• Barriers to childcare[25–27] • Lack of program specific leave policies[25]
Supports	
Personal and familial	• Personal supports from partner and family[26] • Reliable childcare[26] • Partner who could also take time off work[25,26]
Work and organizational	• Formal childcare supports[26] • Work related supports (programs, colleagues, mentors)[26,27] • Flexibility[26] • Bond with other resident parents[26]

These challenges and supports identified among residents provide a stepping-stone to understanding the experiences of early-career physician mothers, but the residency structure and environment is different from practice after graduation, which requires more in-depth inquiry.

As well, policies around parental leaves are rarely studied. In a recent systematic review, Hoffman et al.[29] found few published evaluations of policies on supporting pregnant physicians, maternity leaves, and the subsequent return to work. They identified three studies that evaluated pregnancy and maternity leave policies, all of which were conducted in the United States of America, and found that more than half of plastic surgery residency programs did not have formal maternity leave policies, there was no national parental policy for orthopaedic

surgeons, and hospital and training programs had policies that were often not implemented.[29] The need for clear parental leave and return to work policies was also identified by a national survey of Canadian residents and program directors.[25] Willoughby et al.[25] state that few residency programs have written program-specific parental leave policies which results in variable experiences within, and between, programs. Both female residents and program directors identified the need for clear leave policies and guidance from the university.[25]

The research on maternity leaves provides us with a window into mental health leaves; however, this does not translate directly, largely because of the stigma associated with the latter.

Leaves of absence from work

A minority of papers exploring physician leaves of absence focus directly on mental health issues. Most papers discuss leaves due to physical sickness, with a mention of stress and burnout as contributing factors. The literature shows that physicians have low rates of sickness absence, due to their high threshold for taking a leave.[30] Ultimately, this means that there may be high levels of presenteeism,[31–33] which refers to workers coming to work while ill, either with physical or psychological health problems.[34]

There is a dearth of literature that explores leaves of absence from medicine using a gender lens, and of those, the majority are aimed at maternity leaves and not on leaves due to mental health reasons. When looking for insights on leaves of absence among early-career female physicians, the literature disproportionately talks about maternity leaves more so than mental health leaves. My intention in this study was to focus only on mental health leaves of absence, but parental leaves also intersect with mental health issues so it is hard to tease these apart.

The general literature on leaves of absence explores the factors influencing leaves, barriers to taking a leave, and facilitators for taking a leave of absence; these are summarized in Table 4 and Table 5, organized by the different elements of the HPW conceptual framework. Personal, familial, and work factors influence one's decision to take a leave of absence or exhibit presenteeism (Table 4).

Table 4. Summary of literature on factors influencing mental health and leaves of absence from work among physicians

Factors influencing decision to take a leave of absence	Personal level	• Health and lifestyle[31] • Internal motivations to work and work ethic[32] • Personality and upbringing[32,35] • Sense of self-confidence and self-efficacy[32,35]
	Familial level	• Work-family conflict • Family commitments[36] • Having children[36] • Taking parental leave[36]
	Workplace level	• Poor teamwork and poor team climate[37,38] • Perceived reduced autonomy[37,39,40] • Work overload[30,32,37,39–41] • Poor job satisfaction[30,31,41–43] • High stress working environment[31,37,42]
	Organizational and employer level	• Type and status of employment[32,38,43,44] • Policies and compensation in place for leaves[43] • Types of departmental and social support available[38,39]
	Cultural level	• Stigma to mental health issues and absence[32] • Loyalty to one's patients, coworkers, and institution[31,32] • Learned behaviours and attitudes on one's health and illness, work, and professional identity[32,40]

Several personal factors were explored in the literature that influence a physician's decision to take a leave of absence or exhibit presenteeism. First, demographic characteristics such as ethnicity were found to have no association with presenteeism.[43] Second, health and lifestyle factors, such as being overweight, having a poor diet, and a lack of exercise were discussed and higher presenteeism was found to be associated with physical activity, but not body mass index or alcohol intake.[31] Third, physicians identify as having a high work ethic and being internally motivated to work to provide a meaningful contribution to society, which hinders their decision to take a leave.[32] Lastly, one's personality, upbringing, and their sense of self-confidence and self-efficacy can further impact these decisions.[32,35]

The leave of absence literature has not focused on familial factors influencing one's decision to take a leave due to mental health reasons. A few papers discussed parental leaves of absence, however they did not discuss mental health which can intersect this experience.[36]

The influence of work-related factors on a physician's ability and decision to take a leave was most thoroughly discussed in the literature. Factors at the level of the work environment that influence one's decision to take a leave include poor teamwork and poor team climate,[37,38] perceived reduced autonomy,[37,39,40] work overload,[30,32,37,39–41] poor job satisfaction,[30,31,41–43] and a high stress working environment.[31,37,42] Factors at the organizational and employer level that influence leave of absence experiences include the type and status of employment,[32,38,43,44] the policies and compensation in place for leaves,[43] and the types of departmental and social support available.[38,39] Factors at the level of medical culture that can facilitate or prevent one from taking a leave include loyalty to one's patients, coworkers, and institution,[31,32] and stigma to mental health issues and absence,[32] respectively. Several papers also identified the impact of physician's personal perspective on their health and illness and their decisions to take a leave of absence. These perspectives may be learned behaviours or attitudes perpetuated by the broader medical culture throughout training and work. Physicians minimize their illness due to their constant interaction with severely sick patients and often fail to recognize their own vulnerability to illness and mental ill-health.[40] Physicians also believe that working through their illness will help them recover sooner and feel the need to uphold their professional identity even when ill.[32] Together, these culturally influenced personal constructs and perspectives on one's wellbeing hinder physicians from taking a leave of absence and contribute to presenteeism.

Table 5 outlines the barriers and facilitators for taking a leave of absence among physicians at the level of the workplace, organization, and cultural levels.

Table 5. Summary of literature on barriers and facilitators for leaves of absence among physicians

Barriers to taking a leave of absence	Personal level	• One's own work ethic and responsibility to their patients[31,39] • Deskilling following a leave[35]
	Work and organizational level	• Irreplaceability of the physician in the workplace[31,39,41,43] • Lack of support and protocol regarding leaves of absence[35,36,45,46] • Work factors such as the type of employment[8] and high workload[31,39]
	Cultural level	• Stigma surrounding mental health and leaves of absence[35,37,43,45,47,48]
Facilitators for taking a leave of absence	Workplace Level	• Sufficient staffing[32] • Flexibility and reduction in working hours[36,49] • Availability of part-time positions[36]
	Organizational level	• Improved family and social support[49] • Implementing planned career breaks[49] • Providing better training to identify and respond to mental health issues[45,47] • Increasing access to occupational health resources[45,49] • Providing confidential treatment to physicians suffering from mental health issues[33,40,49]
	Cultural Level	• Addressing the stigma surrounding mental health • Increasing awareness and education surrounding mental health issues among physicians[33,40,45,47]

Personal barriers that hinder physicians from taking a leave of absence include one's own work ethic and responsibility to their patients,[31,39] and deskilling following a leave.[35] At the workplace and organizational level, barriers include the difficulties to replace the physician in the workplace,[31,39,41,43] the lack of support and protocol regarding leaves of absence,[35,36,45,46] and work factors such as the type of employment,[31] and high workload.[31,39] The stigma surrounding mental health and leaves of absence is a barrier at the level of medical culture.[35,37,43,45,47,48]

Facilitators for timely and simple leave of absence processes have similarly been divided into subthemes at the workplace, organizational, and cultural levels. At the workplace level, interventions such as sufficient staffing,[32] flexibility and reduction in working hours,[36,49] and availability of part-time positions[36] were suggested. At the organizational level, the literature discussed improved family and social supports,[49] implementing planned career breaks,[49] providing better training to identify and respond to mental health issues,[45,47] increasing access to occupational health resources,[45,49] and providing confidential treatment to physicians suffering from mental health issues.[33,40,49] At the cultural level, interventions addressed the stigma surrounding mental health. Several papers suggested increasing awareness and education surrounding mental health issues among physicians.[33,40,45,47]

Gaps in our knowledge

The gaps identified in the literature are present in each element of the HPW conceptual framework. There is a lack of intersectional analysis on the impact of gender on mental health in the workplace and the experience of taking a leave of absence. Further research is needed to understand the impact of the masculine structure in which female physicians work, particularly as it intersects with early career stage.[6] This is an important gap to address because gender inequalities and power imbalances have mental health impacts and can directly influence the process of taking a leave of absence from work. Taking a leave of absence is an important strategy to protect or improve one's mental health; however, some physicians see it as a failure to promote or sustain mental health at work. There is a clear gap in the literature surrounding the pathways to taking a mental health leave of absence and the implications surrounding it. There is a need for evidence-based and gender-responsive policies, practices, and programs to promote and support the mental wellbeing of physicians.

In this chapter, I reviewed the literature on mental health at work and leaves of absence among physicians with particular attention to the literature on how gender intersects with these concepts. In Chapter Three, I will describe the methodology used to conduct this study including data collection and data analysis.

Chapter 3: Methodology

A qualitative approach was employed in this research because it is most suitable to the research question and objectives which aim to generate a holistic understanding of mental health and leave of absence experiences of early-career female physicians. This research design allows the participants to explore their experience with mental health and provide a better understanding of this phenomenon from the point of view of the female physician.[50] Additionally, a qualitative approach will give insight into the context that influences physicians' mental health and their motivations and reasons for taking a leave of absence from work.[50] Lastly, a qualitative approach allows for flexibility in design which facilitates the exploration of unexpected findings.[51] This enabled me to explore the influence of the factors identified in the HPW conceptual framework, but also enabled new and emerging issues and factors to come to the surface for more in-depth analysis.

Creswell[52] describes qualitative research as a holistic account focused on participants' experiences and the meanings they attach to these experiences. Throughout the qualitative research process, the multiple perspectives and meanings that participants hold about the problem are understood.[52] The researcher must report on these multiple perspectives and develop a larger complex picture of the problem, factors that are involved, and their interactions.[52] In this way, qualitative research is exploratory and interpretive, values the context in which participants are situated, and my role as the researcher is to search for a deeper understanding of participants' lived experiences of mental health and leaves of absence.[53] Additionally, I am explicitly interested in understanding the gendered dimensions of these experiences. The specific qualitative research approach is using in-depth semi-structured interviews.

Data collection

Data sources

Data sources were semi-structured interviews with female physicians in their early career. Interviews were individual, given the sensitive nature of the topic and experiences, and followed a semi-structured format with probes. This semi-structured open ended interview protocol allowed for the systematic collection of data and comparability of responses, while still allowing the interview to be conversational, enabling new ideas to emerge.[54]

Participants were chosen for this study using purposeful sampling. In purposeful sampling, the participants chosen can best inform and help to develop an understanding of the research question.[52] I included physicians who identify as women in their early career, which is defined

by Dyrbye et al.[9] as being within the first 10 years of practice following graduation from a residency or fellowship program. I did not exclude participants based on age and was open to including female physicians who entered medicine later in life. In order to participate in the study, participants did not need to have experienced a leave of absence or any specific mental health problems, because their experience may still provide insights on these topics. For example, a participant may have considered a leave, but not formally taken one due to barriers, which are important to address.

I employed a maximum variation sampling strategy in order to allow for variability in experiences across different specialties and enabled me to understand the influence of a broad range of factors. Participants were specific in terms of the unique context of early-career female physicians, but variable in their experiences. I sought saturation of the whole group of early-career female physicians but not of the subgroups. My inclusion of various specialties was to ensure I have variability and as such is not part of any comparative analytic strategy. I conducted nine interviews with female physicians across a variety of specialties including family medicine, medical, and surgical specialties.

Recruitment

Participants were recruited through a variety of strategies including independent recruitment and recruitment through the broader HPW study. The recruitment materials for this study received ethics approval from the University of Ottawa Research Ethics Board separately from the broader HPW study. Participants who agreed to participate in my study were asked for consent to participate in the broader HPW study as the data is applicable to the HPW partnership as well.

First, I reached out to female physicians on social media by sharing a recruitment poster that asked physicians interested in participating in the study to contact me (Appendix A). I made similar posts on Facebook and LinkedIn groups, such as the "Physician Moms Group," that can be openly accessed. These groups have a large sample of female physicians in their early career and allowed me to recruit widely so that there are equal opportunities for participation of those who work in various settings and specialties across Ontario. The recruitment poster identified that this was a study on mental health and may have yielded more participants with mental health issues than in the general physician population.

Second, snowball sampling was used to recruit participants via participants themselves. Participants were asked to forward my contact information and study details from the recruitment materials to any interested colleagues who may follow up with me for participation.

Third, self-recruitment to interview through the HPW survey was used and participants who identified as early-career female physicians were asked to participate in this sub-study. Only one interview was conducted for each participant and the data was used in both studies.

Data collection

Interviews were conducted virtually with individual physicians and followed a semi-structured format. Interview questions were structured around participants' experiences with: (1) early-career following graduation from training program, (2) mental health in the workplace, (3) workplace stressors and unique female challenges, (4) navigating leaves of absence from work, and (5) interventions and supports for early-career female physicians.

The interview protocol was based on the interview guide used for the HPW project to maintain the flow of questions based on the Contextualized Path Model. I added and removed some questions to make it more relevant to this particular study and target population (Appendix B). I applied this interview guide for two pilot interviews that both lasted about an hour and provided rich data, which demonstrates its feasibility. These pilot interviews were included in the sample. The pilot interviews were conducted in the winter of 2020, shortly prior to the beginning of the COVID-19 pandemic in Canada. The remainder of the interviews were conducted during the context of the pandemic in the fall of 2020 and winter of 2021.

I interviewed participants only once and each interview lasted approximately 60 minutes. Interviews were conducted either in person, prior to the COVID-19 pandemic, or through video conferencing using Zoom. The interviews were all conducted in English. The interviews were taped using the audio feature on Zoom and transcribed for analysis.

Data collection occurred during the COVID-19 pandemic, therefore discussion on COVID-19 arose organically during the interviews. The impact of the pandemic is not a key focus of this study, but the data does take into account the impact of COVID-19 on early-career female physicians' mental health.

Data management

All interviews were digitally audio-recorded and transcribed verbatim using online transcription software, Otter.ai. Transcripts were uploaded and transcribed by the software, followed by a detailed reading and editing of the transcript. Handwritten notes and observations taken during the interviews were used to facilitate data coding and identification of key themes. Transcripts were uploaded into NVivo, a qualitative data analysis software program, for thematic coding and retrieval of coded quotations.

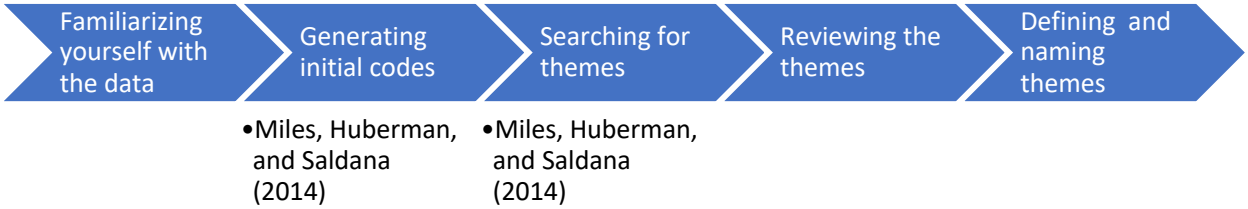
Data analysis

Following the approach in Miles et al.,[55] data analysis was conducted concurrently with data collection. This was achieved by transcribing, analyzing, and coding interviews as they are conducted which gave me the opportunity to think about the data I collected and generate strategies for better data collection moving forward.[55] Data analysis involved summarizing interviews, transcription of interviews, and coding of the transcripts using NVivo.

Following each interview, a Summary Form was used to summarize the most important information gathered from that participant (Appendix C).[55] The Summary Form for previous participants helped to modify the interview protocol for the following participants and ensure that missed target questions get asked and new questions were added to probe further on new concepts.[55]

Data analysis was conducted using Braun and Clarke's[56] method of thematic analysis, to analyze, identify, and report patterns in the data. This method of analysis was chosen because it is flexible and can be applied across many theoretical frameworks and epistemologies.[56] I followed the five phases of thematic analysis including (1) familiarizing yourself with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing the themes, and (5) defining and naming the themes.[56] Miles et al.'s[55] approach to coding and data representation matrices for theme development was used as a supplementary approach throughout the thematic analysis.

Figure 2. Braun and Clarke's Five Phases of Thematic Analysis and Supplementary Approaches



Coding of transcripts was conducted in NVivo. Both inductive and deductive codes were used. A codebook of deductive codes was developed a priori using themes from the research questions, literature, and the HPW conceptual framework.[55,56] The codebook provided a reference for all codes used in the study, outlined what the code means, and when to apply it to the data (Appendix D).[57] Deductive codes included examples such as primary causes of mental health issues, impact of presenteeism, enablers of leaves of absence, and gender differences. Inductive codes that emerged throughout the data collection and analysis were added progressively to the codebook. These included examples such as leave of absence disturbed

and general medical culture. The codebook was reviewed by my thesis supervisors to refine and collapse codes into meaningful groups.

Codes were then sorted and categorized into themes by reading through the coded data to identify relationships between codes, such as codes which tend to appear together, and begin sorting these codes into broader themes.[56] I explored the underlying ideas and assumptions in the data to drive theme development at a more abstract level.[56] Themes continued to be refined and defined until the coded data became internally homogenous within each theme and externally heterogenous across the themes.[56] I used the themes generated through thematic analysis in parallel with the conceptual framework to reflect how early-career female physicians experience mental health in the workplace and how they navigate leaves of absence from work.

Ethical considerations

Several ethical considerations were part of this study and ethics approval from the University of Ottawa Research Ethics Board was obtained before conducting the study. As noted above, this study received ethics approval separately from the broader HPW project.

A consent form was sent to participants prior to the interview and provided details on the purpose of the study, confidentiality and anonymity, audio-recording, and voluntary participation and the ability to withdraw from the study at any time (Appendix E). Additionally, the consent form outlined participation in both the HPW project and this thesis sub-study, which participants had the option to opt in or out of either study.

Participants' participation and identity remained confidential. Participants' name, organization, and other identifying information was disguised to protect their anonymity. Raw data is stored in the HPW secure server at the McMaster University Secure Empirical Analysis Lab (SEAL) and is only accessible to the researcher and the HPW team. Once data was collected, it was transferred to the SEAL lab, using password protected MobiKeys, to be securely saved for the duration of the project and retention period.

As a thank you for participating in the interview, interview participants received a $20 honorarium in the form of gift cards or e-transfers sent to their chosen email addresses.

Data quality and trustworthiness

Trustworthiness of the research study was established using strategies outlined in Lincoln and Guba[58] to maintain credibility, transferability, dependability, and confirmability.

To assure credibility in the findings and interpretations, the researcher has prolonged engagement in the field of physician mental health.[58] As a research assistant on the broader HPW project, I have been engaged in this field and conducting interviews with physicians, residents, and stakeholders in physician mental health prior to beginning this thesis project, beginning with December 2018. This allowed me to understand the culture of medicine and the phenomenon of interest, mental health experiences, before carving out the specific population of interest, early-career female physicians.[58] A pilot study on the topic of early-career female physician mental health and leave of absence experiences was also conducted between January 10, 2020 and May 22, 2020 for a course titled "Qualitative Methods" (MGT 5102) at the University of Ottawa. These studies have allowed me to develop prolonged engagement in the field of physician mental health and understanding the experiences of early-career female physicians. Comparisons between the pilot study and data collection for this thesis provided an opportunity to see if there were comparable themes, particularly before and within the context of the pandemic.[58]

Peer debriefing was another technique used to establish credibility.[58] Debriefs with the HPW Medicine Case Study team and the HPW Trainee Network, a group of trainees working across a variety of case studies on the project, were conducted to probe for biases and assumptions, and explore and defend emerging hypotheses.[58] Meetings with the HPW Trainee Network provided opportunities for catharsis by speaking openly about experiences interviewing workers suffering from mental health issues and the impact this has on the interviewer.[58]

Immediately following each interview, a short debrief was conducted, between myself and another HPW researcher who took part in the interview, to discuss emerging topics and ensure we are not introducing personal biases or misinterpreting participants.

Transferability of research findings was achieved by developing a thick description of the population, culture, and relationships studied for those interested in transferring findings to other contexts.[58]

External audits conducted with thesis supervisors involving iterative reviews of the process of conducting the study, the data, findings, interpretations, and recommendations were used to establish dependability and confirmability in the study.[58] These audits provided useful feedback to develop stronger conclusions.[58] An audit trail including raw data and quotations, detailed field notes, procedural notes, and instruments were maintained to ground the findings in the data and enhance trustworthiness.

