

THE RELATIONSHIP OF QUALITY OF WORK LIFE, WORK-LIFE BALANCE AND
FLEXIBLE WORKING ARRANGEMENTS ON FEMALE PHYSICIAN'S INTENT TO
LEAVE THEIR MEDICAL CENTER

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I dedicate this dissertation to my Father, Doyle Johnson. Just after my International study trip to Belize, he was diagnosed with cancer and passed away not long after. When I wanted to give up and give in rather than finish my studies, his memory was my inspiration to continue. Be proud Dad – I finished!

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ABSTRACT

THE RELATIONSHIP OF QUALITY OF WORK LIFE, WORK-LIFE BALANCE AND FLEXIBLE WORKING ARRANGEMENTS ON FEMALE PHYSICIAN'S INTENT TO LEAVE THEIR MEDICAL CENTER

by Elaine Bird Purdy

This study aims to examine the role of quality of work life, work-life balance and flexible working arrangements and their influence on the retention of female physicians working at an academic medical center. When quality of work life and work-life balance is lacking, female physicians experience dissatisfaction and many leave the job. Failure to meet the quality of life needs of faculty can increase turnover and impact the school's ability to attract new talented faculty.

The study was conducted with female physicians employed at three academic medical centers located in the southeastern region of the United States: University of Arkansas for Medical Sciences, University of Alabama, Birmingham School of Medicine and Vanderbilt University Medical Center. This study was carried out through quantitative self-administered surveys, using Pearson's r and chi-squared analyses on 125 survey responses.

The results suggested that females with poor work-life balance or work quality are significantly more likely to hold intentions to leave. Furthermore, those who worked longer hours on average each week were at significantly higher risk of having poor work-life balance. While flexibility of working arrangements did not have a significant relation to intent to leave it did have strong relationship to work-life balance.

This information may result in a better understanding of the working environment for female physicians at an academic medical center and could be valuable for workforce management that better supports the recruitment and retention of female physicians.

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CHAPTER I

INTRODUCTION

Medical school faculties are finding it increasingly difficult to retain female physicians (Degen, Li, & Angerer, 2015; Strong et al., 2013). Low quality of work life and poor work-life balance were among the reported reasons for dissatisfaction of physicians on their job (Kwong, Chau, & Sawase, 2014; Shanafelt et al., 2012). Providers in academic medical centers traditionally worked long hours, often 50 to 60 hours per week, and many hours include early morning rounds and faculty meetings (Norman & Hall, 2014). Physicians of academic medical centers have three areas of responsibility: clinical care, research, and teaching of which require a significant time commitment to manage the full workload (Daskevich et al., 2016). Additionally, time period for earning tenure, an important component in academic medical centers for retention and promotion, places even more pressure on an already heavy workload for physicians early in their career (Geraci & Thigpen, 2017).

There is a significant upward trend in health care providers who desire a better work-life balance (Ariely & Lanier, 2015; Strong et al., 2013). Females, who desire to have a career and a family, lead the movement to encourage employers to provide better opportunities for work-life balance including flexibility in work schedules. The labor force today is composed of more workers than ever who look to flexibility in work hours to ensure work-life balance (Major & Burke, 2013). As such, this study aims to provide empirical evidence as to the influence of the quality of work life and work-life balance on female physicians' intention to leave the profession. This study also aims to provide better understanding of how flexible working arrangements and other demographic factors affect the quality of work life and work-life balance of female physicians.

This chapter provides a brief background of the problem, the problem statement, purpose statement, and research questions. The theoretical framework and the nature of the study including the research method and research design will be discussed. Definition of key terms, assumptions, scope, limitations, delimitations, and significance of the study will also be presented. The chapter will conclude with a summary of pertinent information about the study.

Background

The popularity of work-family balance as a subject of debate among the researchers and practitioners, along with the increasing prevalence of work-life balance strategies in organizations all over the world, cannot be overemphasized (Fernandez-Crehuet, Gimenez-Nadal, & Reyes Recio, 2016; Kapasi & Galloway, 2015). Enhancing the work-life balance of employees is a strategy used by leaders to sustain the workforce. Interest in issues related to work-family balance has been primarily driven by the notion that work-family balance provides a comprehensive solution to a wide range of challenges that societies face in the 21st century (Fernandez-Crehuet, Gimenez-Nadal, & Reyes Recio, 2016; Kapasi & Galloway, 2015). Work-family balance is associated with the changes integrated into work patterns for every employee -- regardless of gender, race, or age -- to achieve a sense of rhythm that will allow them to effectively combine work with other roles and responsibilities (Kossek et al., 2014). At present, policies are being designed by public and private organizations to facilitate work-life balance, thereby seeking to resolve challenges relating to the decline of the long-established male-breadwinner system, the increased focus on the quality of work life, the changing nature of work, and the anticipated economic risks brought about by an aging population. As such, there has also

been considerable interest in the availability and appropriateness of work-life strategies in the workplace.

Flexible work arrangements are increasingly being offered by organizations in an effort to accommodate the efforts of employees to balance home and family concerns with professional lives (Belanger, Watson-Manheim, & Swan, 2013; Kim, 2017; Krooks, 2013). Introducing flexible work arrangements in organizations is said to be one of the most important means of attaining balance between work and other commitments (Michielsens, Bingham, & Clarke, 2013). Recent studies have suggested that organizations that establish a family-friendly work environment are more likely to obtain benefits relating to a higher level of job satisfaction and organizational commitment, as well as a reduced level of turnover intentions (Jahn, 2015; Timms et al., 2015). Work-life strategies have been designed to assist workers with other aspects of their lives, including their professional development, personal wellbeing, and responsibilities in the family. The strategies have included a wide range of policies and programs, one of which is flexible work scheduling (Wadsworth & Facer, 2016). Through telework, employees are able to work remotely from homes or in other locations through the use of various Internet options, hence an alternative work format (Wadsworth & Facer, 2016). Specifically, telework has been recognized as one of the most practical and favorable solutions in terms of flexible work arrangements for the general working population. However, telework as a flexible work arrangement needs to be further tested and accepted in the field of healthcare where services are expected to be rendered personally by healthcare professionals (Mercer, Russell, & Arnold, 2014).

The nature of corporate culture about the prioritization of work-life balance and quality of work life is a significant factor in almost any discussion about worker satisfaction, issues of equitable treatment, and overall organizational effectiveness (Krooks, 2013). In the emerging

domain of flexible work arrangements and addressing concerns related to the experience of work-life conflict for employees, corporate culture is an especially significant factor, as there is evidence that progressive programming may not be effectively realized if the organizational environment does not instrumentally and/or emotionally support these programs and the workers who avail themselves of these programs (Kiaye & Singh, 2013). Issues arising from the conflict of work and family life demands have implications not just for the employees experiencing the anxiety and stress, but also for the organization as a whole (Krooks, 2013). Employees who are unhappy or distressed will often be less productive and less committed to the organization than employees who are not subject to work-life conflict stresses which may lead to lower quality of work life, or even worse may lead to the employees leaving the organization. The higher rates of absenteeism and turnover that are seen for dissatisfied or overwhelmed workers often translate to financial loss for the organization (Krooks, 2013).