Reflexivity

As a female health systems researcher, with an ambition to pursue medicine as a career and actively applying to medical programs during the time this study was conducted, it is important to discuss preconceptions and motivations for pursuing this research and developing the research product.[59] Throughout the process of data collection and analysis, I engaged in reflexivity, a process of examining the impact and perspective of the researcher and uncovering motivations and implicit biases in my approach.[60]

This was achieved by keeping a journal to reflect on the methodology and analysis including thoughts, ideas, and potential biases. Following each interview, I reviewed the transcript and created a summary form with key ideas, main themes the participant discussed, the information gained for each target question in the interview guide, information that was missing, other important or interesting information from the participant, and questions or probes I had to consider for the following interviewee.[55]

Pivotal decisions in the research process were documented, explained, and discussed with my thesis supervisors to prevent misrepresentation of the data. As previously mentioned, this thesis is a sub-study of a broader HPW project looking at mental health, leaves of absence, and return to work experiences across a range of professions, including medicine. The methods and findings are situated within this broader context. Both thesis supervisors are engaged with the HPW project across other professional case studies and have a close understanding of the project and broad topic of mental health and leaves of absence, while maintaining objectivity from the medicine case and this study population.

In this chapter, I described the methodology used to conduct this study and my personal standpoint vis-a-vis this topic. In Chapter 4, I will present the findings through the perspectives of participants across three major themes and several subthemes.

Chapter 4: Results

In this chapter, I present the findings of the study that addresses each of my objectives; (1) to explore the perspectives of early-career female physicians regarding their mental health in the context of their work, (2) to explore early-career female physicians' motivations for taking, or not taking, a leave of absence, and the barriers and facilitators that prevent or enable a leave to be taken, (3) to understand how early-career female physicians accommodated taking a leave of absence at work, and (4) to identify promising practices and supports that can support early-career female physicians in the workplace with regards to mental health and leaves of absence.

I start by describing the demographic details of the early-career female physician sample including age, practice specialty, years in practice, and familial characteristics. Next, I explore early-career female physicians' gendered experiences of mental health. I provide an overview of their mental health experiences, the contextual influences of mental health, how early-career female physicians cope with mental health issues and seek care, the stigmatization of mental health and disclosure, and attrition from medicine as a consequence of poor mental health. Then, I present the findings on early-career female physicians' experiences with leaving work. I discuss physicians' motivations for taking a leave, the stigmatization of leaves and the culture surrounding them, the lack of redundancy in the system (i.e., a shortage of staff leading to difficulties with coverage) as a barrier to taking leave, the concept of disrupted leaves of absence, and the impact of collegiality as a facilitator to leaves. Lastly, I present the existing supports that are available and explore the promising practices recommended by female physicians that would support their mental wellbeing and leave of absence experiences at work.

This study focussed on early-career female physicians; however, the discussions went beyond their experiences in early-career and included their medical school and residency experiences. Participants' reflected on their experiences from a longitudinal perspective and noted how these sometimes compounded over the various courses of their training and medical career. The results highlight the intricate trajectory of mental health throughout this pathway. I feel it is important to include these experiences as part of this thesis and elucidate the importance of mental health awareness and supports early in training.

Demographic data

Nine participants were included in this study, all of which self-identified as women and were physicians in Ontario in their first 10 years of practice. Bogler et al.[10] defines early career as the first five years of practice, while Dyrbye et al.[9] defines it as the first 10 years. In this sample, all

but one participants are in their first five years of practice; the other is nine years into practice. Table 6 describes the demographic and work characteristics of participants in this study.

Table 6. Demographic and work characteristics of participants

Characteristic	**Number of participants (n=9)**
Years in practice	
1	1
2	1
3	3
4	1
5	2
9	1
Residency	
Family Medicine Specialty	7
Medical Specialty	1
Surgical Specialty	1
Fellowship	
Palliative Care	3
Intensive Care	1
Orthopaedic Surgery	1
No fellowship	4
Specialty practicing in	
Family Medicine	3
Palliative Care	3
Surgery	1
Mixed	2
Other workplace characteristics	
Locums	2
Academic Practice	5
Familial status	
Married or with a partner	7
Single	2
Children	6
No children	3

I intended to employ a maximum variation sampling strategy across different specialties throughout Canada to understand the influence of a broad range of factors; however, participation was restricted to the province of Ontario. In addition, there was over-representation of female physicians working in family medicine specialties, with only two

participants from a medical or surgical specialty. It is possible my sample may be a reflection of over-representation of women in family medicine and the under-representation of women in other specialties such as surgery. All participants were less than 40 years old, with most being in their 30s.

The gendered experience of mental health of early career female physicians

The mental health experiences of early-career female physicians are described through four broad themes including: an overview of mental health experiences, coping with mental health and seeking care, disclosures and stigma around mental health, and attrition from medicine.

An overview of mental health experiences

All but one participant experienced mental health issues throughout the course of their training and career. One participant had been diagnosed with a mental illness and received treatment, three had experienced severe mental health issues and received treatment but did not receive a diagnosis, and four experienced general mental health issues such as burnout, of which two sought help and received treatment and two did not. The one participant who felt "fortunate that… my mental health has been quite good" (Participant 3) still accessed mental health services from a psychotherapist in a preventative way. The common mental health experiences that were discussed were burnout, depression, anxiety, stress, and general mental ill-health. A summary of mental health and leave of absence experiences are summarized in Table 7.

Table 7. Summary of mental health experiences of participants

Participant Number	Specialty	Experienced mental health issue?	Received diagnosis?	Mental health issue experienced?	Experienced when?	Sought help?	From who?	Treatment?	Leave of absence taken?
P1	Family medicine	Yes	Yes	Major depressive disorder	Diagnosed in medical school and continued	Yes	Family doctor and psychiatrist	Medication	Yes
P2	Family medicine	Yes	No	Postpartum depression, burnout, and	Residency and practice	Yes	Psychiatrist, family doctor, and psychologist	Medication	No
P3	Family medicine	No	No			Yes, preventative	Psychotherapist		No
P4	Medical specialty	Yes	No	Depression and anxiety	Med school and residency	Yes	Wellness resource at institution, Psychiatrist	Psychotherapy and medication	Yes
P5	Family medicine	Yes	No	General mental health issues, stress, overwork,	Residency	No			No
P6	Family medicine	Yes	No	General mental health issues, burnout	Residency and practice	Yes	Wellness resource at institution	Therapy	No
P7	Surgical speciality	Yes	No	General mental health issues/Not specified	Residency and practice	No			No
P8	Family medicine	Yes	No	General mental health issues/Not specified	Residency, fellowship, and practice	Yes, preventative		Therapy	No
P9	Family medicine	Yes	No	Depression and burnout	Residency	Yes	Psychiatrist and therapist	Cognitive behavioural therapy	Yes

Contextual influences of mental health

Based on the HPW conceptual framework, four levels of influence on mental health are important to tease apart. Participants' responses were mapped onto these a priori themes.

Individual

Participants recognized that physicians' personality may influence their mental health experiences and it was suggested that medicine attracts people of a certain personality that may be more likely to be affected by mental health concerns.

> "I think the fact that everything we do is fee for service and remunerated by what your output is, and when you get a group of motivated people, which is mostly human nature, but I think particularly in medicine maybe, it kind of selects that sort of personality, then you get people who really have a hard time turning off. And it is hard to relax and have time away from work without feeling idle…" (Participant 7)

> "Certainly you don't get this far through your training without a specific personality. …medicine breeds and attracts Type A's, they breed the anxious people, the people who are very perfectionistic… And it takes a while for you to adjust your own expectations, and I think while you try to figure that out it can be a very difficult time." (Participant 8)

Age is another factor that influences physicians' mental health, particularly in early career when physicians may look "younger" that expected.

> "Well, I think there's a lot of microaggressions. And I think that that wears on people, it becomes tiring to kind of have to justify your existence. …It is definitely better than what it was, but it's still not where it needs to be. Especially the idea that you have to prove yourself somehow to either colleagues or patients… All of that wears on you, all of that is more tiring. And if I'm asked like five times, 'are you sure you're old enough to be practicing?' Yeah, the first time was funny. The fifth time is like, 'I'm done. …I don't really want to talk about my age.' I think it gets to people emotionally." (Participant 6)

At the level of the individual, factors such as one's personality and predispositions to mental health issues may influence physicians' experiences with mental health. Additionally, demographic factors, such as age, may lead to microaggressions from patients or colleagues which over time can impact physicians' mental health.

Familial

Influences at the familial level includes a variety of roles such as parent or earner, providing caregiving to family members, relationships, and family planning, among others. Participants had several varying experiences around parenthood and childbearing that influenced their mental health. One participant was struggling with infertility and found it "hard not to ruminate on that." (Participant 8)

> "Infertility has been a big issue in my life. And I think that is a big stressor because that involves a lot of appointments and organization... I think that the management of not only infertility, but pregnancy and those kinds of things, really does factor in. You have to find time to do those things. And these are things that are usually done Monday to Friday, nine to five, when you're supposed to be working. So I think that those are really hard things to manage. And so that's defiantly a stressor that is very different for me than it is for my husband or any other male here. You're trying to manage medical appointments, medications, medication side effects, pregnancy side effects, nausea, those kinds of things. And those are all things that you just kind of have to grit, bear, and factor into your day." (Participant 8)

Pregnancy is another female-specific challenge that has implications on mental health, not just the physical challenges that impacts women such as nausea and difficulties standing for long hours, but also the balancing of appointments.

> "…when I found out I was pregnant, I was also on call… My partner was in another city and for me the personal experience I went through because it was an unexpected pregnancy was that I had no mental space to deal with this because I was getting paged all the time, I was sick, and then I couldn't find anyone to cover me. So I was trying to navigate my work week with figuring out how pregnant I was, making a decision with my partner about it. I think it was just that I had no mental space to address this problem because I couldn't think for myself because I was working at the same time." (Participant 9)

Participants with children described challenges with work-life balance as working mothers.

> "So in terms of affecting mental health, I think the unrelenting kind of work demands and never being done. And always kind of trying to measure up against men who didn't have kids or mat leaves is a little frustrating along the way. Because you either take a short mat leave to try to keep up or you take one and then you kind of get behind. So prioritizing family definitely affects your career, for sure." (Participant 7)

> "[Critical care] is an area of medicine that can be really hard, particularly as a young mother. And the hours are long. The call was hard. I remember very clearly pumping milk for my daughter in between doing other things in the intensive care unit. So, always very supportive, but I think the environment is difficult." (Participant 4)

Female physicians may also take on the role of primary or sole breadwinner in the family which places additional pressure on them to stay well and continue going to work.

> "I don't know, I think it's a funny thing, where I'm sure I can meet criteria at different times for the burnout thing. But I also just kind of refuse to because I'm it for my family, and I'm the breadwinner, and it's on me and I can't be sick, so I just kind of recognize that this is not sustainable." (Participant 7)

Familial factors around having children including fertility journeys and pregnancy have significant implications for early-career female physicians' mental health. These added stressors contribute to poor work-life balance and are often difficult to accommodate in the workplace. When a female physician is a primary or sole breadwinner, this adds another layer of stress and may prevent them from seeking care.

<u>Work and organizational</u>

At the level of the workplace, organization, or institution, there are several factors that directly impact mental health. These can be seen throughout training in medical school or residency, during the transition to early career, and during practice in various specialties and employment settings (private practice, locums, or academic institutions).

Work content: the intensive nature of medical work

The intensive and intrinsic nature of medical work is very difficult across all specialties. In particular, the emotional demands, ethical dilemmas, and critical or traumatic events that are prevalent in the profession influence physicians' mental health.

> "Being a surgeon and the outcomes of your patient being in your hands, literally, is stressful. Dealing with very delicate surgeries and potential for nerve injuries and quite serious complications is stressful." (Participant 7)

> "There's a culture of really trying to look out for each other in palliative care. We acknowledge that we face some kind of tough stuff, some really tough conversations, some really tough situations, ethically and otherwise." (Participant 3)

One participant described how difficult situations have been exacerbated during the pandemic.

> "The part that been super difficult, particularly because of the pandemic is that dying at any time is very difficult. But dying right now is very lonely because of the visitor restrictions. And that's been a huge, huge challenge to my work." (Participant 3)

Digital stress and administrative burdens were also felt by early-career female physicians.

> "The administrative piece. I don't like doing paperwork, I don't like doing 17-page forms. I don't really even like doing my own charting. I do it because it's important and I have to do it. But I sort of feel like there's a lot of bureaucratic nonsense that takes up time, that takes up hours of my week… sometimes for nothing or sometimes for something that's needlessly difficult." (Participant 6)

Stressors around work content tend to be universal across specialties and physician groups. The intrinsically difficult nature of providing patient care is not something that can be changed; therefore, it is important to acknowledge the mental and emotional toll this takes on physicians in order to support them at work.

Transitions to early career

Early career is a time when physicians leave the training environment from residency or fellowship. This involves a transition from an institutional setting and salary fee structure to a variety of settings that often results in less supports and independent work. Female physicians in early career explore the impact of transitioning into practice on their mental wellbeing as being stressful due to increased responsibility and workload.

> "The most stressful part in transition was that now the buck kind of does end with you. As a resident, there always is somebody else that you can turn to where the final responsibility remains with them. And so now, it's totally up to you. It's not that you don't have colleagues to ask in terms of support or advice, but the end decision in terms of any patient decision that you make is yours. And so that part was a little bit more stressful. And over the last few years that has reduced, as you become more confident, but definitely, I think that was the hardest part, transitioning." (Participant 5)

> "The first months of practice are really stressful. I think I made the mistake that a lot of people make where we take on a lot of work or you feel bad turning down work… So I did feel like I was getting burnout towards the end of my first year, because I had

> accepted to take on extra work, I was accepting extra shifts, because I had just gotten this job and it was a really good job, and I wanted to be helpful… But the high reward came with really high costs as well." (Participant 9)

Early career involves many changes in work structure and the level of responsibility one has over their patients. These factors influence one's mental health and make early career a particularly stressful time.

Work and professional context

The participants' work context and specialty were also identified as impacting their job satisfaction and mental health. One participant described a negative experience with her workplace colleagues and management and how it led to feelings of anxiety and starting her medications back up.

> "And then I was probably fine for a very long time until things at work... there was a lot of changes with management and we'd gotten contracts. And people weren't very happy. And like just a lot of structural changes at work that I didn't like, and that increased anxiety a lot. And then I had a lot of insomnia on top of that. So I started [medication] back up at that time. And then I think I've actually never stopped." (Participant 2)

The majority of participants had completed residencies in family medicine, though they were practicing in different sub-specialties and work environments. Many participants described their workplace and specialty in terms of how many other female physicians and other staff worked there.

> "I think critical care has always been, although there are more women in it, I think now, it's always been a very male-centric place to work, for a really long time, at least in [City] the intensive care units really didn't have a lot of women in them. I'd say in the past couple of years, we've trained more women and so they've been available. And I think I've received a lot of support along the way." (Participant 4)

> "My workplace is predominantly female right now, which is really great. There's four new hires, which I'm one and the other ones are all female as well, and all of our nurses are female. And most of my learners have been female. A lot of the kind of older white dude docs are male, but a lot of the new people are female. So it's nice that we're a pretty women friendly zone… it's a very kind of welcoming environment." (Participant 3)

The relationships one has at work with colleagues and management is critical to physicians' wellbeing at work. Feeling represented at work such as working with other female physicians or mothers influences the workplace culture and makes female physicians feel supported by sharing similar experiences.

Medical culture

Medical culture was described by participants as one of "self-sacrifice" and many female physicians explained the negative impact of this culture on their mental health.

> "That's always been the case. It's always been like; we glorify sick people who work. …I remember the resident who was vomiting on general surgery and continued to work on call, and wouldn't let us tell the senior like, those would get nothing other than a pat on the back and great props. That was not a, 'Hey listen, this guy is not looking out for his wellness. I'm worried about burnout or I'm worried about impact on patients…' That's just not how the culture is. Self-sacrifice, and we really, really value so self-sacrifice." (Participant 1)

> "But I think self-sacrifice is something we really need to look hard at. I know, personally, it's important for me to feel like I'm putting my patients above all else. But I think we really need to think hard about what that is, and actually think responsibly, like think, is that a responsible mindset to have? Because is that sustainable? Is that a sustainable way to live? No, we know it's not." (Participant 1)

There is also a perpetual cycle in medicine that is hard to break. Those in leadership perpetuate the culture that they trained in, which was often to power through mental or physical struggles. There is also a culture of harassment and bullying which is experienced by trainees, particularly females.

> "It's so hard. It's so engrained into training and we all experience it I would say. I think you'd have a lot harder time finding a woman who said she was never harassed in some way based on the fact that she was a woman, rather than finding someone who said they were." (Participant 8)

The culture of medicine is not a unique female stressor and the expectation of showing up to work is felt across all genders. However, the culture draws on its masculine structure and makes it even more challenging for female physicians in the workplace. At the workplace level, the cultures of stoicism and self-sacrifice make it difficult for women to find work-life balance, instead they are expected to prioritize their work over their mental and physical wellbeing.

Harassment and bullying are prevalent in medicine and many female physicians have experienced this first-hand, which influences one's wellbeing at work.

System and societal

The intersection of gender at a systems and societal level was explored by participants in terms of societal gender roles at work and medical culture.

Societal expectations of gender roles at work

Throughout interactions with both patients and colleagues, it is felt that the "expectation is that the doctor is male." (Participant 8) Female physicians also felt like they had to work harder to prove they were the physician in charge.

> "It's like a running joke between some of my male colleagues here. There was one particular situation for example. I spent all this time with this family, I had a whole conversation - and I introduce myself when I see patients as 'I'm Dr. ___ I'm the supervising doctor on the unit' or I say 'I'm the staff doctor so I'm the supervising doctor for all of the residents you will see.' I find a way to introduce myself as the boss in two different ways into an initial meeting. So I sat down with this family, had this whole big important conversation, chatted with them the whole time... I was with a male resident. The next time I saw them in the hallway and I said hi to them, as I was walking away I heard the wife, who I spent hours with the day before, say 'That's the nice nurse that's working with the doctors here.' And you can't help but laugh but it happens all the time. So it's an interesting thing." (Participant 8)

> "I think in general, and it could be over-sensitization, because I've talked about this with female and male colleagues and we don't know if it's something that we're overly sensitive to or not, but I think it does affect your confidence a bit sometimes if you are a more sensitive person because if I go into the room with a male student or a male nurse, patients automatically think the male is the doctor. We tend to get called ma'am a lot, especially if people are angry, instead of doctor. I think those little things can affect you sometimes, just in terms of your confidence or how people choose to respect you or interact with you. I'm not sure how it affects us in the long term." (Participant 9)

Societal gender roles became apparent in the way female physicians were treated differently by patients and by other staff. One physician had experienced the intersection of race as well as gender in her interaction with patients and staff at work.

> “There's a difference in perception from patients. So I took over from a male physician, and I've had mixed responses from my patients. Some have been like, ‘Oh, cool, I've never had a lady doctor before. I'm happy to talk to you.’ And then other people were like, ‘Oh, well, you know, you're young, you're going to get married, you're going to have kids, then you're going to leave me. What are you going to do?’ And you know, that's a bit invasive and inappropriate. And then you also have people who question what you're saying, because you're not a man. And it's actually even interesting when you work with male medical students, who the patient thinks is the doctor walking into the room, almost inevitably, the male medical student will be addressed by doctor, the female physician will be the assistant of some kind. And when you're a woman of color, you get even a different experience. I've had colleagues assume that I was the unit clerk, even though I have a stethoscope on my neck or without fail, I will be asked to clear a tray of food from the bedside. And like these are not bad things. But when you talk to your male colleagues about it, they have literally no experience of that at all. And people are also overly familiar with you, I get a lot of questions about my age, I get a lot of questions about my race. And that definitely happens with male colleagues, but I would say a lot less.” (Participant 6)

The impact of societal expectations of female physicians and the microaggressions experienced by physicians are similar to those related to younger aged physicians, as described under individual level factors influencing mental health. The intersection of gender, age, and racialization for female physicians during early career amplify their experiences and create the added stressor of explaining or justifying your role as the physician.

Societally, women are also expected to provide more emotional labour, and this was felt by female physicians both at home and at work. Women tend to prioritize their patients’ well-being over their own wellbeing and “feeling an overwhelming need to take care of everything else and everybody else.” (Participant 8)

> “So the role of a woman in a patriarchal capitalist society is one where your worth is measured, in terms of how much you can give. So I think that this is not unique to my profession. But there is this expectation that emotionally we must be available, that physically we must be available, and that somehow we must also contribute in the vein of our body by having children. …So it's hard for me to conceive of that changing within medicine alone. I think it has to change in the world. And that is its own difficulty.” (Participant 6)

> “If you consider women to be more kind of- I don't want to say emotional creatures, but like, doing a lot of empathy and taking on a lot of other people's emotions. And that can be quite hard in palliative care. And certainly, I know the men who go home and who have stay at home wives and stuff who care for their children are well taken care of when they get home so they can actually recharge.” (Participant 3)

Sometimes being “emotional” was attributed negatively to female physicians and can be seen as a weakness.

> “But I think it's like emotion in general kind of… not wanting to be emotional, perhaps you're more likely to be labeled as like an emotional female. It's a bit more of a stereotype to be like an emotional female. I definitely have felt during my career... it's interesting, because on the one hand I've gotten an award for caring for my patients basically, for being empathetic. But on the other hand, there's like a 'too much' you know? And I think it all kind of plays into the culture, where there's what we say on paper, and then there's kind of what we're saying with our actions, and not with our words.” (Participant 1)

The expectation that women provide emotional labour becomes prevalent in the type of care that is provided to patients and who provides that care. One participant described her experience by comparing the doctor and nurse role and the differing expectations for each as they intersect with gender.

> “And one of the interesting things is that even though there's a male physician on some of the other teams… there's always a female nurse. And so the female nurses are doing a lot of the kind of supportive listening, they'll go and sit with someone and accompany them and stuff like that. So it's a lot of the women who are doing a lot of the emotional labor. And as far as myself, being a woman, I often do a lot of that now. I don't know if it's just that I'm new to practice, I'm not as able to just kind of cut that and just be like, ‘I want to go and adjust your medications over here.’ I don't know that that's necessarily a good thing or a bad thing, but it's a thing. I definitely feel myself putting in a lot of that, and some days finding it more difficult than average to kind of just let things be and do just the doctor role. The nursing role and the physician role is very similar. But the nursing role does a lot of family support, disposition planning, and making sure that communication with other groups is going well. Whereas the physician is like physician to physician contact usually, and adjusting medications, ordering tests and stuff, or doing that assessment. But I definitely find myself doing both.” (Participant 3)

Ultimately, the concept of being emotional is a doubled-edged sword for female physicians; there is an expectation on female physicians to attend to the emotional needs of patients and colleagues, but there is also a disdain of being emotional.

The emotional labour expectations of women in society intersects with the culture of selflessness in medical culture which bears a heavy weight for female physicians. They are expected to provide care for others outside of what is expected of their male counterparts and sacrifice their own wellbeing in the process, leading to increased emotional exhaustion and burnout.

Female physicians experience other inequalities in their profession including a gender pay gap and less opportunities for promotion or leadership and has mental health consequences.

> "We have a common thread… whenever the awards come out to the hospital, we'll scan them and inevitably, someone's like, 'It's 85% men' and stuff like that, or who's getting looked at for the Chair of the department? So opportunities for promotion is certainly something my people and I have noticed for women. …It's demoralizing, totally demoralizing. And when a lot of men are making decisions, that could certainly affect things." (Participant 3)

If women are not in leadership positions, it becomes difficult to understand female physicians' gendered experiences at work and enact culture change.

Coping with mental health issues and seeking care

Seven of the nine participants sought mental health care either in a responsive way for mental health concerns and illness, or in a preventative way to mitigate stress and burnout. Care was sought from psychiatrists, therapist, psychologists, family doctors, and wellness resources in training such as the Employee Assistance Program (EAP) or the Physician Health Program (PHP). Physicians participated in a variety of treatments including therapy, psychotherapy, cognitive behavioral therapy, and three of the seven who sought care were on medications for their mental health at some point during their career or training.

Preventative mental health care

Mental health care, such as seeing a therapist or psychologist, is a strategy physicians use to maintain their mental wellbeing and prevent exacerbation from stress and burnout. Participants who worked in palliative care explained that they were advised in training to seek help early on because of the job-related stress.

> "I remember one of my education half-days as a fellow in palliative care, the doc got up and said, 'Listen, find a therapist. Find somebody you like and trust. Whether you go and see them once a year, twice a year, twice a month, twice a week. Have somebody that you can call when you need to because this job is taxing emotionally.'" (Participant 8)

> "And one of the things that was suggested to us as part of our fellowship was to see a psychiatrist or a psychologist, just as a kind of a wellness practice, and this was recommended to all the palliative care fellows and all the ICU fellows, knowing that we see some stuff sometimes that could be traumatic to a lot of people. And so we were recommended to develop a relationship with a therapist kind of in case we ever needed them, to have somebody that we know and we like that we can pay to help us. So I have seen a psychotherapist two times, six months apart mind you, but she said she'd keep me even though I see her so infrequently. And, you know, we talk about stuff related to work, we talk about stuff related to my family, like it's a whole gamut of stuff. And I think it's good in order to develop healthy coping mechanisms and kind of to do some reality testing." (Participant 3)

Therapy, and other preventative mental health care, also cultivate resiliency which is an important attribute to help physicians adapt and bounce back from hardships.[20]

> "I think that I've been lucky to be resilient enough to not be severely afflicted with depression, anxiety and those kinds of things. But it's taken a lot of work, it's taken a lot of therapy, you know those kinds of things." (Participant 8)

In summary, preventative mental health care takes many different forms and can be provided by various practitioners. It is important to recommend mental health care preventively from leadership at work as a way to help physicians cope or build resiliency, given the difficult nature of medical work. Having an established relationship with a mental health provider prior to experiencing symptoms of mental health issues may be an important facilitator to accessing the care you need in a timely way.

<u>Reactive mental health care</u>

Reactive mental health care is care sought in response to a mental health issue. Some participants sought out care themselves by using resources available at work or through their family doctor.

> "So early on in medical school… I found it was really, really difficult. I ended up seeking help from the wellness resource that we had at the medical school and ended up seeing

> a psychiatrist. I don't think we had what final diagnosis, but I definitely had symptoms of depression, symptoms of anxiety... it was interesting sort of as I was learning about different things, particularly depressive symptoms, and then seeing them in myself or experiencing them was different. So I saw that psychiatrist for psychotherapy fairly regularly for a while. I didn't stop my studies, I was able to continue them. But definitely, I'd say, sort of for at least a year, it was very difficult. …I started medication at that point as well, which I think helped to smooth things over." (Participant 4)

One participant shared her experience with struggling in residency and requesting accommodations for her licensing exam, which were denied. Upon failing her exam:

> "I showed up on my family doctor's office, like that day actually. And she was the one who finally convinced me to take meds… She finally convinced me to kind of do something about the anxiety and the mood and just because I couldn't stop crying like at all. I think it was a lot of guilt and a lot of irritability. So that was probably my first experience. And I stayed on them until I passed my exam." (Participant 2)

Three participants were required by the College of Physicians and Surgeons of Ontario (CPSO), their regulatory authority, to be followed by the PHP, to seek care, and be monitored after disclosing their mental health issues, particularly if it led to a mental health leave of absence.

Seeking mental health care as a response to experiencing mental health issues or a crisis was either a personal choice or mandated by the residency program or regulatory body. Mental health care included both various types of therapy and the use of medication.

<u>Accommodations</u>

Experiencing mental health concerns can lead physicians to make or request accommodations at work to help them cope, such as working less hours, looking for alternative work, and switching jobs to have more work-life balance. Some participants had made or were planning on making accommodations to their work by changing their workplace or position.

> "But I've considered different settings for work and I am considering leaving academic medicine for Community Medicine such that I can have more freedom. …But in the meantime, I'll be making decisions that protect my own wellness, and probably that will change my career path significantly. As I think a lot of women do, a lot of women come to that realization and make decisions for their family. When really, I think medicine, the system should change. But we're figuring our own path within the system for now." (Participant 1)

> “I left this hospitalist position for a more stable life-balance position in [City] and I’m sort of trying to change the scope of my practice… I’m looking for more lifestyle balance. So removing the 24/7 call, the idea of being on call overnight. Having the ability to take a sick day, I just couldn’t do that at my other job… So, I just wanted the ability to take a sick day, to not be on call at night, to not necessarily have to work 7 days in a row, and just to have a bit more balance. And something that’s less exhausting at the end of a week.” (Participant 9)

Participants also described setting boundaries around their work by limiting the number of patients they see in a day, limiting the number of days or hours they work every week, or setting boundaries around doing work at home.

> “So I used to work Saturdays and Sundays at the hospital. And now I don't …I confine my work to kind of Monday to Friday, still evenings, I usually go in after clinic. So it's still a bit of a long day. But I can actually take like two days on the weekend. And I may do like a couple hours of paperwork, but I usually will cap it at three and then I won't touch my computer. I won't remotely log on. I won't check it on my phone. I just will not look at all until Monday morning.” (Participant 6)

Some participant took ‘mental health days’ off on their own to protect their mental health and prevent their symptoms of stress and burnout from getting exacerbated.

> “I also know when I need a break. So I tend to schedule myself like a long weekend or like a random mental health day in the middle of a week, every three months or so. Most of the time I look at my schedule, I'm like, ‘Oh, why am I not working this day? I really don't understand.’ And then when I finally get to that week, I'm like, ‘Oh, yes. Now I know. It's because I need a break from everybody else.’” (Participant 2)

> “And so during residency actually was a time when I would take the odd day off. And so I would call it in as a sick day. But it was technically, for me, like a mental health day, and that was something that I encouraged a lot amongst my colleagues, because I was the chief resident the second year of our residency. Because as residents, we actually are well supported by a union, and we have days that we're allowed to take off. And like I had said before, the buck does not end with us. And I think a lot of times, our colleagues would feel that if we weren't there, then the whole floor would fail and things would be a disaster, but like, that's just really not the kind of system that we worked in. But people just still wouldn't want to take days off, you could tell that they really just needed a little bit of time for self-care. And so that's something that I encouraged. And I

> would say, over the two years, I probably took like five or six days off just sporadically here or there, where I clearly was not sick physically, but I just knew that if I didn't take this day off, and it would be day whatever, 10 in a row working. I felt like my presence there was presenteeism, like I would be there, but I wouldn't really be contributing in a way that would be beneficial to patient care or to my learning." (Participant 5)

Presenteeism is often the result of physicians not taking time off to respond to their own wellbeing and self-care. Taking even sporadic mental health days off may be a preventative way to mitigate the accumulation of stress and fatigue which can lead to more serious mental health issues. Those who took mental health days also encouraged their colleagues to do the same which increases awareness of mental health issues and the importance of self-care and contributes to destigmatization of mental health issues and leaves of absence.

Each of these types of accommodations are ways that physicians can prioritize their own wellbeing and continue to work in a way that is less conducive of poor work-life balance leading to mental health issues. Workplace accommodations are a way to prevent the need for a long-term leave for mental health reasons, by addressing the work-related stressors that affect one's wellbeing.

Disclosure and stigma around mental health

Individuals may experience "personal shame" (Participant 9) associated with their mental health struggles and "feeling like you're the only one who can't handle it," (Participant 9) which leads to isolation from their colleagues. This often stems from the lack of open communication around mental health issues with colleagues.

Stigmatization of mental health challenges also makes it difficult for female physicians to disclose their mental health experience or that they are struggling to their colleagues.

> "In the world of medicine, … I wouldn't say it's a very welcome place to be talking about your mental health. I'm very open in general about the fact that I have mental health issues, but at work, I would not be open about it. And I think people would be uncomfortable if I mentioned it. I think they would not want to know." (Participant 1)

Disclosure of mental health issues and its stigmatization is also present in registration and licensing procedures, particularly in relation to the CPSO. The CPSO was described as a barrier to seeking mental health care because of the lack of privacy:

> “I have spoken to colleagues that have depression and they’re like ‘I’ll never disclose it to the CPSO’ because they know that the CPSO can get very involved with these things. So I think, it just feels like an invasion of privacy that you feel like you should be entitled to like everyone else.” (Participant 9)

Disclosure of mental health challenges to the CPSO can lead to punitive measures, such as license restrictions for physicians who sought help and can have negative connotations on your ability as a physician.

> “I think at the end of the day, the stigma makes it really challenging, especially for physicians where if you have a diagnosis of anything, when you're getting your license, often, they'll even ask for you to disclose some of these details. And for some people, they aren't comfortable disclosing that, or if you do, then it leads to a whole separate pathway that can lead to more paperwork or different restrictions. And so I think that is in itself one of the limiting factors. …it's also part of our CPSO… registration. And so, again, it's there as well. And so it depends on how comfortable people are in disclosing that. But then if you don't disclose it, then you kind of could be hindering your own recovery. … It's getting better, but it's definitely still there.” (Participant 5)

> “We understand that they’re there to protect people but the implication can still be a bit hurtful and because of that I never wanted to go consult a doctor in Ontario and get prescribed anti-depressants during my first years of practice because I didn’t want it on a record anywhere and I just went to see a therapist. And even with my therapist, I wouldn’t disclose necessarily how burnt out I felt because I didn’t want it on any kind of record because it just feels like the CPSO wants all your personal information. And if you’re already struggling with it yourself, it’s like the last people you want- it’s already hard to talk about with your colleagues and then you have to send all this documentation to a complete stranger and feel judged for it because the implication is that you can’t practice or you’re not safe to practice if you’ve had problems with anxiety or depression.” (Participant 9)

Disclosure of mental health issues may, however, lead to positive implications such as increased awareness of mental health issues at work, destigmatization of these experiences, and fostering support from colleagues.

> “I ended up telling a lot of my resident colleagues and a lot of them ended up taking leaves of absence during residency and being quite open about it. So I think a lot of it is just internalized stigma that we have towards it. Like we feel like we’re failing the

> program or we have to be strong all the time, but ultimately a lot of people are struggling, and I think when you're more open about it a lot more people become open about it." (Participant 9)

Disclosure of personal information regarding mental health plays a significant role for female physicians at work and in relation to the regulator. Stigmatization of mental health issues drives the value of personal privacy on mental health issues, which cannot be upheld by the CPSO. However, disclosing this information to colleagues may also be an important strategy to gain collegial support and make positive changes towards normalizing mental health experiences at work.

Gendered experiences of leaving work

Motivations for taking a leave

<u>Leaves of absence for mental health reasons</u>

Three participants had taken leaves of absence for mental health reasons during their residency, but none had taken any form of mental health leave since entering practice. Participants' motivations for taking this leave included feelings of burnout and depression, recognizing previous signs and symptoms of mental health issues, and experiencing stressful life events.

> "I did take a leave of absence during residency because I did have a burnout….I took one month off. I was very depressed, I felt very burnt out, and I had to go seek help. I was followed by a psychiatrist and a therapist. That was about a month long, until I returned." (Participant 9)

> "And then I moved to [City], and started my residency… And I felt the same sort of feelings coming back again, I didn't want to go to work. I just wanted to stay in my bed and sort of recognized it as something that I needed to address. And so again, I reached out to the wellness sort of service for the residents. And that lady was very, very helpful. She said, 'Okay, right now, we got to stop, you can't go to work tomorrow, I'm writing your program director to let her know you're now on leave.' I think that day, I still remember very well it felt like I was somehow not cut out for being in medicine, I wondered about sort of what trajectory this would take, I knew it was important for my health, especially because I'd been there before. And so I kind of felt like I had the warning signs and sought help at a time when I needed it and wasn't afraid to seek help." (Participant 4)

> "When I took my leave of absence in residency, I had been on medication very stable for quite a long time. And then I had kind of a major life event, things got turned upside down a little bit and my mood started to be an issue again. And I was very, very proactive. And I said I needed time off. And I took a leave of absence." (Participant 1)

As noted in two of these cases, helpful assistance was sought from a psychiatrist or therapist. Each of their absences were only about one month long.

Maternity leaves

Although my focus of inquiry was about mental health related leaves of absence, it became evident that maternity leaves were an important topic to the early-career female physicians I spoke to, which itself had implications for their mental health. Five participants had taken maternity leaves and three of those had taken more than one maternity leave. These leaves were taken during residency and in practice during early career. Maternity leaves across participants ranged from three months to a year, a year being the typical length of time for maternity leaves for women of this age cohort. Participants had a range of experiences with how long they wanted to be off work. Some felt that the time they had taken off was too short and were planning on taking longer in the future.

> "And so I took six months off with my first and then I definitely went back I feel too early. It was a time when I still very much wanted to breastfeed my children till one. My first didn't take a bottle, she wouldn't drink water, she wasn't the greatest eater. So every time I went to work, you know, sort of the pumping and everything felt that much more stressful. And then because she wouldn't eat during the day, then she does all night. And then I'd have to do that and go back to work… And so the second time around, I sort of learned from the first and I said, 'You know what, if there's no rush for me to get back to work then I'm going to tell people that I'm not coming back until later.' And so I decided to go back to work at eight months for my second and I worked only a week a month doing palliative care... Did that for an additional four months, and then went back to work. And it felt a lot better the second time." (Participant 4)

One participant felt that her time off for maternity leave was too long and resulted in a loss of skills and confidence in the operating room.

> "And so the first time I took six months, I remember coming back thinking that was too long, like I wouldn't do that again in surgery, it was too long from not being in surgery, and I found that just too hard to come back and to be expected to pick up where you left off when you're adjusting to a baby, who you're leaving now for the first time and

> first kid, and like the emotions that go around them, and then just being expected to be 'on' the way you were when you left. So the second time I took three months and then same thing the third time, so to try to kind of avoid that." (Participant 7)

The accounts of early-career female physicians on taking a leave – whether for mental health reasons or maternity-related leaves – produced some similar experiences.

Stigmatization of leaves of absence

A culture of showing up to work

Similarly to mental health issues, there is stigma around taking a leave of absence which is often driven by the culture of medicine of stoicism. Medical cultural impacts how physicians view leaves of absence, whether for short of longer-term reasons. As one participant describes,

> "It's not an explicit part of the curriculum, but you are trained to show up to work. And that is irrespective of whether you are well or unwell from a mental perspective, physical perspective, whatever it may be, you are trained to show up. And you are celebrated if you are vomiting in the call room and still at work, that is just the culture of medicine." (Participant 1)

> "…there's this perception that you're kind of like macho and a little bit tough as nails? And I don't think anyone would admit to needing time. And I don't think anyone would want to face the perceptions of others when they return, if they came back from that." (Participant 7)

One participant describes the impact that this type of culture has had on her own perception of how mental health leaves are viewed at work.

> "I think taking leave outside of maternity leave, I think people might have some questions about that and I certainly would have to be in kind of bigger trouble to take that I think. I would not want to. Even knowing that mental health is super important, mental health is health. But I don't think that I would wish to do that." (Participant 3)

> "There was some interesting research back in the day with medical students, [which]…said that medical students will cope and cope and cope with their studies until everything else has fallen apart. And I suspect that's probably the same with physicians. Like I think that people will let their personal lives fall apart before they let their career lives fall apart. So I think it would have to be pretty bad. And I had never really considered this because I've never really had to consider taking a mental health leave--

and I feel kind of bad saying that now because that's probably shows some of my bias. So I wish it were not like that." (Participant 3)

Regulatory barriers

Mental health leaves of absence face additional stigmatization from medical regulatory authorities, which can act as a barrier to taking a leave. In Ontario, for example, the CPSO requires that physicians must report on mental health problems and leaves of absence during the registration and renewal process.

> "I think there still [stigmatization of mental health], and I think a big-- I don't wanna say a big problem, but when you look at this CPSO kind of renewal thing of like, when you take a leave of absence, and then you have to kind of report about why… if you've taken it for x, y, z reason. Then when you go back, you need a supervisor for a little bit of time. I mean, it is a big hassle… But I could see myself not wanting to take more than 90 days, because of the stupid paperwork I would have to do. And if I would get my bladder taken out, or was in a car accident, this wouldn't be even an issue." (Participant 2)

> "When I applied for my CPSO license, they immediately see that you took a month off from residency and they ask like for a letter from the Dean saying that you're in good standing, they ask you for a letter explaining why you took a month off, and they'll ask for your doctor's note with your diagnosis, treatment and prognosis. So they want to know the medication you're getting to the dose. They want to know if you're seeing a therapist. And they want to know your prognosis… So I did feel like I was getting burnout towards the end of my first year [of practice]… I didn't take a leave of absence because I didn't want this… I ended up having to disclose to them everything about my leave of absence during residency, quite personal information that I didn't feel comfortable disclosing to them. And because of that, I didn't want to ask for another leave of absence, because I didn't want the CPSO to find out. So for me, that was a barrier in terms of taking a leave of absence at all." (Participant 9)

These add to the culturally induced stigmatization experienced by residents and early-career physicians. Leaves of absence in residency also posed issues for participants when applying for their license to practice.