Problem Statement

The specific problem to be addressed in this study is that it is not known how quality of work life, and work-life balance, and flexible work hours influence the intention of female physicians at academic medical centers (Mercer, McSorley, & Shultz, 2016; Strong et al., 2013). The number of female medical school students has increased in the past two decades (Coulston, Vollmer-Conna, & Malhi, 2012; DeFilippis, Cowell, Rufin, Sansone, & Kang, 2016). The largest numbers of physicians who leave the medical center environment are females. Due to the number of years invested in their own training in school and in residency and fellowships, females begin their medical careers at a time when they are ready to build a family or are a parent of very young children. Quality of work life, work-life balance, and flexible work hours

are a major concern for female physicians to actively enjoy a career and a family. When quality of work life is lacking, female physicians typically experience dissatisfaction and many leave the job. In the medical field, turnover costs are high and recruitment of new physicians is a costly and lengthy process. Failure to meet the quality of work life needs of faculty can increase turnover and impact the school's ability to attract new talented faculty.

Purpose of the Study

The purpose of this quantitative non-experimental correlational study is two-fold. First, the purpose is to examine the relationship between quality of work life and intention to leave and between work-life balance and intention to leave among female physicians at academic medical centers in the southeastern area of the United States. Second, the purpose is to identify whether flexible working arrangements and other demographic factors (age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan) influence the quality of work life and work-life balance of female physicians at academic medical centers in the southeastern area of the United States. The independent variables are quality of work life, work-life balance, flexible working arrangement, and the aforementioned demographic factors while the dependent variable is intention to leave.

Research Questions and Hypotheses

The following research question will guide this study:

RQ: Is there a relationship between female academic medical center faculty intention to leave employment and work-life balance, quality of work life, and availability of flexible work schedules?

HO1₁: There is no statistical relationship between female academic medical center faculty intention to leave and their perception of quality of work life.

HO1_n: There is a statistical relationship between female academic medical center faculty intention to leave and their perception of quality of work life.

HO2₁: There is no statistical relationship between female academic medical center faculty intention to leave and their perception of work-life balance.

HO2_n: There is a statistical relationship between female academic medical center faculty intention to leave and their perception of work-life balance

HO3₁: There is no statistical relationship between female academic medical center faculty intention to leave and the availability of flexible work schedules.

HO3_n: There is a statistical relationship between female academic medical center faculty intention to leave and the availability of flexible work schedules.

Theoretical Foundation

The theoretical framework for the study will be based on two theories: gendering organization theory and work enrichment theory. Acker's (1992) Gendering Organization Theory will be used to provide theoretical insights about the experienced of females in the workplace. The work enrichments theory of Hackman and Oldham (1980) will be used as the foundation for the work-life balance.

The study will employ Acker's (1992) Gendering Organization Theory, which defined gendered processes as the advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, which are patterned through and in terms of a distinction between male and female, masculine and feminine. Moreover, Acker's (1992) theory explained the

gendered substructure of organizations, which is based on the temporal and spatial arrangement of work that prescribe the behavior of organization members based on gender and in relating work life or social life. The gendered substructure of organizations also links the organization and family life while characterizing two types of workers: male and female. Males and females have differential bodily structures and needs (Acker, 1992). Females' bodies, sexuality, and procreative abilities are used as grounds for objectification and, in many cases, exclusion, while men's sexuality often dominates most workplaces (Acker 1992). In the drive for flexibility, management creates part-time and often, low paying jobs to be filled by female workers; hence, this theory supports the current study by providing an explanation for having more female physicians in the healthcare field for flexibility, not just because they want to be with their family or children more, but also because healthcare institutions have the gendered substructure where flexible working arrangement will be based on the Work Enrichment Theory (Hackman & Oldman, 1980). The Work Enrichment theory highlights the importance of both home and work, particularly the interdependence of each from one another. Based on this model, the experience at home will have an impact on work, and vice versa (Hackman & Oldman, 1980). This theory underscores the relationship between work-life and quality of work life in the effectiveness of an individual in these areas of functioning.

Nature of the Study

The nature of the current study will be quantitative. Quantitative research is suited to examining questions pertaining to the examination of relationships between variables (Clayton & Gorman, 2012; Jackson, 2012). The purpose of this study is primarily to determine the relationship between variables -- quality of work life, work-life balance, flexible working

arrangements, demographic factors, and intention to leave. Therefore, it falls very clearly into the realm of the quantitative. By contrast, qualitative research is descriptive, focusing on the issue of “why” or “how” (Babbie, 2010), and deals with the experiences of individual participants rather than the statistically aggregated experiences of a larger sample (Barratt, Choi, & Li, 2011). Thus, qualitative research is a poor fit for the purpose of this study.

The specific research design is non-experimental and correlational. Correlational research considers the correlations between variables, using statistical tests to make meaningful statements about these correlational relationships, including statements of correlation, non-correlation, moderation, and mediation (Clarke & Collier, 2015). Correlational designs do not have the ability to make statements of causation as some variables simply cannot be reasonably (or ethically) manipulated by a researcher. Non-experimental designs require significantly less work to implement than experimental designs, and statements of correlation are still meaningful results for policy and future research (Claydon, 2015).

The participants of this study will be female physicians at academic medical centers located in the southeastern area of the United States. A purposive sampling will be conducted to gather the required sample size for the study (Brus & Knotters, 2013; Robinson, 2014). Data will be collected through an online survey that consists of different validated questions that will measure the study variables. Correlation and multiple linear regression analyses will be conducted to analyze the variable relationships using SPSS Version 24 (Cohen, Cohen, West, & Aiken, 2013).

Definitions

Intent to leave. An employee's plan to quit the present job with the intent to find another job elsewhere (Purani & Sahadev, 2007).

Flexible work arrangements. Flexible working arrangements refers to non-traditional working arrangements in the workplace (Allen et al., 2013). This may exist in the form of (a) reduced-time/part-time arrangements, (b) telecommuting, (c) job sharing, (d) compressed work needs, and (e) flextime. This study will focus on all factors except telecommuting. Although telecommuting may become a viable option for physicians, it currently is not commonly used.

Quality of work life (QOWL). Quality of work life refers to the satisfaction an individual develops for their careers, allowing them to enhance their personal lives through their work and work environment (Shananfelt et al., 2012),

Work-life balance (WLB). Work-life balance is simply the balance between work and family. It references all individuals and their family situation to include married couples with or without children, singles and couples with our without children (Nitzsche et al 2014).