Lack of redundancy in the system: A cause and consequence

The lack of "redundancy in the system" (Participant 8) is a systemic problem stemming from a "shortage of staff" (Participant 9). This constitutes a conundrum for those experiencing mental health issues – they both exacerbate them and also create a barrier to taking a leave. A number

of participants noted difficulty finding a dedicated person who can “pick up your slack” or “cover your workload while you’re gone” (Participant 7). Consequently, the work gets distributed among one’s colleagues at work. This can lead to feelings of guilt in those who need to take a leave, further leading to stigmatization.

> “You can't just like take time off medicine. It's not a desk job where if you don't show up, it's okay, you just have to do a little bit more the next day. Patients need to be seen. And we don't have systems set up where there's backup, except for in Emerg[ency]. There is no backup, if you don't come to work, patients get canceled, they don't get to see a doctor. So there's so much more pressure for you to consider your own wellness and you're putting it over someone else's wellness as well. I think that that's a big thing. Because you're making your colleagues have to take on more work. So if you look out for your wellness, you're sacrificing someone else's.” (Participant 1)

Even during residency, when you are working as part of a larger group of trainees alongside supervisors, you are still required to find someone to cover your leave depending on the residency program and specialty you are in. Participants had differing experiences with covering their practice across specialties:

> “Some specialties again, are more challenging, like where residents are very much required in order to fill the call schedules. You know, I know friends in [obstetrics and gynaecology] who've been pressured, ironically, but also not surprisingly, not to have babies because of the call schedule. But for me, I was in my second year of family medicine, the majority of it was outpatient, and it didn't really matter, patients were going to get seen.” (Participant 1)

> “I had to email my colleagues, who I had lied to and told I was going away for a rotation - I didn’t want to disclose that I was going away on mental health leave - I had to ask for people to cover me. I was trying to be vague about it. But I had not seen that coming, that there is no system in place to cover a resident who is going on leave where they don’t have to disclose or ask for help from other colleagues.” (Participant 9)

Family medicine, for example, is better suited for locums and physicians can find a locum physician to cover their workload while they are on leave. In surgical specialties, finding a surgical locum to cover your patients is not common practice and it becomes challenging to take any time off.

> "…it's not common, like you wouldn't get a locum the same as in family medicine… in family medicine it's very common to have someone come and take over your practice for two weeks when they go on vacation, for example, or a month or whatever. And mat leave that would be a common thing, but we don't have that in surgery. So if you're off for any extended length of time, if say it's two weeks or whatever, then you just have to… move [your patients] around and you cover that. So that when you're back, you deal with all the stuff that you missed. But if you went for a longer time, then your patients need to be followed and your colleagues would have to do that. There's no such thing as like locums to come in and help cover your practice because there's just not a lot of extra [body part] surgeons kicking around who have idle time who can come and fill in for you." (Participant 7)

Accessing locums is a strategy to accommodating your leave in the workplace; however, this comes with its own set of challenges. A family physician in a group practice explains that:

> "If I take a day off, I know that my colleague can cover my patients. And because she's kind that way, but she's not going to cover like all my patients, just the emergency things. And if I need to take a longer period of time, she can't do that indefinitely. So I have to find the locum and finding a locum especially in [Urban city] is like a fool's game, it's really hard to do. We can often barely find people to cover our vacations, let alone a spontaneous… need to leave. So then you worry, 'Well, who's going to take care of my practice when I'm gone?' And there's a lot less incentive to take time off." (Participant 6)

There is a significant impact on colleagues when a physician goes on a leave, because "there's no system in place to compensate for you when you go." (Participant 9) Often, the work a physician is responsible for gets distributed to other physicians in the workplace when a member of the team goes on a leave. This makes physicians conscious of how much time they take off and causes them to feel guilty for putting extra work on their colleagues.

> "I booked my vacation, and I felt actually very guilty about booking a vacation because I sort of thought, 'Well, it's been really busy with the pandemic, and I really should be there.' But then I also thought 'I really don't, this is ridiculous, I'm one person, I am not the be all and end all and everybody will survive if I am not there for a week.' And so I talked it over with my friend… it was just nice to have a sounding board who also similarly goes through needless guilt over these kinds of things to validate that this is something that all of us experience." (Participant 6)

> "And then I felt guilty because then my residents, who are already overwhelmed, had to cover for me. And then I was getting emails from staff asking, 'Are you ok, what's going on' and then I got yelled at by a supervisor because we had a research project and when I told her I was going on leave she was like, 'Well, what's gonna happen with the project?'...So all that was very confusing I would say because there's a lot of guilt that goes into taking a leave and so I think I felt that I was really letting my program down." (Participant 9)

> "There's no system in place to back you up so they [your colleagues] are stuck with your work. And if I felt overworked, they're gonna feel overworked, and we all feel overworked already, so now they have to cover my practice too. So I think that was maybe just the most surprising part. They just don't have a system in place to compensate for that, for someone being away." (Participant 9)

Female physicians are particularly impacted by feelings of guilt when taking maternity leaves, given that they last for longer periods of time.

> "And I think it does affect us, because there's this guilt associated with it. But at the same time, you spent all your fertile years in medical school, so a lot of women want to start their families when they graduate because that's when they have the most control on their schedule. But I think also when they feel the most guilty about it because they're just starting these new positions and they're trying to build their careers." (Participant 9)

In particular, disclosure around requiring a maternity leave is a stressful experience because of the guilt associated with being off work. This extends to disclosure around pregnancy or the desire to have children because it implies a maternity leave in the future.

> "I think we feel like it's gonna be negatively seen because it implies a maternity leave and because the demand on the system is so high and there's so much need for physicians that getting a position, getting a good job, and taking time off from it feels- not like wrong, but you feel judged for it, or you feel a bit guilty about it. So at least that's my perception. …it's like very negatively seen to get a permit and then leave for mat leave right away. It's like you took up this spot and you're not using it. Like you took up a license and you're not filling up your responsibility." (Participant 9)

In all, the lack of redundancy in the system also causes what can be considered the "Catch-22" of leaves, a paradoxical situation specific to mental health leaves of absence.

> "Every time that you are away, you're feeling that pressure like 'Ok, when can I get back?' So that's definitely a challenge… And then you recognize that the reason why you maybe needed to take a break because of mental health reasons is because you were working too hard, now you're subjecting all of your workplace colleagues to that. It's a really, really hard thing to feel like." (Participant 8)

A number of participants, however, explained the importance of collegiality, particularly collegial support from other female coworkers, when considering or taking a leave of absence for any reason.

> "So I have found colleagues, particularly female colleagues, who are mothers to be very, very supportive. That has been my experience. When I was in my third trimester, I was supposed to be doing inpatient. And one of my colleagues said, 'No, you cannot. You're in your third trimester with COVID. Sorry, I'm going to take this.' So she worked my week for me. And similarly with my maternity leave, I felt guilty about my decision to take a year. And so I messaged my colleague, who's actually seeing my patients while I'm off. And I thought, as a courtesy that I should tell her first, because ultimately, she's the one who's picking up the slack. And she is a mother and she said, 'You're replaceable at work, you're irreplaceable as a mother.' And so I've had tremendous support from women in my workplace." (Participant 1)

The lack of redundancy in the system prevents all physicians from taking a leave of absence because of the challenges related to finding someone to cover your practice while you are away, but this is experienced differently by gender. Different specialties have different experiences in accessing locum physicians to take over their patients during their leave and finding a locum is challenging in itself. Across all specialties, feelings of guilt are endemic to taking time off because of the implication this has on colleagues. These issues ultimately stem from a lack of a well-developed system in place to compensate or accommodate for a physician who leaves work.

Leave of absence, disrupted

Even after planning and accommodating a leave of absence from work, participants felt that they could not be entirely removed from their work. Often, female physicians were encouraged to continue working in some capacity during their maternity leaves or to come back to work early, particularly by male physicians and supervisors.

> "I was told recently, repeatedly from my boss, that it was okay, that I could work during my mat leave, and that a lot of women get bored and want to work during their mat

> leaves. So I was told that many times. I am very protective of my time with my family, though. And because I don't feel beholden to this job, you know, I think I'm sort of at a point where, if they're asking too much, then I'll find employment elsewhere. That allows me some flexibility that I think I wouldn't otherwise have." (Participant 1)

> "I was asked by my department head sort of like three months into my mat leave as to whether or not I would help to cover and another person's mat leave. That felt a little bit funny. I said, 'No, I can't, this is my mat leave.' I was a little bit surprised that he asked." (Participant 4)

One participant was also asked to find someone to cover her patients while in residency, after she had already begun her leave for mental health reasons.

> "The only challenge I found was… because we have a practice as residents with patients, they made me find people to cover my own practice. And they emailed me after my leave of absence to tell me that." (Participant 9)

Sometimes, the nature of one's work, such as research grants on a specified timeline, could not be put on hold during a leave. One participant explained the expectation that female physicians continue some work-related responsibilities during their maternity leave, particularly in academic practice.

> "There are expectations on you. And you see that in some of the women in our division. Like the research associates and those kinds of things, who are on maternity leave right now. They're still answering emails, they're still submitting papers, they're doing those things. So is it really being on leave? But then you're also not being compensated. So what does that mean? It's almost like you're working for free just to make sure that your career stays afloat. Which is not the way it should be. There's a fundamental problem there." (Participant 8)

The felt expectation that female physicians continue working in some capacity during their leaves from work can have negative consequences for someone who is taking a mental health leave of absence, which in turn may hinder their timely recovery.

Attrition from medicine

Participants mentioned leaving medicine as a potential outcome of mental health challenges left unaddressed. Some had considered leaving the profession themselves and others knew colleagues who left.

> "…there have been maybe like five sit downs with my husband in the last three years where I've said, 'Okay, this is it, like, we're out? Like I have to leave.' What does that tell you? I'm not sure. And it's been because of work stress. So I guess that could be considered burnout. Like at times when I have considered leaving medicine in my first three years of practice. Like that's kind of telling. But what's kept me, to be truthful, is sometimes that the harder path is actually leaving. It's easier to stay, it's easier to carry on. Because to leave means to take an action. So I'd have to talk to my supervisor or my division head, I'd have to face my colleagues and say I'm leaving. And that's a hard thing to do. Really hard thing to do. And so the default then is to keep going." (Participant 7)

> "Actually, one of my really good friends is just leaving medicine right now. And she's been in practice for two years and a half… and she burnt out this summer. She took a month off… And then went back to work, and she tried a progressive return to work, and she realized it wasn't for her. So she's leaving." (Participant 9)

One participant had considered leaving medicine but identifies the financial barrier of paying off her student debt.

> "I'm still trying to navigate within the medical field finding a job that works. And partly it's because I have a lot of student debt. There's not a lot of other jobs that allow you to pay off 6 figure debt that you accumulate during residency, so I find that makes you stuck in the beginning because you really want to pay that off. So that to me is a huge barrier to considering other professional options." (Participant 9)

At the more extreme end of the spectrum, challenges around taking a leave of absence and mental health issues may result in physicians leaving the profession entirely.

Supporting early-career female physicians: the gap between what exists and what is needed

Throughout the interviews, early-career female physicians explored several promising practices, supports, programs, and other interventions that would be beneficial to implement which support physician mental health and one's ability to take a leave of absence. Two levels of such supports will be discussed. The first is that of existing mental health supports that are available and can be accessed. The second are promising practices that physicians recommended and would like to see implemented.

Existing supports available

The discussion surrounding existing supports that were available was dominated by supports for mental health, with little focused at leaves of absence. The supports discussed included both those that participants were aware of but had not accessed, and those that they had reached out to previously. They can be categorized at different levels, depending on where the support is coming from; (1) association level, and (2) institutional level.

Association level

Since all participants lived and worked in Ontario, the majority of the available supports are Ontario specific, though similar supports exist in each province through their provincial medical associations. At the association level, participants discussed the Ontario Medical Association (OMA) and the Canadian Medical Association (CMA) as providing resources for physicians specific to mental health. Provincial health programs were commonly known by participants. In particular, the OMA Physician Health Program (PHP) was most prevalent. Participants identified their ability to connect physicians to a psychologist who is specialized in providing care to physicians. This program had been accessed by some participants both voluntarily and as mandated by the CPSO.

> "…the OMA, for example, they can put you in touch with a psychologist who is trained for physicians." (12Mar20)

> "This was my one and only leave of absence for mental health in residency, and that was for a month. And then I had graduated return to residency. And because of these issues, when I applied for my independent practice license… the College of Physicians and Surgeons of Ontario asked that I be followed by the Physician Health Program affiliated with the Ontario Medical Association. So I was basically monitored for two years." (Participant 1)

The OMA also offers other mental health supports to physicians, such as insurance coverage.

> "The OMA offers us medical insurance, and new this year, they increased our limit for psychological services by a lot. I want to say it's in the 1000s now. So that was, I thought, really good for people who are using those services." (Participant 5)

> "The OMA is on their game, at least in Ontario. They advertise a lot to early career physicians, for people who are transitioning. So I had OMA related benefits as a med student, subsequently as a resident" (Participant 3)

> "Yeah, through the Ontario Medical Association, there's resources for physicians. And I mean, resources are typically like psychologists who have said they'll work with physicians, I think. And so I think that's more or less what the support is." (Participant 7)

The CMA was mentioned by a participant as an organization that "is very supportive and has a lot of new wellness initiatives to help" (Participant 5) and has ramped up wellness supports during the COVID-19 pandemic.

Supports at provincial and national association level are important to help physicians access mental health services and promote wellbeing in the profession.

<u>Workplace or institutional level</u>

There are also supports provided at the hospital or university level for those that are employed or work in an institutional setting. The workplace offers an Employee Assistance Program (EAP) that can be accessed for mental health concerns, but it didn't sound like they were well used.

> "Hospital-wise, I know that they have EAPs and whatnot. It's not something that I've reached out to yet, but I know that they are there." (Participant 5)

> "So we have an EAP through the hospital, which has free mental health, I believe." (Participant 3)

Many participants described wellness committees at their affiliated university and workplaces, though here too not often used.

> "The University has a Wellness Committee with a Wellness Office for physicians..." (Participant 3)

> "There's a Wellness Committee in the hospital. So I know that there are places definitely that I could turn to if I need help." (Participant 4)

> "There's a Wellness Committee at work. I don't know that they have improved my wellness in any way." (Participant 1)

> "I know that there's within the University like a Wellness Lead… and she's sort of a person that you could reach out to as well and I actually did once… I think I heard her talk and she mentioned how she has people come to her who are on the brink of ready to leave medicine. And it seemed like she had experience with that." (Participant 7)

Formal mentorship programs for early-career female physicians also exist in some capacity during residency, though these are offered through the university or institution and may not be available once someone graduates. In fact, those early-career physicians may themselves become mentors to others, though they are seeking help themselves. Mentorship programs, or lack thereof, has mental health implications for female physicians.

> "I was a faculty mentor for 2 or 3 people. …it's all women in the residency training program - and I think that the younger women [residents] want to gravitate to the younger women who are doing the things that they want. And so I think that you kind fall into this in-between where you're a bit more of a connection to the residents because you were kind of recently one, and you don't necessarily feel like you're exactly in the older class yet, so you're kind of this in-between. Your life is just a little bit more relatable to them I think." (Participant 8)

Supports at the workplace or institutional level exist, such as the EAP or Wellness Committees, but were not accessed by participants. Participation in mentorship programs between residents and staff physicians were more prevalent among early-career female physicians.

<u>Social supports</u>

Social supports were highlighted by the majority of the participants and focussed around informal peer supports. Peer supports that exist and were accessed by participants took the form of group chats, lunches and dinners with co-workers, groups over social media, and informal discussion about complications or difficult patient cases. A majority of these peer supports were with other early-career female physicians that participants could relate to either in person or through social media.

> "I did actually form a whole group of women surgeons and so in [my specialty] there's only one other and within [surgery] though, there's quite a few… So I got a group together and we were meeting for dinner actually every two months, and did that for over a year. Our last meeting was last February and COVID has just completely made that not possible. …So it's on hold for now. But that was something that was really good. And you know these things, it sounds minor, but it really is I think one of the effects of COVID. That's not what your study's on, but how are just the social supports that we put in place- how much they actually really matter?" (Participant 7)

Support groups online include a variety of online forums, Facebook groups, and other support networks for early-career physicians and female physicians.

> "I know that there are a couple of female physician specific support groups, there's also a few early in career physician support networks that exist, mainly over Facebook. …And I've seen people ask a lot of questions and kind of get answers from that kind of platform. Is it really like a personal kind of support? Like would I call anybody up at 11pm because I had a question… no, but as kind of a broader support network, I've seen those be available as well." (Participant 5)

> "I don't know if you know about the Canadian Women in Medicine group organization. So I think they're doing a lot of groundwork, and a lot of things to support. And I'm hopeful that it gets better. I'm part of an online forum of like women physicians who suffer from mental health issues, and I would say a lot are supporting… but still a lot of the conversation starts, 'I'm not comfortable posting this in the general group.' Right? So they only put in people who've been added. Because we kind of are all similar." (Participant 2)

> "There are forums, there are online things, but there's also like 50 different online forums that we're supposed to be signed up for, and it's just too many. There's a Facebook group that's helpful." (Participant 6)

Peer support from coworkers was also important to some participants. The impact of the pandemic on these opportunities for peer support was felt by participants and highlighted how necessary these supports are for mental health.

> "I think [the pandemic] brought to light some things that were actually helping a lot of people to cope from a mental health perspective. So for example, I'd say sort of with palliative care, it's very much of a group dynamic. Where the burden of what we see is lessened by sharing that burden or knowing that there are others to share that burden. So ever since the pandemic we've been isolated from each other. So we would use to have lunch with each other, we just talked about our families, it might be an informal way to talk about difficult cases. It was a break in our day where we could do that. So now we can't eat together, we can't really socialize together. For a long time rounds were done separately. And so without that face to face contact, I think that's actually had a big impact with our team." (Participant 4)

Peer supports, both broader online supports and collegial supports at work, appear to be the most accessible and utilized forms of supports for early-career female physicians. These have varying degrees of effectiveness but are important resources, nonetheless.

Promising practice recommendations

In response to the problems faced by early-career female physicians, they offered several recommendations and promising practices for mental health issues and leaves of absence that would support them in the workplace. These include social supports, such as peer support and mentorship, formal supports for mental health care, formal supports around taking leaves of absence for mental health and parental leave, and promising culture changes.

Social supports

There was a strong thematic focus across all participants to have social supports, both formal and informal. The most common forms of social supports that were recommended were peer supports and mentorship opportunities. Many participants took part in some form of peer support and some recommended informal or peer supports specifically for early-career female physicians.

> "I'm sure it exists and I just haven't looked into it but if there's like female support groups, like for females in their first 5 years of practice that they can uniquely access, that would be really cool. I even wonder if they already exist and I don't know about them. But I think it's just knowing that it's there helps to destigmatize it on its own, to know that these things exist and they exist because there's a need in the first place. I think that increasing awareness about it could really help." (Participant 9)

> "You know what the most important thing is? I have the [Name] Group Chat. And we encourage each other quite a lot to go above and beyond. So having a tribe of women has been exceptionally important for my kind of wellness and development, particularly in the medical world." (Participant 3)

Mentorship

Some participants mentioned mentorship groups that exist in their institutions, however there was a need for more formalized and effective mentorship program, especially for early-career and female physicians.

> "Number one, professional mentorship. Early on, formalized professional mentorship rather than asking people to just lean on their contacts from residency. As somebody who didn't have a lot of great contacts from residency, I felt really lost. And I feel like that really frustrated me early on. So allowing for early career physicians to feel like they have somebody that they can talk to. …an actual formalized mentorship where I can ask somebody 'Hey, how do I get paid this way?' That would be great." (Participant 6)

> "I know that there is mentorship out there, but I wonder if it needs to be more formalized. I think, from my point of view, it's really hard to know if a mentor is assigned to me as to whether or not we see eye to eye on a lot of different things or that mentor is able to support me in the things that I want to do not just at work, but also sort of at home, and how it all fits together." (Participant 4)

A couple of participants noted the importance of female mentors in particular, especially those with lived experience:

> "…definitely hearing or being in touch with a woman who maybe had similar early careers, would be helpful to see how they navigated through different parts of the system. But maybe, to me that feels like support, but maybe not necessarily a solution either, because I think it's actually the institutional requirements that need to change and not us to their requirements." (Participant 4)

> "I think that strong female mentors is really important and something that I'm a part of a division that has a formal mentorship program. So I have a division - like a mentor, somewhere else that was kind of matched to me. They said 'What do you want in a mentor' and I said 'somebody who is a young woman with a family.' That was my kind of big request. So I think effective mentors is helpful. …I work in a place that is pretty small so to find somebody that would fit that for me… it's just kind of that access is really hard. I do think that having somebody that's been though some of these challenges before is really, really helpful." (Participant 8)

Developing, or improving, mentorship programs aimed specifically at early-career female physicians is an important strategy to support their wellbeing in the workplace, particularly if the mentor is someone female physicians can relate to and have similar experiences with mental health and leaves of absence.

<u>Formal supports specifically for mental health</u>

Formal supports for mental health present in a variety of ways including debrief sessions, insurance coverage for mental health services, and the provision of mental health supports in the workplace. Debrief sessions were discussed by two participants who had tried to initiate them in their workplace but were faced with barriers to their implementation.

> "I think regular sharing of complications would be helpful in an environment that you can feel, you can be honest, and you're not going to be judged, and you're not going to be talked about. So we don't have that. And I made it point of organizing …Morbidity

and Mortality rounds, where you talk about complications. …And my colleagues after he's like, 'I was worried about what you're going to show or say… the stuff you brought up, those aren't complications, that's just like part of expected outcomes.' Like, he didn't even consider it. And I was like, wow, this was quite telling. …And so to have that regularly to see that you're not the only one who has complications, it would be good, it would be nice, it would be helpful. …I would benefit from knowing other people get these things, too." (Participant 7)

"And then one of the projects that I'm working on is trying to integrate something called 'Schwartz Rounds' at the hospital, which is a kind of more of a… group debrief… So it's an interprofessional kind of case review of difficult situations that's open to all of the medical staff of like nursing, if the janitorial staff want to come... it's come one come all, students, physicians, nurses, whoever, and they talk about a specific case, and it's not focused on the medical side so much as the more emotional side of things. So we're applying for funding right now to try and get that started at the Department of Medicine." (Participant 3)

"Like even at our own hospital, sometimes we have really hard cases… I was talking about this with a colleague because we had a really tough case recently and I was like 'Who can we talk to?' Like there's no one here to debrief cases with us, like a psychologist or something in the hospital for the physicians who are there to debrief on like really tough case that you don't know how to handle or you're struggling with emotionally. So even just systems like that." (Participant 9)

Some participants identified the need for free and easily accessible mental health care given the difficult nature of physicians' work and recommended these services in the workplace.

"It's maybe unrealistic but it would be really cool if every hospital at the hospital level, had resources available for mental health. …like either a psychologist available on hand, or like a physician available on hand." (Participant 9)

"I think that all physicians should have access to a free therapist, but that's my personal opinion. Because physicians of all stripes will see traumatic death, challenging diagnoses, crazy families that will not leave you alone and will yell at you. And that can really wear on a person and we should all have the ability to pay somebody to hear that from us instead of kind of burdening our family." (Participant 3)

One participant discussed the potential negative consequences of having mental health supports at work, preferring instead a more arms-length approach offered by formal programs through the OMA and CMA.

> "The trouble is, often these communities, you could look at it one way and say, we're really big, but at the end of the day we all somehow know each other. And so, you could have like a wellness or a mental health support person in house, but then it's kind of too close to home oftentimes, and so people won't reach out anyway. So I don't think that locally, or institutionally, often, I think that's kind of why there's that limitation. And so that's why I think that the OMA supports and the CMA supports are very helpful, because it's more arm's length, and gives people a little bit more comfort with confidentiality. But in terms of supporting leave, you need that to be kind of at your institution." (Participant 5)

The expansion of insurance coverage for mental health care was also discussed.

> "I think that more robust mental health coverage for things like therapy—so we do have the Physician Health Program, but my understanding is that even if you do call it, it's like short term counselling, though I could be wrong. But I pay for external insurance to cover my therapy, which is fine, but… We pay our Provincial Association thousands of dollars a year, it would be cool if they could offer something to help us cover that cost." (Participant 6)

More comprehensive mental health supports were recommended at the institutional and provincial level to address mental health problems. Mental health issues can be preventatively addressed through the implementation of debrief sessions after difficult cases and having easily accessible mental health care. Physicians struggling from mental health issues would also benefit from having in-house and arms-length mental health services and more robust mental health coverage for long-term problems.

<u>Formal supports for leaves of absence</u>

Formal supports to help early-career physicians navigate leaves of absence were discussed with a focus on both mental health and parental leaves. Leaves of absence can be supported by "having a real process" (Participant 6) and having "transparency… around what are the policies, what is possible, and how does that work." (Participant 1). Flexibility surrounding leaves was also noted by participants.

> “Flexibility in terms of scheduling, I’m sure would be really helpful for people coming back and just for health in general.” (Participant 3)

Across all types of leaves, the most prevalent recommendation to support physicians in taking leaves was to increase the redundancy in the system.

> “Yeah, just like having more doctors. It’s just really unrealistic, but just having more doctors… I think just knowing that… there’s people there to cover for you. Which once again, it’s not everyone- if you can’t work, you can’t work. I think you’re just like quite aware of this barrier when you’re seeking help.” (Participant 9)

> “I think that if there was some resource where people could find coverage in a centralized way, because again, right now, when I book for a locum, I email the locums I know and see if they have friends and put something on. It's a really piecemeal situation. And I have to do all the legwork. And there's again, there's a website, but nobody goes on the website, and nobody ever uses it. So it's totally useless resource.” (Participant 6)

> “I think some redundancy in the system. And so what I mean by that is, if I’m not there, nobody’s there. If I’m not there and somebody’s able to be there, it takes a lot of weight off of you … I knew that there was somebody there that could step in or there was some way that things could be restructured to kind of help with that.” (Participant 8)

As noted by several participants, physicians are not covered during time off because they are ‘self-employed’ and many work fee-for-service. Recommendations were made to have leaves covered financially.

> “Yeah, I think if there's some kind of, well, like salary. If you're on salary, it'd be a lot easier. Now, you missed the day at work, and it's an unpaid day. You face like, going for a COVID test and knowing ‘Okay, if I'm waiting for a COVID test, I can't work, and if I'm positive, I'm going to be two weeks off of work. And that's going to be unpaid.’ It makes it very just internal dilemma.” (Participant 7)

> “Yes, drug benefits and formalized leave. We have neither of those things… formalized plans for maternity leave, paternity leave in the physician group doesn’t exist. And that makes things very challenging.” (Participant 8)

> "I know a lot of female physicians who are the main breadwinners in their families and so they deliver and they're immediately back at work. Because we don't get mat leave… Like covered. Like basically paid. Cause I think we can take whatever time we want, we're just not going to get paid." (Participant 9)

Gender-specific recommendations

Recommendations that would help support early-career female physicians at work more generally were also identified. Recommendations around improving workplace response to harassment to take the responsibility away from the person reporting the harassment were explored by a participant.

> "I think at least certainly education needs to change. But there also needs to be a lot less tolerance of those things. So my experiences were reported, friends of mine experiences were reported - these people still work, these people still teach, these people still encounter people in a less powerful situation than they are. And as I'm sure that you've heard many times, not just in medicine, but it becomes the onus of the person to speak and prosecute them. …Whereas an anonymous complaint does not hold much weight. So you either have to be the face of this, and own it and take it all on, and be the person that this person will know ruined their career or… you say nothing. Because nothing else is strong enough to get things to happen, which I think is a really challenging thing." (Participant 8)

One participant described the importance of leadership training to help early-career female physicians advocate for themselves and set boundaries at work.

> "I think that leadership training and the training to ask for what we want is important. And the reason that I bring that up is because not long ago, I did some extra training. And one of the things they talked about is developing strengths. But then the next step onto knowing what your strengths are, is finding the words to be able to say, 'these are my strengths in this context. And therefore, I would like you to put this on my plate, while taking this other thing that's maybe not my strength off my plate' and trying to practice how to do that." (Participant 3)

Childcare opportunities at work were another support for female physicians.

> "I think, ultimately, if we're going to support women in the workplace, there have to be systems, right? …there have to be childcare opportunities, there has to be some built in

> flexibility, there has to be some fail safes, and there is none in medicine. For the vast majority." (Participant 1)

> "I think there are little things… possibly having a daycare or having different things like that, that might help support people taking leave." (Participant 5)

As a resident, one participant had proposed a new strategy to increase flexibility for physicians taking maternity leave to her residency program and was denied.

> "And I had proposed that… during your maternity leave you could participate to educational sessions, and then in exchange, you would get those educational sessions kind of the day off when you come back from your mat leave. So like one Friday a month, and you could use that as study time or whatever. And it was denied. It was a big fat no. And I was like, 'But why? I'm not really sure?' To me, it was the perfect exchange, right? Like, I come while I'm on mat leave, and there, I get an extra day to study…" (Participant 2)

Early-career female physicians suggested recommendations that would support them at work and addresses sources of mental health concerns and gender-specific challenges.

<u>Promising culture changes</u>

Participants also made recommendations that could improve their workplace and medical culture as a whole to address the problems regarding mental health and leaves of absence. Culture change stemming from leadership was a common theme among participants, highlighting again the importance of having supportive women in leadership positions.

> "Well, I think a culture where people encourage you take the time and people model it, because the other thing is that you would just see your supervisors doing the same thing. So you're like, 'Well, if my boss is coming to work sick, I guess I have to come to work sick.' And also, maybe there's very little slack built into this system. And now when I look back with hindsight, I can see that actually, as a medical student, I was a little bit useless. And I could have taken a day here and there and nobody would have actually been put out. My senior resident could have done it, a staff physician could have seen their patients, instead of running a clinic simultaneously. I could have just not been there. But at the time, you just think this is going to reflect badly on me. I think now with COVID, people are actually taking this sort of seriously, taking action, because you really can't go to work sick, because you don't want to get the whole unit infected with

COVID if you have COVID. So from that perspective, that's been sort of a blessing in disguise." (Participant 6)

"Well, I think if it comes from leadership, and I think, some defined parameters. To say, if you've done this, you've done enough. I would love that. To acknowledge that a healthy and happy employee or a work environment, consists of people who are doing things that bring them joy, and are outlets for them. And I think that we have a long way to go with respect to that. …So I feel like it would come from leadership. …like for us, we have a group of 30 and one person who's the head. And if that person, when you met or when you started practice, or each year, met and said, 'What are you doing outside of work? How are you finding the workload? And what is it that energizes you? How can we make this schedule work for you? How many days would you like to be working? Is this working for you?' …if that was acknowledged, to say, 'Let's put some boundaries on this and help people with that.' I think that would be a really big start." (Participant 7)

"That's what I see as being more useful is education and setting up systems like wellness… I think initiatives that focus more on education that look at systems for how to change culture, those to me are the right direction." (Participant 1)

Some participants felt that culture change is a matter of time, as younger generations enter the workforce.

"I just need our generation to kind of take over the majority. I think that'll change a lot. I think that in the next 10 years, when it's like more of my people come into more positions of leadership, become department heads and… Hopefully, with some ideas. I think that things will get a lot easier because like the millennials just tend to get that a little bit more. …So I think that's perhaps more kind of weight towards there's a real cultural change." (Participant 3)

"Yeah, they're very systemic, it's very hard to change. But I think that the newer generation of med students that are going through, you see a little bit more education around that, you see a little bit more value on kind of gender equality and those kinds of things. So I'm hopeful we're moving in the right direction." (Participant 8)

As medical curriculum changes and younger generations of physicians enter practice and positions of leadership, systemic changes will occur, and medical culture will shift to better align with values around equity and wellness.

In this chapter, I presented the study findings from the perspective of early-career female physicians. I described the demographic details of the early-career female physician sample and explored early career female physicians' gendered experiences of mental health. This included an overview of their mental health experiences, the contextual influences of mental health, how early-career female physicians cope with mental health issues and seek care, the stigmatization of mental health and disclosure, and attrition from medicine as a consequence of poor mental health. Next, I presented the findings on participants' experiences with leaves of absence from work across various sub-themes including: physicians' motivations for taking a leave, the stigmatization of leaves and the culture surrounding them, the lack of redundancy in the system as a barrier to taking leave, the concept of disrupted leaves of absence, and the impact of collegiality as a facilitator to leaves. Lastly, I presented the existing and recommend supports for early-career female physicians regarding mental health and navigating leaves of absence at work. In the next chapter, I summarize the major findings in each of the three major thematic areas and discuss them in relation to the extant literature to address the study objectives.

Chapter 5: Discussion & Conclusion

In this chapter, I summarize the major findings and discuss them in relation to the extant literature. The three main topics I will be discussing are: (1) the gendered experiences of mental health of early-career female physicians, (2) the gendered experiences of taking a leave of absence, and (3) how to support early-career female physicians in the workplace. I focus predominantly on the major themes from the findings that intersect with female gender and early career stage.

Gendered experiences of mental health of early-career female physicians

Early-career female physicians had a variety of mental health experiences, but overall, their mental health suffered because of factors that intersect with their gender and career stage.

The idea that female physicians experience unique stressors at work that influence their mental health is well explored in the literature. The findings of this study were comparable to the literature on female physician mental health. Stressors explored by Byerly,[23] Robinson,[22] and Bogler et al.[10] encompass systemic inequalities such as gender biases and harassment, motherhood, and lack of female representation, which were all discussed by participants. In particular, the challenges outlined in Bogler et al.[10] were all experienced by participants, suggesting that these stressors are widespread and little changes to address them have been made over the years. This strengthens the literature and draws parallels between the practice of medicine in other jurisdictions and specialties and the context in Ontario. In addition to demonstrating consistency with past findings, this study contributes to the literature by describing how the transition to early career can impact mental health because of increased responsibility at work and less supports for physicians. This study also provides additional insight on the culture of self-sacrifice and the expectations of female physicians to provide emotional labour which leads to poor mental health.

Gender biases

Bogler et al.[10] identifies that early-career female physicians face implicit gender biases from both patients and colleagues and give the example that female physicians are less likely to be introduced as the doctor. This was a prominent challenge for participants who described their experiences with being called the nurse or unit clerk and having to work hard to prove they are the physician in charge. As participants explored, these types of microaggressions are further compounded when gender intersects with younger age and ethnicity.

In an older article, Frank[61] found that among female physicians, the number of perceived bad mental health days was significantly associated with a history of harassment. Further,

harassment influences fatigue, depression, and suicidal ideation.[61] To this day, a culture of harassment is present in medicine and medical training and predominantly affects women physicians.

Emotional labour

An interesting theme explored by participants was the expectation the female physicians provide more emotional labour. In their review on emotional labour and health care, Erickson and Grove[14] discuss the role of gender across various health professions, including medicine. The occupational culture and educational experience of women nurses and physicians follow the traditional gender roles and power relations that expect women to be caring and nurturing towards others.[14] This supports the findings that being emotional was considered a negative trait and female physicians were more likely to take on the emotional labour associated with patients than their male colleagues. The implications surrounding emotional labour and the traditional power relations associated with it may explain why female physicians may be considered "below" their male colleagues and may experience discrimination or differential treatment from nursing or other staff and from patients.

Additionally, increased provision of emotional labour may lead to increased compassion fatigue, or "a state of physical/emotional distress caused by repeatedly caring for those experiencing traumatic episodes."[62] among women physicians. A study on American surgeons found that female surgeons exhibit higher levels of burnout and compassion fatigue compared to their male counterparts, which was further exacerbated by having less professional experience.[62]

Motherhood

The pathway to motherhood was a prevalent stressor identified by participants including planning for children, pregnancy, struggles with infertility, breastfeeding, maternity leave, and the subsequent return to work. The masculine structure of medical work can also be seen through the lack of accommodations for female physicians who are mothers. This has important mental health implications, which is why it came up in the context of interviews on mental health related leaves.

Robinson[22] identifies the stressors associated with pregnancy and motherhood, such as choosing when to time the pregnancy to align with training and career and deciding how to accommodate maternity leaves and return to work including childcare arrangements and guilt around not being present full time with their child. The challenges surrounding maternity leave were important for participants and add to the extant literature, particularly the challenges associated with accommodating a leave during practice, deskilling following a leave, and

breastfeeding upon return to work. Robinson[22] also identifies the role strain between being a professional and a mother or wife at the same time. These stressors were described in the American context but are evidently present in the Canadian context as well.

Being a mother also presents with additional stressors from domestic responsibilities which creates work-life conflict.[63] When domestic labour is unequally distributed, career advancement and academic productivity may be hindered for female physicians.[63] Ultimately, this may lead to career dissatisfaction which may explain the higher rates of attrition from medicine for early-career female physicians. Participants did not explore in depth the distribution of labour at home, but it was noted that balancing work and home responsibilities may be different from male physicians.

The impact of these gendered stressors may lead to further mental health problems such as anxiety, depression, post-traumatic stress disorder, and substance use disorders, among others.[22] Participants described their experiences with burnout and other mental health issues such as depression and anxiety, but did not explore substance use.

Peer support, gender representation, and leadership

It is evident that peer support is an important strategy to address mental health concerns, particularly peer support from colleagues that are of similar demographic, career stage, and life stage as you. As such, it is important to increase representation of female physicians in masculine specialties such as surgery, to allow women the opportunity to connect with colleagues similar to them and facilitate peer support. A lack of role models and encouragement may also contribute to the lack of representation of female physicians in certain specialties and in leadership, which in turn is a source of stress and has mental health implications.[22]

By increasing the number of female physicians in leadership, participants described that this could lead to positive culture changes, positive role models, and gender-sensitive interventions. The gender disparity in leadership also leads to implications on the mentorship of female physicians. Byerly[23] explains that women are more likely to be mentored by lower-level managers and given life advice but not career strategies, while men are more likely to be mentored by senior executives, be given career strategies, and be sponsored by their mentees. In medicine, this further leads to the discrepancy of women in leadership positions and the lack of female leadership role models.

Gendered experiences with leaves of absence of early-career female physicians

Barriers to leaves of absence leading to presenteeism

There were few intersections of gender and career stage on one's experiences with taking a mental health leave of absence. Early career female physicians faced similar barriers to taking a mental health leave of absence as explored in the general physician literature, which can ultimately lead to presenteeism.

There is a small body of literature on presenteeism and leaves of absence that takes gender into consideration which reports a variety of results. Some studies found that there is higher presenteeism among women physicians, while others report that there are no gender differences.[64] A study measuring sickness absence among general practitioners in Sweden found that female physicians had higher prevalence of sickness absence and most commonly noted reasons related to stereotypical female gender roles, such as a greater concern for patients.[64] My study did not explicitly explore presenteeism among female physicians but identified several barriers physicians experience which contributes to presenteeism.

Participants also identified that presenteeism was prevalent in medicine because of a culture of showing up to work regardless of mental or physician condition. This culture is well studied in the literature and is linked to presenteeism.[32] Giaever et al.[32] explain that professional culture in medicine such as loyalty among physicians, social bonds at work, importance and meaning of medical work, and receiving positive feedback from colleagues and supervisors for staying at work contributes to presenteeism. Similarly, participants experienced guilt when needing time off work for mental health reasons because of the additional workload placed on colleagues. These factors that contribute to a culture of showing up to work are linked to female gender roles such as concern for others, as Sendén et al.[64] explain.

Giaever et al.[32] identify that presenteeism is a consequence of "irreplaceability," including being irreplaceable at work due to having specific competencies. Pit and Hansen[65] also identified that having a sense of responsibility over patients because there is no one to replace physicians if they leave as contributing to presenteeism. Participants described the barrier of irreplaceability on one's ability to take a leave of absence as a lack of redundancy in the system, and not having an effective system to cover your patients during the leave.

These barriers to taking a mental health leave of absence prevent early-career female physicians from taking the time they need to address their mental health concerns. In turn, physicians remain at work, exhibiting presenteeism, and further exacerbate their mental health issues.

Stigmatization

Stigmatization of mental health issues compounded by the stigmatization of leaves of absence in the profession makes the experience of taking a mental health leave of absence particularly challenging.[32,47] Stigmatization and its impact on mental health of physicians is a well-studied topic in the literature across all levels of training including medical students, residents, and practicing physicians.[32,47,66,67] Moreover, the participants in my study explored stigmatization from the perspective of the regulatory body as a barrier to taking a leave of absence. Disclosure of mental health issues and mental health leaves of absence to the CPSO leads to disciplinary measures such as being monitored or licensure restrictions and implies that you are not fit to practice.