Assumptions

There are three assumptions for the current study. The first assumption is that the participants will provide their honest responses to survey questions depicting their perceptions of work-life balance, quality of work life, intention to leave, and on flexible working arrangement regarding their job as physicians in an academic medical center. There is no way for the researcher to ascertain the truthfulness and accurateness of the responses of the participants; thus, it can only be assumed and advised to the participants before conducting the survey. The second assumption is that the participants will objectively rate their perceived work-life balance, quality

of work life, and intention to leave using the given scale in the instrument. The third assumption of this study is that the female physicians selected based on a set of inclusion criteria can approximately mimic the characteristics of the total population of female physicians in the southeastern area of the United States. It is not possible to include all the members in the target population. It is assumed that by following the inclusion criteria and applying purposive sampling, the final set of participants would somehow represent the population of female physicians in the southeastern area of the United States.

Scope and Delimitations

The study will be delimited to the selected academic medical centers in southeastern areas of the United States, thus limiting the demographic sample. The researcher wanted to have more in-depth insights from relevant population rather than choosing a wider population with a higher possibility of inconclusive insights. Other factors that may contribute to female physician's work-life balance, quality of work life, and intention to leave the healthcare field such as, sexual harassment and stress, although factors that research indicate have some influence on intent to leave will not be considered for this study.

Limitations

This research may be limited due to researcher's bias. This is due to the fact that the conclusions derived from the results in a quantitative study are dependent on the researcher's interpretation of applicable literature. To adjust for such kind of biases, it is important that the literature review is comprehensive and all insights will be supported by relevant citations. Another limitation is that results from correlational studies are not definitive in causation between the study variables. Babbie (2013) asserted that there could be several reasons why

variables behave the way they do. It is only through experimental study that a researcher can have certainty regarding the true causation between variables as such design involves random assignment, which correlational studies do not possess (Rottman & Hastie, 2014).

Significance

The purpose of the current quantitative non-experimental correlational study is to examine the relationship between qualities of work life as well as work-life balance with intention to leave among female physicians. In addition, the study aims to identify whether flexible working arrangements and other demographic factors (age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan) influence the quality of work life and work-life balance of female physicians. The significance of this study lies in three aspects: benefits to the employers, benefits to the female physicians and benefits to the relevant literature. The benefits for each stakeholder are discussed below.

First, the insights from this study may help organizations develop or enhance their work-life balance policies, most especially those that are targeted to females who are committed to their families as well as their professional growth. It is of great importance for employers to establish rules and policies for the effective management of the workplace especially in the healthcare industry where effectiveness and efficiency are of utmost importance. Balancing of multiple roles, especially for the female physicians, should be considered a top priority when flexible work arrangements and continual education and training are made available (Kiaye & Singh, 2013; Methot & LePine, 2015).

Second, the insights to be gathered from this study will directly benefit the participants themselves; participants may gain insight to whether other female physicians think of working with flexible arrangements, and how participants fare in handling their professional role and caring for home responsibilities. In the study conducted by Hilbrecht et al. (2008), many females expressed some degree of frustration, citing the inevitable and frequent interruptions created through their home-related circumstances. The home situation makes it difficult to realize work goals, often necessitating additional hours spent early in the morning or late at night completing professional work that had been interrupted during the day and early evening by family demands. Thus, this study may provide a description of how working arrangements can affect the personal lives of female physicians and vice versa.

Lastly, researchers have recommended that future research must obtain a more comprehensive understanding of the nature of flexible work, especially in the case of female physicians at medical centers, to determine if work-life balance is actually achieved and quality of work life is maximized (Demerouti et al., 2014; Greenberg & Landry, 2013). Given that this study aims to provide empirical evidences based from the experiences of female physicians who have direct involvement in situations that require them to juggle the demands of being a physician who works at a medical center may provide rich insights as to how work-life balance and quality of work life is achieved or should be achieved. Further, the results of this study will contribute to the growing literature about work-life balance with a focus on female physicians, which has been found to lack studies that provide a good understanding of the actual nature of effective flexible working arrangements.

Summary

The specific problem to be addressed in this study is how quality of work life, work-life balance, and flexible work hours influence the intention of female physicians at academic medical centers (Mercer, McSorley, & Shultz, 2016); Strong et al., 2013). As such, the purpose of this quantitative non-experimental correlational study is two-fold. First, the purpose is to examine the relationship between quality of work life and intention to leave and between work-life balance and intention to leave among female physicians at academic medical centers in southeastern area of the United States. Second, the purpose is to identify whether flexible working arrangement and other demographic factors (age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan) influence the quality of work life and work-life balance of female physicians at academic medical centers in the southeastern area of the United States. Validated survey instruments will be used to measure the study variables and will be subjected to data analysis to address the research questions and hypotheses.

Chapter II will present the review of literature and provide the synthesis of the insights gathered from the relevant body of knowledge to determine what is and what is not known about the topic. Chapter III will present the proposed methodology, which will justify the data gathering method. Chapter IV addresses the data analysis and the results of the tested hypotheses. Also, tables and figures will be summarized and illustrated. Chapter V will discuss the findings in relation to the body of knowledge on the topic.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

The problem of the work-life balance is especially significant in the field of medicine. Health care workers who desire a better work-life balance are raising their voices (Ariely & Lanier, 2015; Strong et al., 2013). Females, who desire to have a career and a family, have led the movement to encourage employers to provide better opportunities for work-life balance including flexibility in work schedules. The purpose of the present study is to examine the relationship between quality of work life and intention to leave, as well as the relationship between work-life balance and intention to leave among female physicians at academic medical centers in the southeastern area of the United States. The aim of this study is to determine whether flexible working arrangements and other demographic factors such as age, ethnic background, educational level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track and career plan, influence the quality of work life and the work-life balance of female physicians at academic medical centers. The general problem that this study seeks to investigate is the nature of the work-life balance, and how flexible work hours may influence the intention of female physicians at academic medical centers (Mercer, McSorley, & Schultz, 2016; Strong et al., 2013). As the studies cited below indicate, this is an increasingly prevalent problem within the medical industry that has to be addressed by researchers in the medical community.

Flexible work arrangements have come to structure labor practices in the twenty first century (Michielsens, Bingham, & Clarke, 2013). While most of the studies cited below describe

the gender gap and the problems for female laborers specifically, there has yet to be a study that takes into account the nature of work-life balance in the age of flexible work arrangements.

Technological advances have offered new ways to improve work-life balance for employees, but they have also created new sets of problems for workers to deal with, as having a flexible schedule does not always offer greater freedom for workers (Krooks, 2013). The present study focuses on ways to analyze and improve work schedules in our highly flexible and dynamic technological environment.

While there are increasing numbers of medical students, the number of females who experience dissatisfaction is increasing (Coulston, Vollmer, Conna, & Malhi, 2012; DeFilippis, Cowell, Rufin, Sansone, & Kang, 2016). However, there is a significant gap in the research which this study should address. To this date, no study has investigated how quality of life and factors like those listed in the previous paragraph affect female's decision to stay in work. In this study, a quantitative non-experimental correlational study is used to determine the relationship between quality of work life and intention to leave and between work-life balance and intention to leave among female physicians at an academic medical center in the southeastern area of the United States.