Additionally, stigmatization of pregnancy and maternity leaves is widely present in medicine which intersects with experiences of early-career female physicians. Rangel et al.[68] found that almost 60% of female surgical residents in the United States of America reported stigma associated with pregnancy and 73% had witnessed faculty members or colleagues make negative comments about pregnant trainees or childbearing during training. This is a gendered phenomenon as male physicians perceive less stigma for taking parental leave than female physicians.[25] In this study, participants identified this stigmatization and explained that it leads to stress around disclosing one's desire to become pregnant or being pregnant because it would be negatively seen in the department and imply a maternity leave.

Supporting early-career female physicians at work

Participants identified several supports that are recommended to support early-career female physicians in the workplace. These included; social support, mentorship, formal supports for mental health, formal supports for leaves of absence, general gender specific supports, and promising culture changes.

Debrief sessions as a formal mental health support

Several supports are offered in the literature that intervene at the workplace level or the level of the individual physician, such as increasing resiliency.[67] A smaller subset of this literature discusses supports that intersect with female gender or early career stage.

Formal supports for mental health recommended by early-career female physicians are important for all physicians across all levels of training, career, and other intersectional characteristics. Participants recommended the provision of debrief sessions at work following difficult or traumatic cases. This is a common practice studied, and recommended, in the literature to promote resiliency and address burnout and compassions fatigue.[69] A study by Toews et al.[70] in the context of nursing found that the consequences of clinical debriefs are

primarily advantageous and positively impact healthcare teams, patients, and organizations.[70] They explain that the purpose of debriefing is to "reflect, evaluate, examine and exchange information regarding clinical practice, professional education and the emotions of those involved in the critical event," and required a skilled facilitator and a psychologically safe environment. Relatedly, Schwartz Center Rounds, an interdisciplinary forum were the psychosocial and emotional aspects of patient care are discussed, is another strategy in the literature that participants noted.[71]

Formal strategies such as these may be particularly well suited to female physicians who work in male dominated specialties and lack peer support to discuss complications or difficult patient cases. A structured forum for sharing experiences and emotions provides resolution to some feelings and increases recognition that others have similar experiences.[71]

A study on gender inequities identified several supports that were recommended by study participants including the promotion of effective mentorship, supporting physicians during periods of increased family responsibilities, providing training on unconscious bias, and improving transparency on promotion criteria and opportunities.[8]

Peer supports and mentorship

The importance of peer supports and formalized mentorship was explicitly stated across participants in this study. These supports are also strongly represented in the literature on female physicians. Landon and Selk[26] reported that two-thirds of Canadian obstetrics and gynecology residents who participated believed that having a mentor was important.

In contrast to Robinson's[22] statement that mentors do not need to be a female, but rather a senior individual who can guide female physicians to succeed, participants in this study expressed the importance of having a mentor who has similar demographic, career, and familial characteristics and who has lived through the same experiences.

Similar to the study findings, Bogler et al.[10] also suggested that formalized and effective mentorship is an essential support for early-career female physicians. They suggest that mentorship is necessary for career advancement; however, participants also attributed mentorship to supporting them with home-related factors that impact their mental health.

While it may be challenging to develop formal mentorship programs during early career, particularly if physicians work in independent practice, residency programs can facilitate these connections that will benefit early-career female physicians beyond their graduation from the program. Peer and mentor supports are important to foster an open environment where early-

career female physicians feel comfortable sharing their mental health experiences which helps address mental health issues as well as navigating leaves of absence.

Increase coverage and redundancy for leaves of absence

Participants in this study identified the need for increased redundancy in the system to help them find coverage when they need to go on leave. This strategy is not specific to female physicians or to physicians in early career; however, it may support early-career female physician mental health because it takes away from the stressor of finding coverage during maternity leaves.

Finding coverage for leaves is explored in the maternity leave literature; however, is a gap in the mental health literature. In their survey, MacVane et al.[72] found a prominent concern around shift coverage for vacancies during emergency physicians' maternity leaves. They suggest implementing formal maternity leave policies so female physicians have realistic expectations of what to expect during their leave.[72] Similar formal policies around mental health leaves of absence could be implemented as well to address the challenges described by participants around a lack of transparency.

Specific to maternity leaves, MacVane et al.[72] suggested policies including increasing parental leave duration and compensation, adding support for physicians working extra shifts to cover colleagues' leave, and addressing breastfeeding issues for women returning to work. Each of these suggestions was mirrored by participants' own experiences and recommendations in the Canadian context.

This study begins to close this gap by identifying similar challenges for physicians going on a mental health leave, as with maternity leave. It is expected that increasing coverage of leaves by increasing the number of physicians, restricting work schedules, or improving policies around leaves are not simple changes, which may be why little research or implementation has occurred.

Culture change

Improving medical culture is important to address mental health concerns, leave of absence challenges, and inequities faced by female physicians at work. Changing the culture of stoicism in medicine, increasing awareness of mental health, and minimizing stigmatization of mental health are relevant approaches explored in the extant literature and by study participants. This type of culture change in medicine requires targeted efforts at the organizational and systemic levels.[23] As Karakash[73] suggests, it will take creativity and courageous leadership across several levels and across organizations and jurisdictions.

Strategies suggested in the literature are congruent with strategies presented by participants in this study. Strategies proposed by Byerly[23] include education for all staff on unconscious gender bias, and recognizing, accepting and providing strategies for harassment. Karakash[73] suggests an organizational culture and professional norms that value work-life integration and personal life. As was suggested by a participant, the implementation of Schwartz Rounds leads to culture change in the organization towards making healthcare workers feel valued and heard and improves interprofessional relations. Additionally, culture change around female-specific challenges, such as pregnancy and breastfeeding can decrease this added stressor on early-career female physicians.

Positive culture change that supports early-career female physicians at work and their varying life experiences will contribute to the maintenance of mental wellbeing or provide them the ability to seek out help.

COVID-19 context

New information regarding the COVID-19 pandemic is emerging on a continuous basis including its impact on the health workforce. The literature on the COVID-19 context explores the mental health challenges faced by physicians working within the pandemic crisis including high mortality, increased risk to self and family, and ethical dilemmas in care.[74] The COVID-19 context also places additional stresses upon physicians, such as financial stress from loss of income when on furlough and increased home and familial responsibilities, such as child care and home schooling, particularly salient for female physicians with young children. These stressors have a gendered impact and may disproportionally affect female and early-career physicians.

The gendered impact of COVID-19 was not explored in my literature review. My study did not explicitly explore issues related to COVID-19; however, the study was conducted in the context of the COVID-19 pandemic. The topic of COVID-19 therefore arose organically during the interviews and participants shed light on some aspects of working during the pandemic.

Some participants described the impact of COVID-19 in positive terms and described that physicians are more likely to take time off when they feel sick leading to decreased presenteeism. In addition, there was an increase in mental health and wellbeing supports for physicians and other healthcare workers. The pandemic has increased awareness of the challenges health workers face and may contribute to positive culture change towards destigmatization of mental health issues.

On the other hand, the pandemic has made it challenging for physicians to connect with colleagues and methods of peer support have been put on hold. This decreases the amount of supports physicians have and can exacerbate mental health issues, especially during a stressful time.

Conclusion

Mental health issues are prominent in the physician population, and these are uniquely gendered across career stage. Early-career female physicians in Ontario, Canada have similar mental health experiences to those in other jurisdictions and countries. The mental health of female physicians in early-career is influenced by the context in which they work and their personal experience with gender-specific challenges. Female physicians tend to take leaves of absence for mental health reasons such as burnout and for maternity. Physicians accommodate their leaves by finding someone to take on their patients and practice while they are away, which can be a stressor. This systemic problem also causes them to feel guilty for putting extra work on their colleagues. Disclosure of personal information regarding mental health, gender-specific challenges, and pregnancy plays a significant role for female physicians.

Formal leave policies such as compensated maternity leave, increased redundancy in the system by having doctors available to cover leaves, and effective mentorship programs and support groups would help overcome some of the barriers faced by early-career female physicians. Culture change towards mental health awareness and destigmatization will facilitate the accommodation of mental health leaves of absence and improve the work lives of early-career female physicians. Ultimately, there is a need for evidence-based and gender-responsive policies, practices, and programs to promote and support the mental wellbeing of female physicians, particularly in early career.

Contributions and health system implications

This study generates knowledge on the specific population of early-career women in the context of medicine within Canada. The findings that I presented in this study can contribute to both practice and social action.[53] These findings contribute to the understanding of gender-specific challenges and promising practices that can support early-career female physicians in the workplace. Female physicians in early career are particularly at risk of poor mental health and addressing this problem may, in turn, lower the attrition rate of early-career female physicians from medicine.

Interviews with female physicians paralleled what is known from the literature and generated a detailed understanding of how they experience mental health and leaves of absence in the workplace, particularly in Canada. This study can be used by individual physicians, those in

leadership at an organizational level, and by policy makers to better understand Canadian physicians' gendered experiences with mental health and leaves of absence and implement necessary supports at each level.

These findings may help early-career female physicians at a personal level to realize that they are not alone in their challenges and offer some recommended supports such as connecting with peers, taking part in mentorship programs, and seeking care for mental health preventatively.

At the organizational levels, there are implications for those in leadership to address the inequities faced by female physicians that impact their mental health. Leaders should be cognizant of familial commitments and challenges surrounding maternity leaves experienced by female physicians when creating and enforcing policies around leaves of absence.

Presenteeism, staying at work while ill, and absenteeism, leaving work without reason, each have important consequences for the health system. In relation to mental health, the lack of redundancy is both a cause and an effect of this among physicians. Policy makers may consider developing equitable leave of absence policies for physicians that allow them to take time off for mental health or other reasons and develop effective systems for finding coverage during one's leave. Structurally, this needs to be addressed by having a centralized system or a designated individual who can fill in these gaps when someone goes on leave. This will distribute the legwork from the individual physicians needing to go on leave, to someone who is responsible for ensuring that leaves are covered. This is particularly important from a gender lens because of the increased need of female physicians in early career to go on leave for maternity and the mental health implications associated with leaves of absence which can be further exacerbated when one needs to accommodate their leave.

The CPSO, and other regulatory bodies, should consider the implications that monitoring physicians has on their mental health and the barriers that it provides for physicians wanting to seek mental health care. In particular, the way seeking mental health care is framed by regulatory bodies should shift from a negative to a more positive connotation, to encourage physicians who are struggling to seek care and to contribute to the destigmatization of mental health issues. The CPSO has a responsibility to balance patient safety with creating supportive culture change in the profession. This may encourage more physicians to attend to their mental health and seek care preventatively as a protective factor against more severe mental health issues. In addition, more transparency in the process and required disclosures, and how these are conducive to patient safety needs to be better communicated to all physicians.

Systemically, there is a need for gender-responsive policies, practices, and programs to promote and support the mental wellbeing of female physicians. Participants described changes such as increased coverage for mental health services and clear policies for reporting harassment that takes the onus off the victim. In addition, formalized leave of absence policies that offer a transparent understanding of how leaves are accommodated, and financial coverage of leaves was suggested by participants. The feminization of medicine is such that an increasing number of physicians are women, particularly at early career stages, so it is important for the health system within which medicine is situated to reflect its changing demographics and needs.

Limitations

In this section, I present the limitations of my study. First, given the predominant participation of family medicine physicians from Ontario, the study may have limited generalizability to other settings. However, through the use of a rich, thick description of the participants and their work settings and culture, this will enable transferability of results to other contexts through shared characteristics.[52]

Second, participants self-selected to participate in the study and given the challenges with recruitment during the first wave of the COVID-19 pandemic, all participants who volunteered were interviewed. However, there was an over-representation of physicians practicing in family medicine specialties and a lack of representation of surgical or medical specialties. In addition, participants that volunteered to participate may have varying experiences from those who actively chose not to participate.

Another limitation of this study is the small sample size of only nine participants. As proposed, I was able to reach saturation of the whole group of early-career female physicians and not of the subgroups for analysis; however, a larger sample size would have made for even stronger analysis. A larger study would be necessary to develop an in-depth understanding of the experiences of female physicians and to tease apart the impact of work structure and specialty on physicians' mental health.

Future research

A similar qualitative or mixed-methods study of a larger sample of female physicians across a range of specialties would be instructive. This will provide more nuanced information on how female physicians within different specialties experience mental health and leaves of absence at work. For example, in this study, it was mentioned that surgical specialties are more male dominated and women in these fields may experience more harassment. Further interviews with women in surgical specialties would best inform their experience with these challenges

and how specialty impacts them. Case studies that compare experiences in surgical specialties and non-surgical specialties or across each level of the career trajectory, including physicians in training and early to late career physicians, would provide more in-depth analysis and comparisons between groups.

Further research may also consider the experiences of early-career male physicians who may have similar experiences, particularly male physicians who are fathers and have taken parental leave, and the implications this process has on one's mental health.

The use of a life course calendar may be beneficial to represent each participant's experiences through their graduation from training, transition to early-career, and context of early-career work with respect with their mental health and leaves of absence. A life course calendar maps experiences over time and can produce nuanced longitudinal data about complex phenomena, such as mental health.[75] The life course calendar can be analyzed by comparing experiences of individual participants, comparing calendars of participants within the same specialty, and comparing across different specialties. The life course calendar would also be instrumental in mapping the leave of absence experiences of physicians and help build upon the pathway to leaves of absence that was created from the pilot study. This will create a more concrete and thorough pathway including more details on the process of leaves of absence for mental health during early career.

Further inquiry into the role of regulatory bodies on the stigmatization of mental health issues and leaves of absence is needed to better understand the impact that denying oneself care to prevent disclosure of mental health issues and the implications that non-disclosure to regulatory bodies has on physicians' mental health. This may have important implications for policy and how regulatory bodies assess physicians' wellbeing.

Further research on the influence of maternity, maternity leaves, and other gender-specific factors would be instrumental to tease apart the relationship with female physician mental health.

References

1. Clow B, Pederson A, Haworth-Brockman M, Bernier J. *Rising to the Challenge: Sex- and Gender-Based Analysis for Health Planning, Policy and Research in Canada*.; 2009. doi:10.1017/CBO9781107415324.004
2. Morgan R, George A, Ssali S, Hawkins K, Molyneux S, Theobald S. How to do (or not to do)... gender analysis in health systems research. *Health Policy and Planning*. 2016;31(8):1069-1078. doi:10.1093/heapol/czw037
3. Canadian Medical Association. *Number and Percent Distribution of Physicians by Specialty and Gender, Canada 2019*.; 2019.
4. Canadian Medical Association. *Number and Percent Distribution of Physicians by Specialty and Sex, Canada 2000*.; 2000.
5. Hughes E. In medicine, gender still matters, survey finds.
6. Frank E, Zhao Z, Sen S, Guille C. Gender Disparities in Work and Parental Status Among Early Career Physicians. *JAMA network open*. 2019;2(8):e198340. doi:10.1001/jamanetworkopen.2019.8340
7. Morgan AU, Chaiyachati KH, Weissman GE, Liao JM. Eliminating Gender-Based Bias in Academic Medicine: More Than Naming the "Elephant in the Room." *Journal of General Internal Medicine*. 2018;33(6):966-968. doi:10.1007/s11606-018-4411-0
8. Viamonte Ros A, Markham S, Wu D, Nicholas P. A Rapid Scoping Review of Gender Inequities in the Medical Profession. *Nursing & Health Sciences Research Journal*. 2019;2(1):12.
9. Dyrbye LN, Varkey P, Boone SL, Satele D V., Sloan JA, Shanafelt TD. Physician satisfaction and burnout at different career stages. *Mayo Clinic Proceedings*. 2013;88(12):1358-1367. doi:10.1016/j.mayocp.2013.07.016
10. Bogler T, Lazare K, Rambihar V. Female family physicians and the first 5 years. *Canadian Family Physician*. 2019;65:585-588.
11. Bugaj TJ, Valentini J, Miksch A, Schwill S. Work strain and burnout risk in postgraduate trainees in general practice: an overview. *Postgraduate Medicine*. 2020;132(1):7-16. doi:10.1080/00325481.2019.1675361
12. Mundschenk M-B, Krauss EM, Poppler LH, et al. Resident perceptions on pregnancy during training: 2008 to 2015. *The American Journal of Surgery*. 2016;212:649-659. doi:10.1016/j.amjsurg.2016.06.018
13. Holder SM, Peterson ER, Stephens R, Lee ·, Crandall A. Stigma in Mental Health at the Macro and Micro Levels: Implications for Mental Health Consumers and Professionals. *Community Mental Health Journal*. 2019;55:369-374. doi:10.1007/s10597-018-0308-y
14. Erickson RJ, Grove WJC. Emotional Labor and Health Care. *Sociology Compass*. 2008;2(2):704-733. doi:10.1111/j.1751-9020.2007.00084.x
15. Hammarström A, Hensing G. How gender theories are used in contemporary public health research. *International Journal for Equity in Health*. 2018;17(34). doi:10.1186/s12939-017-0712-x

16. Mary Romero. *Introducing Intersectionality*. Polity Press; 2017. Accessed June 22, 2021. https://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=5166452
17. Shields SA. Gender: An Intersectionality Perspective. Published online 2008. doi:10.1007/s11199-008-9501-8
18. Mihailescu M, Neiterman E. A scoping review of the literature on the current mental health status of physicians and physicians-in-training in North America. *BMC Public Health*. 2019;19(1):1-8. doi:10.1186/s12889-019-7661-9
19. Canadian Medical Association. CMA National Physician Health Survey – A National Snapshot. 2018;(October):31.
20. Lemaire JB, Wallace JE, Sargious PM, et al. How Attending Physician Preceptors Negotiate Their Complex Work Environment: A Collective Ethnography. *Academic Medicine*. 2017;92(12):1765-1773. doi:10.1097/ACM.0000000000001770
21. Robinson GE. Stresses on women physicians: Consequences and coping techniques. *Depression and Anxiety*. 2003;17(3):180-189. doi:10.1002/da.10069
22. Byerly SI. Female Physician Wellness: Are Expectations of Ourselves Extreme? *International Anesthesiology Clinics*. 2018;56(3):59-73. doi:10.1097/AIA.0000000000000197
23. PARO. Your Contract. Accessed May 23, 2021. https://myparo.ca/your-contract/
24. Willoughby K, Contributions M, Julien M, Zendel BR, Curran V. National survey of Canadian residents and program directors regarding parental leave during residency. *Canadian Medical Education Journal*. 2020;11(5):16-30. doi:10.36834/cmej.68486
25. Landon E, Selk A. Understanding the Experiences of Obstetrics and Gynaecology Residents Who Take Parental Leave During Training in Canada: A Needs Assessment. *J Obstet Gynaecol Can*. 2018;40(11):1453-1458. doi:10.1016/j.jogc.2018.04.001
26. Walsh A, Gold M, Jensen P, Jedrzkiewicz M. Motherhood during residency training. Challenges and strategies. *Canadian Family Physician*. 2005;51.
27. Lavergne MR, Gonzalez A, Ahuja MA, Hedden L, McCracken R. The relationship between gender, parenthood and practice intentions among family medicine residents: Cross-sectional analysis of national Canadian survey data. *Human Resources for Health*. 2019;17(1):1-16. doi:10.1186/s12960-019-0396-y
28. Hoffman R, Mullan J, Nguyen M, Bonney AD. Motherhood and medicine: systematic review of the experiences of mothers who are doctors. *Medical Journal of Australia*. 2020;213(7):329-334. doi:10.5694/mja2.50747
29. Virtanen P, Oksanen T, Kivimäki M, Virtanen M, Pentti J, Vahtera J. Work stress and health in primary health care physicians and hospital physicians. *Occupational and Environmental Medicine*. 2008;65(5):364-366. doi:10.1136/oem.2007.034793
30. Winona Pit S, Hansen V. The relationship between lifestyle, occupational health, and work-related factors with presenteeism amongst general practitioners. *Archives of Environmental & Occupational Health*. 2016;71(1):49-56. doi:10.1080/19338244.2014.998329
31. Giæver F, Lohmann-Lafrenz S, Løvseth LT. Why hospital physicians attend work while ill? The spiralling effect of positive and negative factors. *BMC health services research*. 2016;16(1):548. doi:10.1186/s12913-016-1802-y