To develop this literature review, the following online databases and search engines were used: JSTOR, Science Direct, Google Scholar, Journal Storage, EBSCOhost Online Research Databases, Global Health, Ingenta Connect and Journal Seek. The key search terms and combination of search terms included the following: *work-life balance, female retention in medical profession, workplace survey, survey response, workplace conflict, academic medicine, tenure track, childcare, maternity leave and gender bias*. By using these key words, relevant

studies were generated from the database services listed above. The relevant studies have been included in this literature review.

Eighty-five per cent of the literature in this review was published between 2013 and 2017, to ensure that the most recent findings and reports were included. However, literature on the trials and tribulations of female medical employees is limited. Some older articles, as well as studies conducted outside the United States, were included in order to provide perspective on the changing nature of the industry worldwide.

In this literature review, the researcher will provide an expanded background to the research problem discussed in the earlier chapter. The first section identifies the literature search strategy used to write the literature review. The second section focuses on the theoretical framework of the study, which include work enrichment theory and gendering organization theory. The third section focuses on the changing nature of the medical profession, including generational differences between older more senior employees and those entering the workforce at this moment in history. The fourth section discusses the relevant literature on the difficulties in maintaining a healthy work-life balance and the dangers of burnout. The fifth section examines literature, which proposes solutions to the work-life balance problem. The sixth section discusses the quantitative methodology of the present work. The seventh section summarizes the literature review.

Theoretical Framework

The theoretical framework for the study will be based on gendering organization theory and work enrichment theory. Acker's gendering organization theory (1992) will be used to provide insights about the singular experiences of females in the workplace, and Work

Enrichment Theory (Hackman & Oldham, 1980) will be used to highlight the importance of both home and work, especially when it comes to these two institutions' independences from each other. These theories have been applied in contexts related to the study of female entrepreneurs (Agarwal & Lenka, 2015), as well as studies regarding the efficacy of flexible work arrangements (Michielsens, Bingham, & Clarke, 2013). Like these studies, the present work will engage with social aware theories based on a real awareness of the manner in which gender as a category affects the professional outcomes of female employee and students. Like in Argawal and Lenka (2015), the present work will take gender as a primary category for understanding social experience. And yet Work Enrichment Theory will balance the study, noting, as Michielsens, Bingham and Clarke (2013) do, that institutional arrangements and organization theories are also in play when analyzing the lives of individual employees.

According to Acker, gendered process is the advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, which are patterned through and in terms of a distinction between male and female, masculine and feminine (Acker, 1992). For Acker, gender helps structure organizations, linking them with other social institutions such as family life. This theory fits with the purposes of the present study because organizations seeking flexibility will often create part-time and often low paying jobs to be filled by female workers. Acker's theory provides an explanation for having more female physicians in the healthcare field because healthcare institutions have gendered substructures where flexible work is more appropriate for females (Acker, 1992).

Scholars like Williams, Muller, and Kilanski (2012) have used gendered organization theory to investigate the basic organizational logic of companies in the so-called new economy, which is characterized by job insecurity and network structures. Gendered organization theory

places a gender lens on the evolving organization of work, and identifies mechanisms that reproduce gender inequality in the contemporary workplace.

Similarly, the work enrichment theory (Hackman & Oldham, 1980) highlights the significance of home and work, and gives us an adequate understanding of how these two institutions and structures are interdependent. Hackman and Oldham's model shows us that experiences at home will have an impact on experiences at work, and experiences at work will have an impact on experiences at home. The borders between the two are porous, and any theory that does not take note of that is insufficient for the needs of this study. For an individual to function at an appropriately high level, there needs to be an understanding of the relationship between work-life and quality of work-life.

Work enrichment theory is based on the notion that the task itself and the environment in which the task is completed are key to employee motivation. As we will see below, Sopher (2016) gives an adequate example of how work enrichment theory can be used to demonstrate the efficacy of environmental motivation dynamics. Job enrichment functions to offer employees opportunities to undertake tasks and responsibilities through which they will acquire new skills and reduce workplace tensions that could lead to intergenerational conflict and disagreement described by Sopher (2016).

Given that this study focuses on whether work-life balance and quality of life are factors in female physicians' intention to leave their place of work, the combined theoretical frameworks listed above are well suited to provide an understanding of individuals as well as institutions. Any discussion of work-life balance and the nature of institutions should focus both on the institutions themselves as well as the employees who work within the institutions. This combined theoretical framework functions to provide an adequate and diverse scope of inquiry on the

present problem. The efficacy of flexible work arrangements, as well as the nature of quality of life issues for females as opposed to males, requires a thorough engagement with theories of institutions and practices. Both gender organization theory and work enrichment theory provide such rigorous engagement.

The Changing Nature of the Medical Profession

The first section of this literature review will investigate the background problems revolving around the institutional nature of the medical profession. One of the signal concerns of this study is the manner in which institutions can be improved so as to help physicians balance their work and life demands. In order to undertake the study, it is significant that we understand the nature of hospital work in both academic and non-academic settings in the United States and beyond. An understanding of the institutional setup of the medical profession is required for improving those institutions.

The theoretical framework for this study, as outlined above, uses institutions as one of its signal concerns. Acker's (1992) Gender Organizational Theory takes the belief that institutions structure the lives of those who operate within them. But institutions do not necessarily strictly mean the business and schools through which people pass. Norms and conventions such as gender roles also count as institutions in this broader sense, and institutions, like everything else, are bound to change over time. The nature of historical change can be grasped by looking closely and analyzing the ways that institutions structure and delineate the forms and practices of experience for females working in the medical profession today (Acker 1992).

It is important to begin with an awareness of the nature of medical institutions and the changing demographics, as the present study is primarily concerned with a demographic

question, namely the experience of female physicians. Bowman & Gross (1986) provided an overview of the literature on females in medical school and practice, locating the differences between male and female physicians on a number of issues. Importantly, the study found that the number of females in medical practice was expected to increase by one hundred and fifty three percent between 1981 and 2000. The literature has also shown female physicians have lower productivity and lower income than male physicians. The study found a female preference for urban areas that could lead to geographic misdistribution problems. According to Woodward et.al. (2001), the amount of hours that family physicians of both genders spend working has increased steadily from 1993 and 2001. Woodward measured the self-reported hours spent weekly on professional activities, finding that the difference between the hours these physicians preferred to work compared to their actual work hours was significant. If the rate of the increase continues, as Woodward notes, the family structures that underlie reproductive and familial bonding time will begin to erode. The amount of hours spent on professional activities is directly inversely proportional to the amount of time spent with family. As the number of hours spent in professional contacts increases, the number of family hours will, according to this formula, decrease. It is worth noting that Woodward documents the changes in this proportion that could lead to a reduction in professional activity from female physicians. Additionally, pediatricians and child physicians, female physicians with children and married female physicians are three groups that tend to work fewer hours than other physicians during this time period (Woodward, 2001).