32. Rosen T, Zivin K, Eisenberg D, Guille C, Sen S. The Cost of Depression-Related Presenteeism in Resident Physicians. *Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*. 2018;42(1):84-87. doi:10.1007/s40596-017-0867-1
33. Gosselin E, Lemyre L, Corneil W. Presenteeism and Absenteeism: Differentiated Understanding of Related Phenomena. Published online 2013. doi:10.1037/a0030932
34. Cohen D, Rhydderch M, Reading P, Williams S. Doctors' health: Obstacles and enablers to returning to work. *Occupational Medicine*. 2015;65(6):459-465. doi:10.1093/occmed/kqv056
35. Ross EC. Returning to work from extended leave: A trainee perspective. *EMA - Emergency Medicine Australasia*. 2017;29(5):581-582. doi:10.1111/1742-6723.12859
36. Rugless MJ, Taylor DMD. Sick leave in the emergency department: Staff attitudes and the impact of job designation and psychosocial work conditions. *EMA - Emergency Medicine Australasia*. 2011;23(1):39-45. doi:10.1111/j.1742-6723.2010.01372.x
37. Heponiemi T, Elovainio M, Presseau J, Eccles MP. General practitioners' psychosocial resources, distress, and sickness absence: a study comparing the UK and Finland. *Family Practice*. 2014;31(3):319-324. doi:10.1093/fampra/cmt086
38. Thun S, Halsteinli V, Løvseth L. A study of unreasonable illegitimate tasks, administrative tasks, and sickness presenteeism amongst Norwegian physicians: an everyday struggle? *BMC health services research*. 2018;18(1):407. doi:10.1186/s12913-018-3229-0
39. Carrieri D, Briscoe S, Jackson M, et al. "Care Under Pressure": a realist review of interventions to tackle doctors' mental ill-health and its impacts on the clinical workforce and patient care. *BMJ open*. 2018;8(2):e021273. doi:10.1136/bmjopen-2017-021273
40. Rantanen I, Tuominen R. Relative magnitude of presenteeism and absenteeism and work-related factors affecting them among health care professionals. *International Archives of Occupational and Environmental Health*. 2011;84(2):225-230. doi:10.1007/s00420-010-0604-5
41. Rosta J, Tellnes G, Aasland OG. Differences in sickness absence between self-employed and employed doctors: a cross-sectional study on national sample of Norwegian doctors in 2010. *BMC Health Services Research*. 2014;14(1):199. doi:10.1186/1472-6963-14-199
42. Lui JNM, Andres EB, Johnston JM. Presenteeism exposures and outcomes amongst hospital doctors and nurses: a systematic review. *BMC health services research*. 2018;18(1):985. doi:10.1186/s12913-018-3789-z
43. Heponiemi T, Sinervo T, Elovainio M, Kouvonen A. Is the public healthcare sector a more strenuous working environment than the private sector for a physician? *Scandinavian Journal of Public Health*. 2013;41(1):11-17. doi:10.1177/1403494812467505
44. Oxtoby K. Why doctors need to resist "presenteeism." *BMJ*. Published online December 9, 2015:h6720. doi:10.1136/bmj.h6720
45. Gross SR, Marshall EJ, Wolff K. Substance misuse among health care workers: national survey of occupational physicians. *Occupational Medicine*. 2012;62(4):254-260. doi:10.1093/occmed/kqs027
46. Lalloo D, Ghafur I, Macdonald EB. Doctor and dentist contacts with an NHS occupational health service. *Occupational Medicine*. 2013;63(4):291-293. doi:10.1093/occmed/kqt029

47. Brooks SK, Del Busso L, Chalder T, et al. “You feel you’ve been bad, not ill”: Sick doctors’ experiences of interactions with the General Medical Council. *BMJ Open*. 2014;4(7):e005537-e005537. doi:10.1136/bmjopen-2014-005537
48. Miller L. Doctors, their mental health and capacity for work. *Occupational Medicine*. 2009;59(1):53-55. doi:10.1093/occmed/kqn111
49. Myers MD. *Qualitative Research in Business and Management*. 2nd ed. Sage; 2013.
50. Bourgeault IL, Dingwall R, Vries R De, Bourgeault I, Dingwall R, Vries R De. *The SAGE Handbook of Qualitative Methods in Health Research*. SAGE Publications; 2012.
51. Creswell JW, Poth CN. *Qualitative Inquiry and Research Design: Choosing among Five Approaches*. 4th ed. Sage; 2018.
52. Marshall C, Rossman GB. *Designing Qualitative Research*. 6th ed. Sage; 2016.
53. Patton MQ. *Qualitative Research and Evaluation Methods*. 4th ed. Sage; 2015.
54. Miles M, Huberman A, Saldana J. *Qualitative Data Analysis: A Methods Sourcebook*. 3rd ed. Sage; 2014.
55. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101. doi:10.1191/1478088706qp063oa
56. Hennink M, Hutter I, Bailey A. *Qualitative Research Methods*. Sage; 2011.
57. Lincoln Y, Guba E. *Naturalistic Inquiry*. Sage Publications Inc.; 1985.
58. Koch T, Harrington A. Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing*. 1998;28(4):882-890. doi:10.1046/j.1365-2648.1998.00725.x
59. Finlay L, Gough B. *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*.; 2008. doi:10.1002/9780470776094
60. Frank E. Career Satisfaction of US Women Physicians. *Archives of Internal Medicine*. 1999;159(13):1417. doi:10.1001/archinte.159.13.1417
61. Wu D, Gross B, Rittenhouse K, Harnish C, Mooney C, Rogers FB. *A Preliminary Analysis of Compassion Fatigue in a Surgeon Population: Are Female Surgeons at Heightened Risk?*
62. Lyu HG, Davids JS, Scully RE, Melnitchouk N. Association of Domestic Responsibilities with Career Satisfaction for Physician Mothers in Procedural vs Nonprocedural Fields. *JAMA Surgery*. 2019;154(8):689-695. doi:10.1001/jamasurg.2019.0529
63. Sendén MG, Schenck-Gustafsson K, Fridner A. Gender differences in Reasons for Sickness Presenteeism - a study among GPs in a Swedish health care organization. *Annals of Occupational and Environmental Medicine*. 2016;28(1). doi:10.1186/s40557-016-0136-x
64. Winona Pit S, Hansen V. The relationship between lifestyle, occupational health, and work-related factors with presenteeism amongst general practitioners. *Archives of Environmental and Occupational Health*. 2016;71(1):49-56. doi:10.1080/19338244.2014.998329
65. Chew-Graham CA, Rogers A, Yassin N. “I wouldn’t want it on my CV or their records”: medical students’ experiences of help-seeking for mental health problems. *Medical education*. 2003;37(10):873-880. doi:10.1046/j.1365-2923.2003.01627.x
66. Carrieri D, Briscoe S, Jackson M, et al. “Care Under Pressure”: a realist review of interventions to tackle doctors’ mental ill-health and its impacts on the clinical workforce and patient care. *BMJ open*. 2018;8(2 PG-e021273):e021273. doi:https://dx.doi.org/10.1136/bmjopen-2017-021273

67. Rangel EL, Smink DS, Castillo-Angeles M, et al. Pregnancy and motherhood during surgical training. *JAMA Surgery*. 2018;153(7):644-652. doi:10.1001/jamasurg.2018.0153
68. Leff V, Klement A, Galanos A. A Successful Debrief Program for House Staff. *JOURNAL OF SOCIAL WORK IN END-OF-LIFE & PALLIATIVE CARE*. 2017;13(3):87-90. doi:10.1080/15524256.2017.1314234
69. Toews AJ, Martin DE, Chernomas WM. Clinical debriefing: A concept analysis. *Journal of Clinical Nursing*. Published online 2021. doi:10.1111/jocn.15636
70. Deppoliti DI, Côté-Arsenault D, Myers G, Barry J, Randolph C, Tanner B. Evaluating Schwartz Center Rounds® in an urban hospital center Evaluating Schwartz Center Rounds®. *Journal of Health Organization and Management*. 2015;29(7):973-987. doi:10.1108/JHOM-09-2013-0189
71. MacVane CZ, Fix ML, Strout TD, Zimmerman KD, Bloch RB, Hein CL. Congratulations, you're pregnant! Now about your shifts: The state of maternity leave attitudes and culture in em. *Western Journal of Emergency Medicine*. 2017;18(5):800-810. doi:10.5811/westjem.2017.6.33843
72. Karakash S, Solone M, Chavez J, Shanafelt T. Physician work-life integration: Challenges and strategies for improvement. *Clinical Obstetrics and Gynecology*. 2019;62(3):455-465. doi:10.1097/GRF.0000000000000442
73. Gavin B, Hayden J, Adamis D, McNicholas F. Caring for the Psychological Well-Being of Healthcare Professionals in the Covid-19 Pandemic Crisis. *Irish medical journal*. 2020;113(4 PG-51):51.
74. Nelson IA. From quantitative to qualitative: Adapting the life history calendar method. *Field Methods*. 2010;22(4):413-428. doi:10.1177/1525822X10379793

Appendices

APPENDIX A: Recruitment Materials

APPENDIX B: Interview Guide

[Adapted from HPW Partnership]

Color Coded to indicate what is the same, and what has been added.

Introduction: Thank you for agreeing to participate in this interview. We are interested in the experience of mental health issues affecting a range of professional workers. We are interested in how these experiences affect your work life, whether you continue to work or leave work for short or long periods of time, how these leaves are accommodated and in turn how this affects your return to work. What we mean by mental health issues include both short term mental health problems that temporarily limit our ability to function, as well as more persistent and severe medical health disorders that require medical intervention.

For my thesis, I am particularly interested in understanding the experiences of early-career female physicians regarding mental health and navigating leaves of absence from work. What I mean by 'early-career' is physicians within their first 10 years of practice following graduation from a training program. I am interested in how female physicians view their mental health in the workplace and how their mental health can be supported. Additionally, I would like to understand how early-career female physicians experience taking a leave of absence from work and how this process can be facilitated.

Individual Demographics:

1. Can you tell me a bit about yourself (*whatever you are comfortable in disclosing*)
    a. What is your gender identity?
    b. What is the year you were born?
    c. Do you identify as …Indigenous, a visible minority, living with a disability
    d. What is your sexual orientation?

Family Characteristics & Circumstances *[optional map to life course calendar]*

2. Can you tell me …
    a. Who you live with?
    b. Do you have children? What are their ages?
    c. Do you have others for whom you provide care? What type and how often?
    d. What is your contribution to your family's income?
3. Reflecting on your family characteristics and circumstances, what would you describe as most rewarding? Most challenging?

[We may also use a self-administered demographic questionnaire in advance or at the outset of the interview – similar questions to survey instrument]

Profession-Specific Questions *[optional map to life course calendar]*

4. How long have you been in your profession?
    a. Were you educated outside of Canada?
5. Can you tell me a bit about your career trajectory?
    a. Probe: Education and training (residency)
6. Can you tell me about your present position *(or last position if on leave/retired)*?
    a. Are/were you employed or self-employed?
        i. Do/did you work full time, part-time, casual, on contract?
        ii. *If self-employed,* Are/were you a practice owner, partner or associate?
    b. What is your primary location of work (province, urban/rural community, public/private sector) and work setting (community or institutional)?
    c. How has your experience as a practicing physician following your graduation from residency been so far?

Work Context

7. How would you describe your workload - the quantity of your work in general?
    a. Can you estimate the number of hours you work per week?
8. Reflecting on your work characteristics and circumstances, what would you describe as most rewarding? Most challenging?
    a. Reflecting on the **content of your work** (what you do), would you describe your work as stressful? Why or why not? *Probe for:*
        i. physical strain, occupational exposure,
        ii. emotional demands, ethical dilemmas
        iii. "Digital Stress" (emails, online forms, Electronic Medical Record, etc.)
        iv. Critical events and/or incidents in the workplace, including the experience of PTSD, or other ethical dilemmas
    b. Reflecting on the **context of your work** (how you are able to go about doing it), would you describe this as stressful? Why or why not? *Probe for (as relevant):*
        i. Work overload, multiple demands and deadlines
        ii. Control, flexibility and autonomy over what you do and how you do it
        iii. Psychological safety at work, where bullying, harassment, discrimination or workplace violence are absent
        iv. Psychological support from Co-workers? Supervisors? Good relations with Staff/employees? Patients/clients/students?
        v. Employment insecurity
        vi. Stress of applying for tenure/partnership/permanence, promotion
        vii. Stress of running a practice, managing people, meeting budgets
9. How would you describe your workplace culture? *Probe for whether it is:*
    a. An environment that is physically safe (e.g., from violence or workplace hazards)

b. *An environment where there is clear leadership & clear expectations of you in terms of tasks and workload*
c. *An environment of civility & respect*
d. *An environment of fairness and trust*
e. *An environment that fosters a sense of community amongst colleagues, supervisors (if any), patients/students/clients)*
f. *An environment where you feel involved, have influence & feel engaged*
g. *An environment that enables growth & development*
h. *An environment that recognizes and rewards accomplishments*
i. *An environment that enables work-life balance*

10. Do you experience any blurring of work and home life boundaries? If yes, provide an example.
    a. Do you work outside of regular hours/on-call? How often? Is it remunerated?
    b. How many vacation days are you due/do you take? Do you take work with you?
11. *[If the worker has a supervisor]* Are you comfortable talking to your supervisor/manager about any **work-related challenges** you face? What about **non-work-related ones**?

Mental Health Issues & Work *[optional map to life course calendar]*

12. Have you experienced any mental health problem or condition over the course of your career working in your profession?
    a. If no, what do you attribute this to?
    b. If yes, what specifically did/do you experience? *Probe for*
        - *Distress, Burnout, Anxiety, Depression or other Mood Disorder, Substance use, PTSD, Suicidal thoughts, other please specify*

    ii. When did it start? How often did you experience this?
    iii. What exacerbated this problem or illness?
        - *Probe for personal, familial or work related factors*

    iv. What helped to alleviate it?
        - *Probe for personal, familial or work related factors*

    c. *Probe: Attrition – early-career physicians have some of the highest rates of attrition (leaving the workforce) due to a variety of factors, among them being poor mental health. Have you experienced this personally or anyone you know?*
13. Have you ever come to work when you would have recommended a colleague under similar circumstances to stay at home or take a leave? [PRESENTEEISM]
    a. If so, how frequently has this occurred?
    b. What was the main reason you didn't stay at home or take a leave?
    c. What impact do you think this had on your productivity at work? Work quality?
14. Have you changed how you work to help manage your health problem or condition?
    a. If yes, how so?

Probe whether participant works reduced hours, missed days of work, take time off during a day, go to work late, have difficulties performing job duties due to fatigue and stress

b. If not, what prevents you from doing so?

15. Are you aware of any mental health promotion programs/services for you at work
    a. Have you accessed these services? Why/why not?
    b. What was the primary focus of these services (on you as an **individual** or on your **work or work context**)?
    c. Are/were they helpful or not helpful? Why or why not?
16. We're curious about whether you think gender (and other social identities) affects one's mental health experiences at work.
    a. Do you think there are differences in what women, men and gender diverse individuals **experience**? If so, please describe.
    b. Do you think there are different **expectations** of women, men and gender diverse individuals with respect to mental health and work? If so, please describe.
    c. What is your view on the role gender plays in medicine?
    d. How do you think gender impacts your experience in the workplace?
    e. What are the gender-specific workplace stressors that you have encountered?
        i. Probe: Can you give me some examples?
    f. How have any gender-specific workplace stressors impacted your mental health?
        i. Probe: harassment, discrimination, bullying, inequitable treatment

Leaves of Absence *[optional map to life course calendar]*

17. Have you ever taken a leave of absence from work?
    a. **If no**, why not? (*probe for: need, availability, accessibility, cost*) [BARRIERS]
        i. If you could take a leave, would you? [LEAVE CONSIDERATION]
        ii. What would help in that regard? [FACILITATORS]
    b. **If yes**, what was the primary precipitating factor (personal/familial or work) [REASON]
    c. Can you describe the process of negotiating your leave? [LEAVE PROCESS]
        i. When did this happen? Have you taken more than one leave?
        ii. Who did you approach? Why?
        iii. What happened?
            - Are there any formal policies, programs or practices that helped or hindered this process? [LEAVE POLICIES]
                a. Through union or professional association or from work/employer directly?
            - Is there coverage for leaves of absence from your work?
            - Is there a locum or replacement option?
        iv. How accommodating do you find your workplace is towards requests for leaves of absence? [LEAVE ACCOMMODATIONS]

- How supportive was your employer, manager/supervisor?
- How supportive were your co-workers?
- Who knew/did not know your arrangements?

v. How long did your leave last? [LEAVE LENGTH]

- What did you do while on leave? [LEAVE ACTIVITIES]

vi. What was the impact on your leave? On your patients/clients/students? On your career trajectory? On your family? [LEAVE IMPACT]

18. We're curious about whether you think gender (and other social identities) affects the experiences of considering and negotiating a leave of absence from work for mental health reasons. [GENDER & LEAVES]
    a. Do you think there are differences in what women, men and gender diverse individuals experience of this **process**? If so, please describe.
    b. Do you think there are different **outcomes** of negotiations for women, men and gender diverse individuals? If so, please describe.

OPTIONAL:

19. Have you taken any other non-medical leave from work (e.g., maternity/paternity leave)
    a. How was this experience different?
    a. How have unique challenges, such as pregnancy or infertility, impacted your work?
    b. How have these challenges impacted your mental health?
        i. Probe: Can you give me an example?
    c. What role does stigma play in relation to these unique challenges in the workplace?
    d. Do you feel supported at work with respect to your unique female challenges?

Return to Work Issues *[optional map to life course calendar]*

ASKED ONLY OF THOSE WHO HAVE TAKEN A LEAVE

20. Have/did you return(ed) to work?
21. If **no**, can you describe why not? [RTW BARRIERS]
    a. Probe for personal/familial and work related factors
    b. Did you have access to early retirement or Long Term Disability as an option?
22. If **yes**, can you describe the arrangements for your return to work? [RTW FACILITATORS]
    a. Are there any formal policies, programs or practices that helped or hindered this process? [RTW POLICIES]
        i. Through union or professional association or employer/place of work?
        ii. How accommodating these policies are? If not accommodating, how they could be improved?
    b. What role did your … [RTW SUPPORTS]
        i. … manager/supervisor play in the process of your return-to-work?

ii. … your union/professional association
iii. … your co-workers?
iv. … your family or family circumstances?

c. Have you returned to the same working conditions or have you had any accommodations [RTW ACCOMMODATIONS]
   i. …same position as before OR
   ii. position with less responsibility OR
   iii. part-time, casual or contract position
   iv. Did you have the discretion to make these changes or did they require negotiations?

23. Do you still experience ongoing health issues now that you are back at work?
    a. How do you manage these?
24. We're curious about whether you think gender (and other social identities) affects the considerations and negotiations around return to work. [GENDER & RTW]
    a. Do you think there are differences in what women, men and gender diverse individuals experience of this **process**? If so, please describe.
    b. Do you think there are different **outcomes** of the negotiations around return to work for women, men and gender diverse individuals? If so, please describe.

Promising Practices

25. What changes would you suggest could have made things better for you at work? [INTERVENTIONS]
    a. [probe: policies, practices and programs]
    b. If you had a blank sheet of paper, what intervention would you design or develop to …
       i. Improve mental health at work in general? [INTERVENTIONS – MH PROMOTION]
       ii. To address critical incidents precipitating the need for a leave? [INTERVENTIONS – PRECURSORS TO LEAVE]
       iii. To make it easier to take a leave of absence when necessary? [INTERVENTIONS – LEAVES]
       iv. To help people return to work when they are ready? [INTERVENTIONS – RTW]
    c. What key features do you think are necessary to increase the likelihood of this/these intervention(s) being used by other members of your profession? [PROFESSION UPTAKE]
    d. How might the circumstances for women, men and gender diverse individuals (and those with other social identities) be more fully taken into account in these interventions (policies, programs or services)? [GENDER & INTERVENTIONS]
    e. How can early-career female doctors be better supported in the workplace to decrease their mental health concerns?

i. Probe: At the level of the organization, policy, or government level?
ii. If you were in a position of leadership in your organization or at a larger scale, what would you implement to support early-career female physicians with their mental health in the workplace?

Do you have any other comments/suggestions as we move forward in this research?