In addition, there are stark differences between different generations within the medical profession. As the demographics shift along with working conditions, the various ideologies circulating within the US medical industry will also reach a conflict. For instance, Beutell (2013)

found that there is a significant generational difference between members of Generation X, so-called Millennials, and baby boomers. Boomers, include the generation born in postwar era, from 1945 to the mid-1960s, while Generation X includes those who came of age during the 1970s, 1980s and 1990s, and the Millennials include those born after 1990. While members of the older generations, like Gen X and the Baby Boomers, believe that more hours should be worked per week, those who belong to the millennial generation see the importance of a fair and appropriate work-life balance (Beutell, 2013). The most important factors for determining how work will interfere with family are mental health and job pressure, yet work-family conflict and synergy were related to a more comprehensive set of job, marital and life satisfaction statistics, which differed between each generation (Beutell, 2013).

Intergenerational conflict can lead to differences in the workplace, which does not make for a productive or healthy work atmosphere (Sopher, 2016). Sopher found that generational differences in the workplace are statistically more likely to create an atmosphere of conflict within the office environment. Conflict, according to Sopher, is statistically related to a work-life balance that causes negative effects on the amount of employee satisfaction in the office. Intergenerational conflict is often the source of many disagreements in the workplace, which originate in difference in viewpoints. The fact that it is statistically more likely to create an atmosphere of conflict within the office environment indicates that the nature of the work-life balance is beginning to change with the transition between generations. This could have something to do with what Keltgen (2007) found as the changing nature of expectations for millennial employees. Keltgen found that Millennial have adjusted expectations for employers by expecting new benefits such as signing bonuses, financial planning services, and childcare. Such benefits packages do not accurately describe the workload that many face in the medical

industry, and Keltgen (2007) undertook a comparative study of generation Y and the millennial generation, noting in conjunction with Sopher (2016) that disagreements over benefits have changed the workplace by creating further sources of conflict for those of differing generations. Sopher (2016) and Keltgen (2007) note the negative aspects of intergenerational conflict as it relates to workplace atmosphere and the competitive nature of physicians in the medical profession.

Some as a growth opportunity sees the generation gap in the medical profession. Berthold (2008) argues that there are different ways to measure the worth of an employee than the amount of hours worked. While many older doctors believe that young students are lazy, this may be an illusion of the generation gap. According to Berthold (2008), the key to understanding this gap is taking note of the different understandings of professionalism between the generations. Professionalism in this case is defined as total dedication to one's job. Competing visions for what should be expected regarding work-life balance find outlets in the issue of professionalism. While younger workers tend to resent long hours, members of the older generation see this as a lack of professionalism, leading to further workplace clashes. But Berthold (2008) sees this as an opportunity to measure the worth of an employee by means other than the amount of hours that one works. As the baby boomer generation begins to drift into retirement and part time work hours, younger generations will find new ways to measure the worth of an employee based not strictly on hours worked but on quality of work done.

Yet older doctors may see a way of adjusting their opinions of younger doctors, as suggested by Prince (2009). As a result of the aging population of physicians, there is a growing shortage of younger physicians coming into the medical profession to take their place. Therefore, according to Prince (2009), the ability to recruit young physicians has become a significant issue

for older doctors on the recruiting boards of hospitals and medical centers. This is key to the success of any healthcare institution, be it academic or service-oriented, and recruiters must learn to understand the values of younger employees rather than dismiss them as lazy, entitled or having a lack of professional ethic.

Despite the millennial generation's inability to foster self-reliance (Borges, Manuel, Elam, & Jones, 2006), it is still important to understand the organizational and institutional questions as they relate to these changing demographics and institutions. As stated in the introduction to this section, the nature of institutions can often be a determining factor for how experience is structured. Work-life balance is itself an evolving concept, and this study seeks to understand how this concept has changed and is adapting to the new material conditions of production in the medical sector. The nature of institutional organization and the inter-generational norms that structure the professional lives of both males and females have the potential to widely affect the areas of life that stretch beyond the workplace, such as personal life and domestic life. This is one of the signal issues that are trying to be understood in this study.

Work-Life Balance and the Dangers of Burnout

To further understand the problems regarding work-life balance for female physicians, one must also understand the grueling nature of the medical profession itself. As the review of the present literature demonstrates below, burnout is a significant issue for physicians who are struggling to balance between domestic and professional needs. Burnout is also a significant problem that affects personal relationships and can drastically alter the structure of the work-life balance for physicians working around the world today. Although the present study focuses on

female physicians working within the southeastern area of the United States, this review will examine literature reflecting the nature of burnout worldwide.

To date, no study of burnout has taken the nature of flexible work arrangements into account. While flexible work arrangements and the advantages of technological advances such as telecommuting may be seen by some as a solution to the problem of burnout (Bélanger, Watson-Manheim, & Swan, 2013), there are others who note that the problem of burnout is not something that can be solved or ameliorated by such practices, as if placing a bandage on a wound. Burnout is itself a structural phenomenon that deserves analysis at the institutional level, and will most likely see a solution at the basic and fundamental structure of the institutions in question (Shanafelt, et al., 2012).

The medical profession in the United States creates a work environment that predisposes employees to so-called *burnout*, which Ariely and Lanier (2015) defined as a dysfunctional impairment that includes emotional exhaustion, loss of empathy, cynicism and general dissatisfaction. Burnout can lead to a decline in the personal, psychological and physical well being of contemporary physicians in the United States. Ariely and Lanier (2015) note that the trend towards burnout are consistent with other studies in the field of United States medical sociology, and that burnout is indeed a problem that needs to be addressed if one is to understand the nature of work-life balance for female physicians working in the United States. While burnout is common in many other fields, Ariely and Lanier (2015) point to the overall prevalence in their particular field of study, which is medical sociology. Such trends point to the notion that it is not necessarily the nature of the professional environment but the nature of the profession itself, the actual work being carried out by physicians, rather than the institutions that they inhabit. Medicine is a practice that is known to cause psychological trauma and stress, as is any

field that deals with life and death issues. But burnout in this case is even more dangerous as physicians who suffer from it may increase their chances of doing damage to their patients. This is certainly an issue affecting work-life balance and one that needs to be addressed in order to understand the problems facing those who practice medicine today (Ariely & Lanier, 2015).

Burnout is far more likely to occur in physicians than those in any other professions (Shanafelt, Boone, Tan, Dyrbye, Sotile, Satele et. al., 2012). In the study by Shanafelt, forty-five percent of physicians reported at least one symptom of burnout, and the highest rates of burnout among physicians was at the front of line care access, such as family medicine, general internal medicine and emergency medicine. Compared with a probability survey of US adults in other professions, physicians were more likely to have symptoms of burnout and to be dissatisfied with work-life balance (Shanafelt, Boone, Tan, Dyrbye, Sotile, Satele, & Oreskovich, 2012).

According to Shanafelt et al. (2012), the consequences of burnout can lead to disastrous effects for the work-life balance. The rate of burnout reported within the US medical profession indicates that it is a significant effect of this specific industry. The nature of burnout is such that it is bound to affect not only the professional life but also the personal life of the employee in question. Shanafelt et al.'s (2012) comparative study of the rate of burnout is indeed significant for an understanding of the nature of work-life balance in female physicians. Work-life balance is crucial to determining the success of a particular profession, and success in the medical industry is perhaps more significant and crucial than in other sectors, due to the nature of the work. Employees who suffer from a negative work-life balance are more likely to suffer from symptoms like burnout and therefore are more susceptible to the tendency to lack concentration and to do harm to their patients. Therefore, as Shanfelt et al. (2012) make so clear, each aspect of this issue is interrelated and a single change in one aspect can affect all other aspects. In order to

reduce burnout in employees in the medical profession it is therefore imperative that the work-life balance is also improved, so that patients can receive the best care and return to health in a timely and efficient manner.

The cycle of stress due to burnout from a medical career does not adequately compare to workers in other professions. These problems are far more common in the medical profession (Nievas & Thaver, 2015). Despite this, graduate medical education (GME) does not usually offer services for its residents that include leisure activities. And like most issues surrounding stress, burnout can lead to family problems such as divorce, isolation and depression. Nievas and Thaver (2015) note that burn out is often an issue with leadership. Graduate medical education is the first port of call for those about to enter the medical profession Nievas and Thaver (2015) put forth the notion that burn out is not simply the fault of the professional bodies in the workplace but may be a significant problem with training. According to Nievas and Thaver (2015), leadership training and other recommendations for improvement are imperative for any understanding of the work-life balance and ways to improve it. Job satisfaction may be poor due to conditions within the specific medical institutions, rather than with the nature of the profession itself (Nievas & Thaver, 2015).

It is therefore necessary, according to Nievas and Thaver (2015), to look outside the dominant institutions in order to find solutions to the problem of work-life balance. Nievas and Thaver (2015) promote the idea that it is not necessarily the environment, but the nature of the employees themselves that could lead to burnout and the stress reactions so common to those who do not have a proper work-life balance. By locating the issue within the employees themselves, the authors note that any solution to the problem must be found by drilling within the personality of the worker and by locating the issue before such employees enter these

institutions. The remaining literature will show that such extra-institutional questions are important to understanding the work-life balance, and those institutional critiques like Acker's (1992) do not always hold the ideal solution to the problems in question.

The secondary literature shows that most remedies for work-life balance are indeed limited. Even at so-called home-based businesses, work-life balance is difficult to manage (Kapsai & Galloway, 2015). While the number of people who work from home is increasing along with the number of home-based businesses, the ostensible benefits of working from home may not provide the solutions that one assumes. Kapsai and Galloway's study (2015) found that few of the participants were able to achieve the ideal work-life balance that they sought after when they first created their home-based business. Rather than strike a good balance, the participants reported a blurring of the two distinct areas of life, which proved detrimental to the very concept of work-life balance. This blurring, rather improving balance, can often distort the necessary separation between the public and private spheres. While one consequence of improving work-life balance would be to decrease the amount of time spent at work and commuting to and from work, it is often deleterious when one tries to blend the two. According to Kapsai and Galloway (2015), studies show that psychological health is improved by the separation of public and private spheres. Conflating work and life as they converge within the same domestic setting can often lead to other forms of conflict and frustration that are not simply eliminated by foregoing the office structure itself.

Calls to improve work-life balance with other adjustments, such as lowering the work week to four days rather than five, is not always successful either (Wadsworth & Facer, 2016). Wadsworth and Facer (2016) found that on average there were few significant difference by gender on work-life balance on the impact of scheduling a negotiation between the two. The study

also found that female employees demonstrated slightly more positive attitudes towards the four-day schedule, as did employees with children. Ultimately the study underscored the importance of engaging employees when making significant organizational changes. The implementation of alternative work-schedules is not only a matter of decision-making at the top but involve (2016) those who will be subject to the implementation as well. The four-day workweek can also place additional stress on employees by packing in more work into a shorter amount of time. Often work-life balance is affected negatively by allowing employees the extra day and as such a day is only a non-work day in name only. According to Wadsworth and Facer (2016), it is not uncommon for employees to work additional hours from home on their ostensible day off, which, in the case of female employees, is often combined with the gendered labor of domestic activities.

The notion of flexibility, while ostensibly focusing the critique on the intuitions themselves, implicitly shifts blame on the employee if he or she is unable to reach an ideal work-life balance and avoid burnout. The solutions analyzed by Wadsworth and Facer (2016) and Kapsai and Galloway (2015), point directly at the employee for finding a solution to the problem for which this study is attempting to find a solution. Any institutional critique which does not take into account the nature of the person being processed by such institutions is insufficient for understanding the proper nature of the problem of work-life balance, and yet studies like those mentioned above indicate that a strict change in the institutions themselves will not offer a solution to the problem of work-life balance.

It is not impossible to improve the work-life balance, as it has been done for physicians in Northern and Central European countries, whose doctors shared fewer reports of burnout and negative work-life balance than their counterparts in Southern and Western Europe (Fernandez-

Crehuet, Gimenez-Nadal, & Reyes Recio, 2016). Much of the existing literature on the subject shows that fewer individuals report difficulty in balancing work and so-called life in Northern countries. Fernandez-Crehuet, Gimenez-Nadal, and Reyes Recio (2016) attempted to contrast the working policies and cultural outlooks of the two sets of geographical areas, noting that it is not only the professional cultures at stake but the surrounding cultural norms that dictate how often one should work and what sort of dedication one should put into the amount of work one does. While Denmark, the Netherlands, Finland and Sweden have a higher value on the scale relative to Southern and Western European countries, it can be inferred that these countries do not simply differ in the cultures of work and professional life, but that the wider cultural significance of work-life balance bleeds in to professional organization.

The literature discussed in this section notes the tensions between critiques of individual employees and the responsibilities of the institutions within which such individuals work. Though the nature of flexibility and the promise of such techniques like reducing schedules or creating open work hours demonstrates the potential to produce burnout, the present study will take into account a broader definition of gender and work-life balance necessary to understand the true nature of the problem in question. The following sections will seek to understand the literature on gender in the workplace and highlight the particular challenges that female physicians face within such institutions.