APPENDIX C: Interview Contact Summary Form

Research Participant:
Worker Group:
Interviewer:
Date:

Key Points and Reflections:

Demographics	-
Family Characteristics and Circumstances	-
Professional Context (& Training)	-
Work Context	-
COVID-19	-
Mental Health Experience	-
Intersectionality	-
Leaves of Absence & Return to Work	-
Programs, Policies, Interventions	-
Promising Practices	-
Conclusions and Moving Forward	-

APPENDIX D: Codebook

1º & 2º Codes (Parent & Child Codes)	3º Codes (Grandchild Codes)	Description
BACKGROUND		Background information about the participant to provide context for their answers and perspectives based on the subcodes:
Individual		Background information on gender identify, age, identity (Indigenous, a visible minority, living with a disability), sexual orientation
Familial and relationships		Use for discussion regarding familial relationships, spouse, significant others, or other significant relationships in personal life. Includes characteristics and circumstances of home life
Profession specific	▪ Education ▪ Career	Background on participant's **education** and training. Includes schools, locations, and years for undergraduate, graduate, residency, and fellowship training. Do not use for discussion outside of the participant's own education history. Background information on **profession**, current position, location of work, type of work, employment type.
WORK		
Work content		Describes content of work including: iii. physical strain, occupational exposure iv. emotional demands, ethical dilemmas v. "Digital Stress" (emails, online forms, Electronic Medical Record, etc.) vi. Critical events and/or incidents in the workplace, including the experience of PTSD, or other ethical dilemmas
Work context		Describes context of work including: i. Work overload, multiple demands and deadlines ii. Control, flexibility and autonomy over what you do and how you do it iii. Psychological safety at work, where bullying, harassment, discrimination or workplace violence are absent iv. Psychological support from Co-workers? Supervisors? Good relations with Staff/employees? Patients/clients/students? v. Employment insecurity vi. Stress of applying for tenure/partnership/permanence, promotion vii. Stress of running a practice, managing people, meeting budgets
Workplace culture		Describes workplace culture including safety, respect, sense of community among colleagues and supervisors.
Work-life boundaries		Describes work and home life boundaries including blurring of boundaries, working outside of regular hours, time allotted to vacation.
MENTAL HEALTH		Use for discussion on mental health (MH) issues based on the following sub-codes:

MH Issues	▪ Burnout ▪ Stress ▪ Depression ▪ Anxiety ▪ PTSD ▪ Other	Use for mental health issues discussed or experienced.
MH Primary Causes	▪ Individual ▪ Familial ▪ Work related ▪ Interprofessional ▪ Organizational/Regulator ▪ Training	Use for the primary causes of mental health issues including individual, familial, work related (including work content and context), interprofessional relations, and organizational context. **Individual** factors include gender, age, ethnicity, Indigenous status, career stage of the worker; chronic conditions or disabilities, personal resiliency **Familial** factors include partner, children, other family members, family situation, marital situation, being a parent/co-parent/caregiver, lack of work/family balance, financial situation, being a breadwinner, affordable care **Work content** factors include long hours, heavy workload, emotional labour, compassion fatigue, critical incident, patient/client/student relationships, bullying, discrimination, post-traumatic stress, etc. **Work context** factors include employed/self-employed; models of care; continuity of care; work/practice culture (expectations of work/call), lack of paid sick days Use for discussion around **interprofessional relations** at work leading to mental health issues. **Organizational** factors include things on a broader level in medicine outside of the specific work environment. Includes discussion about the regulator (e.g., Royal College) or other organizations. **Training** factors includes anything associated with medical school or residency that leads to mental health problems. Use this for specific to the training portion, not the work environment.
MH Accommodations		Use for discussion around accommodations made to work to support or mitigate effects of mental health, such as working less hours, switching jobs, or doing different tasks.
Impact on	▪ Self ▪ Patient/clients ▪ Workers ▪ Colleagues/managers ▪ The profession	Use for the impact of mental health issues on patients or clients, other workers, colleagues, managers, or the overall profession.
COVID-19 & MH issues	▪ COVMH – Issues ▪ COVMH - Causes ▪ COVMH - Impacts	Use for discussion around the mental health issues arising from COVID-19, the COVID-19 related causes (which may cut across individual or personal causes, familial causes, or work-related causes) and other COVID-19 related mental health impacts.
Barriers to MH Care	▪ Stigma ▪ Lack of awareness ▪ Lack of interventions	Use for discussion around barriers to access or pursuing mental health care. Includes the impact of **stigma** on seeking help, **lack** of mental health interventions available for use, and lack of **awareness** of interventions.
Enablers to MH Care	▪ Role of colleagues ▪ Role of manager/supervisor	Use for discussion around what enables, facilitates, or support physicians to seek help.

		Use for discussion around the role of **colleagues** in workplace interventions for MH or their role in supporting (or not supporting) physicians seeking help. Use for discussion around the role of **managers, supervisors** or others in workplace interventions for MH.
MH Coping		Use for discussion on how physicians cope (or don't cope) with mental health.
PRESENTEEISM		Use for discussion on presenteeism based on the following sub-codes:
Presenteeism experience		Include reasons for not staying home or not taking a leave
Prevalence		Describes how workers perceive or discuss prevalence of presenteeism or the extent of the issue in the profession.
Impact	▪ Work quality ▪ Work productivity ▪ Relationships with colleagues ▪ Relationships with patient/clients/students	Use for how the impact of presenteeism is understood, discussed, or experienced. Includes the impact of presenteeism on work quality, productivity, relationships with colleagues, and relationships with patient/clients/students.
COVID-19 impact		Use for discussion on impact of COVID-19 on presenteeism
LOAs		Use for discussion on leaves of absence (LOA) for mental health or other reasons based on the following sub-codes:
Consideration	▪ COVID-19 related	Use for discussion around the consideration of taking a leave, whether or not one was taken. Include discussion on considering or taking leave since **COVID-19** pandemic began.
Length	▪ Short Term ▪ Long Term	Use for discussion on the length of leaves such as short-term or long-term leaves.
Numbers		Describes the number of leaves taken or typically taken by workers.
Reasons	▪ MH issues ▪ Personal ▪ Familial ▪ Work related ▪ Professional ▪ Organizational ▪ COVID-19	Discussion around the primary precipitating factors for taking a leave. Includes: **Mental health issues** such as burnout, stress, depression, anxiety, PTSD **Personal circumstances** including gender, age, ethnicity, career stage and others. **Familial circumstances** including immediate partner, children, other family living with them/they care for, etc. marital situation, being a parent/co-parent/caregiver, lack of work/family balance, financial situation, being a breadwinner **Work related factors** includes work **content** ((long hours, heavy workload, patient/client/ student relationships, bullying, discrimination, post-traumatic stress, etc) and work **context** (employed/self-employed; models of care; bullying, etc) **Profession-specific factors** include factors specific to particular profession. **Organizational context** including presence/absence of leave policies, provincial variation and organizational culture such as workers' or managers'/ supervisors'/employers' attitudes towards leaves. Changes in reasons for taking leaves since **COVID-19** pandemic.
Process	▪ Negotiation ▪ Expectations?	Use for discussion around the process to taking a leave of absence including: i. When did this happen? Have you taken more than one leave?

		ii. Who did you approach? Why? iii. What happened? a. Is there coverage for leaves of absence from your work? b. Is there a locum or replacement option? Include discussion on the process of **negotiation** a leave including who you spoke to. Use for discussion around what is **expected** of you when asking for or taking a leave of absence.
Policies		Use for discussion around *formal* policies, programs or practices that helped or hindered the process of taking a leave? Include those through union or professional association or from work/employer directly.
Accommodations		Use for discussion around accommodations made in the workplace when requiring a leave of absence, including how your leave is accommodated in the workplace by your colleagues.
Activities		Use for discussion on what worker did while on leave. Includes seeking professional help, not thinking about work, finding alternative employment…
Impact		Discussion on the impact of LOA on individual, patient, students, career trajectory, or family.
Enablers	▪ Support – Colleague ▪ Support – Supervisor ▪ Policies ▪ Work/Practice Model ▪ COVID-19 enablers	Describes enablers to taking a leave of absence including support of co-workers; presence of leaves of absence policies, practicing in an employee model, practicing in urban area, being in a larger team, working in collaborative practice, etc. Use sub-code for discussion on COVID-19 related changes in enablers since COVID-19 pandemic.
Barriers	▪ Guilt ▪ Stigma ▪ Lack of Support – Colleague ▪ Lack of Support – Supervisor ▪ Lack of Policies ▪ Economic ▪ Work/Practice Model ▪ COVID-19 barriers	Describes barriers to taking a leave of absence including financial situation (lack of health insurance/benefits/short-term disability, being the breadwinner), stigma attached to MH, lack of support at workplace, sense of guilt because co-workers need to pick up “slack”, etc)). Use sub-code for discussion on COVID-19 related changes in enablers since COVID-19 pandemic.
RTW		Use for discussion around return to work (RTW) based on the subcodes:
Process		Use for discussion around the process for returning to work.
Policies		Use for discussion around formal policies, programs or practices that helped or hindered the process of returning to work? Include those through union or professional association or from work/employer directly.
Accommodations	▪ Negotiation	Discussion around the changes made to workplace content/context upon returning. Include position, level of responsibility, part-time/contract position, negotiation involved. Include discussion on process of **negotiation** your RTW accommodations including who you spoke to.
Impact		
Enablers	▪ MH Issue	Use for discussion around enablers for return to work based on the subcodes:

	▪ Personal ▪ Familial ▪ Work related ▪ Organizational	The specific type of **mental health issue(s)** they experience **Personal circumstance** including gender, age, ethnicity, personal resiliency **Familial circumstance** including family situation, being married or single, having/not having dependents, affordable care, etc. **Work related factors** such as *career stage*, role of supervisors/managers and others at the levels of work content, work context, and the profession itself. **Organizational context and culture** including presence/ absence of RTW policies; gradual RTW plans (i.e., reduced hours, call or no call), provincial variations.
Barriers	▪ MH Severity ▪ Personal ▪ Familial ▪ Work related ▪ Organizational	Use for discussion around barriers to successful return to work based on the subcodes: The **severity of the mental health issue(s).** **Personal circumstance** including gender, age, ethnicity, personal resiliency **Familial circumstance** including family situation, being married or single, having/not having dependents, affordable care, etc. **Work related factors** such lack of support from manager/supervisor; no changes in work situation (go back to same work situation that caused them to leave) at the levels of work content, work context, and the profession itself. **Organizational context and culture** including presence/ absence of RTW policies; gradual RTW plans (i.e., reduced hours, call or no call).
COVID-19 Impact		Use for discussion on the impact of COVID-19 on return to work including differences in RTW process between PRE-COVID and COVID/POST-COVID era.
PROMISING PRACTICES		Use for discussion around promising practices or interventions including *policies, programs, and practices* that the participant knows about, has used or accessed, or would recommend as an improvement. Use for discussion of interventions aimed at the following subcodes. Includes ways to overcome barriers for each subcode.
MH Promotion	▪ Intervention Focus ▪ Interventions Effectiveness ▪ COVID specific	Use for discussions of interventions (programs, policies, services) aimed at mental health issues, including things that mitigate the negative impact on mental health and prevent mental health issues initially. Describes the **focus** of the intervention including the micro or worker level, the meso or workplace level, and the macro or societal levels. Use for discussion around the **effectiveness** of interventions – were they helpful or not. Use for discussion around **COVID-19** related interventions and those adopted in light of COVID-19 to support MH at work.
Work Conditions		Use for discussions of interventions aimed at improving conditions at work – not related to MH.
LOA		Use for discussion of interventions that make it easier to take a leave when necessary and to address critical incidents precipitating the need for a leave.
RTW		Use for discussion of interventions that make it easier to return to work following leave.
General Promising Practices	▪ Med Culture Prom. Practices	Use for discussion around promising practices for improving the medical profession in general, including medical culture.

GENDER INFLUENCES		Use for discussion on the impact of gender on mental health, leaves of absence, and return to work experiences including the following sub-codes:
Gender Challenges	▪ Female specific	Use for discussion around gender-specific challenges such as pregnancy, birth, or sexual harassment. Include discussion on **female-specific** challenges such as pregnancy, birth, and infertility.
Impact of gender on	▪ MH ▪ LOA ▪ RTW	Use for discussion on the impact or influence of gender on the following subcodes: The impact of gender on **mental health**, **leave of absence**, and **return to work** experiences including differences in the process and outcomes of negotiations.
Gender differences	▪ Gender norms ▪ Gender roles ▪ Gender relations	Describes gender differences in experiences including men and women, transgender, non-binary, and other individuals. **Gender norms** refers to how the cultural, racial, ethnic backgrounds influences gender, such as how we expect individuals to be in society. **Gender roles** discusses the societal expectations of what women (or men, gender diverse individuals) do at home and at work and how this influences their MH, LOA and RTW. Includes the expectations in a partnership such as the reproductive work (e.g., child care), and how these roles are seen at work. **Gender relations** refers to the relations women (or others) have with other women or other genders/gender diverse individuals. Includes discussion on women working in a male dominated workplace/specialty. This will relate to discussion on bias and discrimination at work.
Gendered Interventions	▪ MH ▪ LOA ▪ Early career female specific	Use for discussion on formal gender-sensitive interventions including policies and programs. Include circumstances to take into account for interventions specific for women, men, or gender-diverse individuals. Include discussion on formal interventions aimed at **mental health** and taking a **leave.** Include discussion on formal interventions specific for **early career female physicians.**
Gendered Recommendations	▪ Early career female specific	Use for discussion on recommendations for gender-sensitive actions including prevention or promotion or at the individual, family, work or organizational level. Include discussion on recommendations specific for **early career female physicians.**
QUOTABLE QUOTES		Use as a bin where great thought-provoking quotes go.
Resilience		Use for discussion around resilience including lack of resilience.
Leadership		Use for discussion around how leadership in medicine should support mental health, their role, or their shortfalls. Cross-disciplinary theme of leadership!
Residency	▪ MH ▪ LOA	Experiences describing training programs, including residency or fellowship based on subcodes: Use for discussion of participant's **mental health** or general students' mental health throughout training programs. Use for discussion about taking a **leave of absence** during residency or fellowship.
Attrition		Use for discussion around attrition from medicine and leaving the workforce. Exclude discussion on changing workplaces or finding a different job within medicine. Include discussion on the consideration of leaving medicine.

Orange → emerging/inductive codes

APPENDIX E: Consent Form for Participant Interview

Consent form for
Participant Interview

Title of Study: How early-career female physicians experience workplace mental health and leaves of absence in Ontario: A sub-study of the Healthy Professional Workers Partnership

Funder: Canadian Institutes of Health Research (CIHR Canada Graduate Scholarship-Master's Program)

Lead Investigator:
Mara Mihailescu, MSc(c)
Telfer School of Management
University of Ottawa

Supervisor:
Dr. Ivy Lynn Bourgeault
School of Sociological and Anthropological Studies
University of Ottawa

Co-supervisor:
Dr. Jennifer Dimoff
Telfer School of Management
University of Ottawa

Invitation to Participate:

You are invited to participate in the above-mentioned Master's thesis research study conducted by Mara Mihailescu. This study is a sub-study of the broader *Healthy & Productive Professional Workers: Negotiating Leaves of Absence due to Personal Mental Health Issues and Returning to Work* study led by Dr. Bourgeault. You can choose to participate and have your data used in the broader study as well. Please note that these projects are being conducted independently from the organizations and agencies from which you may have been recruited.

Purpose of Study:

This study aims to understand the mental health experiences of early-career female doctors and how these impact leaves of absence and return to work. To do this, we are both examining current conditions within the profession and seeking to understand various trajectories (mental health, life course, career course) and their intersections and interrelationships by exploring past experiences. From this research, we will learn more about the experiences and mitigation of negative effects of leaves of absences from work and return to work (RTW) practices, programs and policies aimed at female physicians who have experienced mental health personally. This research will help inform policy makers on how to better accommodate the leaves of absence and process of return-to-work female doctors who experience personal mental health issues.

The broader *Healthy Professional Workers* study aims to understand the mental health experiences of professional workers and how these impact leaves of absence and return to work. From this research, we will learn more about the experiences and mitigation of negative effects on leaves of absences from work and return to work (RTW) practices, programs and policies aimed at professional workers employed across a range of sectors who have experienced mental health personally. We will also learn more about the influence of gender on the return to work process. This research will help inform policy makers on how to better accommodate the leaves of absence and process of return-to-work of male, female, non-binary and gender fluid professional workers who experience personal mental health issues.

Participation:

As a participant in this study, you have been asked to participate in an individual interview, via either telephone, Skype, Zoom or Microsoft Teams (depending on your preference). The interview explores your experiences with mental health issues and how these experiences affect your work life, specifically, staying at work while ill (i.e., presenteeism) or leaving work for short or long periods of time, and in turn how this affects your work setting (e.g., employers, managers, co-workers) and how these leaves are accommodated. The interview is anticipated to take 60 minutes and will be conducted at a time and location convenient to you. A subset of interviewees will also be asked to review a completed life course calendar. The life course calendar tool will help us identify key events in your work, family, residential and health trajectories.

Risks:

Participants may experience psychological or emotional discomfort during the

interview when disclosing personal experiences of mental illness. Because of that, we will treat your participation and identity confidential (*see Confidentiality below*). Please also be aware that you do not need to answer questions that make you uncomfortable or that you do not want to answer.

Participants will be provided with the contact and resource information for counseling and mental health services at their organization/institution, or resource information available for the general public, upon request. Resources for the general public include:

Crisis Services Canada: 1-833-456-4566

Crisis Services Canada in Quebec: 1-866-277-3553

Benefits: Taking part in this study will not benefit you directly. However, this research may bring some indirect benefits to you. In particular, in doing this research, we hope to learn more about the experiences and mitigation of negative effects of leaves of absences from work and return to work (RTW) practices, programs and policies aimed at professional workers employed across a range of sectors who have experienced mental health and/or cognitive impairment issues either personally or as caregivers. We hope that what is revealed through this study will help us suggest systemic changes in terms of interventions (i.e., policy, programs and practices) related to mental health issues of professional workers and the process of their return to work that may be needed to address the issues professional workers raise. For that reason, we are committed to making the results of our study known to key policy decision-makers so that such changes could be initiated.

Confidentiality: The interviews will be audio-recorded with participant agreement. The information that you share will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Mara Mihailescu, Dr. Bourgeault, and other project co-investigators. Your answers to open-ended questions may be used verbatim in presentations and publications but you will not be identified.

Anonymity: Anonymity will be protected. There is no identifying information that will link you to your particular data set and you will in no way be identified in any written publication resulting from the study. However, participant's identities are sometimes revealed by the stories they tell. In an effort to maintain confidentiality, participants' interview data will be identified using participant codes and pseudonyms. Contextual information that could identify participants will be modified in order to preserve the anonymity of participants.

Data Storage: Physical records will be kept in the locked home office of the principal investigator, Mara Mihailescu, and electronic documents and audio recordings will be stored in a password-protected, encrypted folder on the personal computers of the principal investigator and project co-investigators.

Compensation: We are pleased to compensate you $20 for participation in the interview. If, for any reason, you decide that you would like to withdraw, even during or after the

	interview, you will still receive the $20 honorarium. This will be sent to you via e-transfer using the email address you used to arrange the interview.
Voluntary Participation:	You are under no obligation to participate. If you choose to participate, you may refuse to answer any questions. You indicate your consent to participate in the study by signing and returning this consent form or providing oral consent during at the start of the interview. If you change your mind about participating, you may simply inform one of the investigators of your desire to withdraw. You can withdraw your participation at any time during the interview session and can withdraw consent of your data at any time following the interview. It is impracticable to withdraw results once they have been published or otherwise disseminated. Please note, for participants of the *Healthy Professional Worker* study, you can withdraw your consent up to 1 week after the interview is concluded by contacting the Principal Investigators or the administrative coordinator, as indicated on the consent form. After 1 week, we will proceed to transcribe the audio tape. At this point in time, we will also delete any participant names from notes, and emails with participant names will be deleted, and the interview will be identified solely by a code.
Information about Results:	The research findings will be made available to participants and other interested parties upon completion of the study via e-mail.

If you have any questions or require more information about the study itself, you may contact the researchers at the numbers mentioned above.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa ON K1N 6N5, tel.: 613-562-5387 or ethics@uottawa.ca

Please keep this form for your records.

Thank you for your time and consideration.

	Please Check Box
1. I confirm that I have read and understand the information in the consent form for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3. I agree to take part in the following studies:	
a. How early career female physicians experience workplace mental health and leaves of absence in Ontario	☐
b. Healthy & Productive Professional Workers: Negotiating Leaves of Absence due to Personal Mental Health Issues and Returning to Work	☐

4. If the interview is taking place on the phone or via Skype, Microsoft Teams or Zoom, I verbally agree to take part in this study, as described in this consent form. ☐

5. I agree that the interview can be audio recorded, though this is not required to be eligible to participate. ☐

6. I agree to the use of anonymised quotes in publications. ☐

7. I would like to receive a summary of the study's results. ☐

Please send them to this email address

_____

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of Interviewer (if I am participating in an interview)	Signature	Date

_____	_____	_____
Name of Researcher	Signature	Date