Female Physicians and the Challenges of Work-Life Balance

One of the central presumptions of the present study is that gender plays a defining role in determining the work-life balance of employees in medical institutions. As Acker (1992) has shown, gender plays an important role in determining the value and structure of individual lives,

both professionally and personally. Acker's (1992) main question is not why females are excluded, but to what extent have overall institutional structures and the character of institutional areas been formed by and through gender. The following section will look at the concrete, quantitative studies that demonstrate the magnitude gender plays in determining the work-life balance and burnout rates of females within the medical profession.

As related to the topic of this study, the challenge of balancing work and life is especially difficult for females compared to males. Kwong, Chau, and Kawase (2014) evaluated the attitudes of Hong Kong surgeons, both female and male, with regards to work and personal life balance. In the study, conducted using a questionnaire designed by a Japanese surgeon, 142 female surgeons reported that home life and work were the first and second priorities for both females and males, although most female surgeons reported that they could not find enough time to satisfy the community activities or to rest. The study concluded that the number of female surgeons is increasing, and that the issues of work-life balance should be addressed to attract more talent to Hong Kong (Kwong, Chau, & Kawase, 2014).

These results are not simply specific to Hong Kong, but can be generalizable for female physicians around the globe. Academic medicine is an extremely precarious venue for those trying to maintain a healthy work-life balance, as academic culture looks down on those who seek a good balance (Strong, CeCastro, Sambuco, Stewart, Ubel, Griffith, & Jagasi, 2013). Multiple professional commitments must also be balanced with demands at home for those who work in academic medicine, as Strong et al. (2014) point out. Using a qualitative study, Strong et al. (2014) found that work-life balance is deemed a challenge by those who work in academic medicine, which is deeply rooted in the cultural structure of academia. Mentorship and interventions that aim to remove the stigma on the reliance of flexibility for those who desire a

better work-life balance could help lead to more satisfaction for physicians in academic clinics (Strong et al., 2014).

Organizational factors within academic medicine mean that female employees have to work harder in order to appear equal in their ability to their male colleagues. By using a comparative analysis of male and female faculty's family needs and the organizational climate within medical schools, Schollen, Bland, Finstand, & Taylor (2009) found that while the females and males were equally productive and worked similar hours, females were less likely to have spouses, and that they spent more time on average dedicating time to household tasks. Females reported more experiences with obstacles to career success and satisfaction. They also claimed to consider departure as a solution to these problems more often than men would. The unwritten rules, which this study found constitutes a bias against females, mean that on average females work harder in order to appear equal in ability to their male colleagues (Schollen, Bland, Finstand, & Taylor, 2009). The work-life factors are obstacles to females more than they are for males.

Studies like those conducted by Agarwal and Lenka (2015) further add to the conception that this is a global issue, irreducible to any local circumstances. Entrepreneurship is a global concept, and the work-life balance of working females across the developed world can be understood through this prism of entrepreneurship and competition. Through an analysis of the gendered family roles and responsibilities as they relate to the culture of the office, Agarwal and Lenka found that females need to gain more flexibility and control of their work and personal obligations, as the benefits of their participation in the workplace are extremely significant.

The workplace conditions of the medical profession are reported to be more strenuous compared to other environments, as Linzer et al. (2002) describe in their study of job satisfaction

for U.S. physicians. The study was drawn from the Physician Work Life Study, which the authors deemed nationally representative. Using a survey-weighted logistic regression, the study found that compared with male physicians, female physicians were more likely to report satisfaction with their specialty and with relationships with both patients and coworkers. In addition, pressure due to time and ambulatory settings was increased for females as opposed to males. Females had 1.6 times the odds of reporting burnout compared with men. Though, when with young children reported support from colleagues, their chance of burnout decreased by 40 percent (McMurray et. al., 2002).

Other studies support these assertions of the disadvantages of females. According to Kuhn (2008), females in academic medicine face more barriers on average than their male colleagues. A taskforce convened by the Society for Academic Emergency Medicine (SAEM) studied issues regarding females in academic emergency. The taskforce conducted a literature review and highlighted key data points regarding the issue of female equality in academic medicine. As a result, they made recommendations for individuals in four different leadership positions, including leadership of emergency medicine organizations, medical school deans, department chairs and individual female faculty members. Members of the taskforce regard career barriers as an important issue to be tackled using improvement methods for recruitment, retention, and advancement of females in academic emergency medicine (Kuhn, 2008).

The issues that involve gender imbalance for the amount of hours worked in a professional setting are often difficult to see, but as the studies reviewed in this section show, female employees are statistically more likely to suffer the effects of burnout and to have difficulty in balancing work and life. Although gender is an important factor for determining this in most industries, it is particularly acute in the medical profession. Female physicians are not in

their essence less adept to the work than males are, it is simply the institutional effects of gender structures playing themselves out amongst workers in the field. As Acker (1992) so aptly demonstrates, processes of interaction between individuals are institutionally bound, and gender provides a key through which to read the organization of these institutions. In the following section we will review the literature on the negative effects for females who are unable to balance their work-life ratio.

The Deleterious Effects of Female Work-Life Ratio

The literature on the present subject has established that the work-life balance is particularly precarious for physicians working in the medical profession. It is the nature of this profession that has caused instances in burnout for those who are unable to find adequate hours or work schedule in order to satisfy a healthy balance between work and life. This section of the literature review analyzes the particularly deleterious effects for females who have difficulty balancing the work-life ratio, which is a problem for both males and females but proves severely damaging for females who cannot find an adequate balance between professional commitments and so-called life commitments. Such damage can manifest itself in females being unable to advance professionally and to develop the personal relationship that add to quality of life and therefore help females support their professional ambitions.

Due to the difficulties in balancing work-life ratio, female physicians do not progress as quickly in academic medicine as compared with men who have found senior positions more easily, on average (Carr, Gunn, & Kaplan, 2015). Carr et al. (2015) investigated the reasons why females have not progressed as quickly in academic medicine as compared with males who have found senior positions. The study was designed to explore the gender climate in academic

medicine using a qualitative analysis of semi-structured telephone interviews. All the studies were conducted within the United States, and the authors identified themes regarding a perceived wide spectrum in gender climate, lack of equality in rank and leadership by gender, a lack of retention of females in academic medicine, lack of gender parity in compensation and disproportionate burdens for females. Interviewees described improvements in academic medicine for female physicians as modest. The finding of the study spoke to the need for more institutional oversight and systematic review by medical schools (Carr, Gunn, & Kaplan, 2015).

But an inability for females to advance also has consequences that stretch beyond the more official institutional aspects noted by Carr, Gunn, and Kaplan (2015). While there is a problem with a lack of gender equality, there are also the often unseen effects of such discriminations. As Gander, Briar, Garden, Purnell, and Woodward (2010) demonstrate in their study of fatigue in New Zealand junior doctors, females face more challenges to their energy levels and sleep patterns than male physicians. Gander et al. (2010) found that females were more likely to report sleep deprivation and trouble balancing the fatigue of work with life at home. This qualitative analysis demonstrated that both men and females share a desire to improve their work-life balance with regard to the demands that parenthood puts on junior doctors, who are usually of childbearing age. In short, the reduction of duty hours alone is not sufficient to manage fatigue risk and help junior doctors improve work-life balance.

The nature of burnout described by Ariely and Lanier (2015) fall under the subsequent effects of gender discrimination that Gander et al. (2010) describe in their qualitative analysis. The lack of energy that overworked females find as a result of their additional domestic labor tasks is a result of burnout that can lead to emotional exhaustion, loss of empathy, cynicism and general dissatisfaction. It is not as easy for females to overcome the challenges that their often

unseen labor, namely the added demands of domestic labor, which are not as substantive as the demands placed on males, therefore piling on additional psychological challenges to female physicians (Gander et al., 2010).

Coulston, Vollmer-Conna, and Malhi (2012) conducted a study that explored the high rates of male surgeons as opposed to females in the profession. The study used the notion of personality as it related to female physicians entering the field of surgery. While fewer female doctors become surgeons than male doctors, there seems to be an unspoken consensus regarding the type of personality required to perform the job successfully. Coulston, Vollmer-Conna and Malhi (2012) issued a survey questionnaire to 580 second year medical students in Australia, finding that fewer females than males considered surgery highly likely as a career. While females interested in survey scored higher in neuroticism and agreeableness, they also placed importance on the ability to help people, while males interested in surgery tended to place their priority on prestige and financial reward (Coulston, Vollmer-Conna, & Malhi, 2012).

The cost to institutions is also worth noting. The cost of nurse turnover for institutions is a highly negative factor and a managerial challenge that can lead to inefficiency. Waldman, Kelly, Aurora and Smith (2004) recommended offering nurses a staying bonus to combat turnover rates. Their study was designed to review turnover costs at a major medical center in order to help healthcare managers gain insights about the managerial challenge, which can be aided with better organizational effectiveness. In order to minimize costs of turnover the analysts found that it was best to reduce the turnover of nurses, which is a significant cost to institutions. Over one fourth of the total turnover cost was due to nurse turnover, which is substantially higher than the relatively low turnover of physicians, which hovers at around 9 percent. A staying bonus equal to 86 percent of his or her annual salary can widely improve incentives for nurses. Such managerial

approaches could not only reduce turnover cost but improve individual issues and approaches within the professional environment (Waldman, Kelly, Aurora, & Smith, 2004).

One of the other difficulties face in the workplace is the problem of perceived respect. Females often feel invisible and find difficulty receiving tenure track positions in academic environments. This is due to institutions not recognizing the competing factors of work and family for females (Andrews, 2008). Male dominated professions do not recognize that females have certain needs that cannot be met with the demand and workload that they are given in the medical profession. According to Andrews (2008), these institutions do not recognize that females have two sets of demands from both home and work. The pattern of males receiving tenure at a faster rate than females is a pattern that will repeat itself, according to Andrews (2008). Andrews suggested that the culture at these institutions should change in order to value collaboration and teamwork, as well as to help promote females and their work in academic medicine.

Academic tenure is on average more difficult to achieve in academic medicine than for other academic fields (Geraci & Thigpen, 2017). Clinician educators are now required to input a significant amount of additional time and effort in order to achieve tenure, which was once not a matter of prestige but simply a matter of course, meant to preserve academic freedom. But Geraci and Thigpen (2017) found that institutions have to balance their own financial risks as well as the demands of faculty members, while still maintaining leadership opportunities for individuals within academic institutions.

The possible measures in order to better the work-life balance in academic medical facilities have some consequences for the nature of academic advancement. Fox, Schwartz and Hart (2006) conducted a study which revealed a significant split in the gender of those who tend

to advance among part-time faculty. While many females select part-time faculty status in order to help them balance childcare, men often choose part-time to moonlight. It is more often the case that females will request tenure rollbacks in order to undertake childcare, meaning that full-time men are more likely to be on the tenure track than females. The study proposes that a protracted tenure track is needed to support family friendly culture and help female physicians receive the flexibility they need to balance work and home life (Fox, Schwartz, & Hart, 2006).

The authors of another study propose a similar method for improving the retention problems for primary caregivers. Hackman and Oldham (1980) conducted a study that investigated the ways that institutions should offer flexibility for their employees to choose alternative work schedules if needed in the future. Such alternative work schedules will help improve recruitment rates by helping physicians balance their work and home lives in a way so as to improve performance and satisfaction in both. Additionally, the report recommends that hospitals and institutions provide educational assistance for spouses or children of employees. The authors also recommend providing resources for child or elder care for dependents (Hackman & Oldham, 1980).

In light of the growing shortage of physicians nationwide, Degen and Angerer (2015) noted that high rates of attrition are a direct consequence of work-family conflicts not being adequately managed. The researchers synthesized seventeen studies from five countries regarding physicians who have or intend to leave their profession. The authors concluded that gender differences were identified in several risk clusters, and factors like long working hours and work-family conflict were relevant for females' intention to leave (Degen & Angerer, 2015). Healthcare managers and policy makers should improve physicians' working hours and conditions to prevent high rates of attrition, according to Degen and Angerer (2015).

But home life that female physicians have to balance is not necessarily restricted to domestic labor. Businesses across the United States have failed to acknowledge the demographic shift and change the work-life expectations for those dealing with an aging population. As more members of the boomer generation have to take care of aging parents the work-life balance should shift (Krooks, 2013). Krooks (2013) unpacks the causes and consequences of such demographic shifts by noting how businesses have failed to adapt by re-jigging the usual expectation of work-life balance for employees. Telecommuting technologies or the modification of start-stop times for workers are two possibilities for adapting to this changing situation. Hourly employees could also benefit from predictable scheduling rather than revised 'just-in-time' schedule techniques, which often result in absenteeism and high turnover (Krooks, 2013).

As we have seen in the present section of the literature review, factors beyond the narrow institutional concerns of gender discrimination in hospitals and academic medical institutions have a more negative effect on females than they do on males. Females are statistically more likely to suffer from the symptoms of burnout (Gander et al., 2010) and to have the additional levels of stress added to their already demanding medical workload through domestic labor and the unseen factor of caring for children and elderly parents (Hackman & Oldham, 1980).

The Efficacy of Flexible Work Schedules

Technological changes, as well as the drastic need for relief in certain sectors of the Western economy, have provided solutions to improve the work-life balance of laborers. This is true for those in the medical professional as well as those in other white-collar industries. Solutions such as telecommuting, or altering work schedules, have provided workers with an

increased amount of flexibility in the contemporary world. The following section will address the question of flexibility as a possible solution to the issue of work-life balance.

Female employee attrition is not a matter of simply controlling lifestyle trends, but must find its solution within the organization of institutions. This is to say that it is only partly the personal responsibility of female physicians to organize their time well enough—institutions must allow the best conditions to help them make the most of their time. Dorsey, Jarjoura and Rutecki (2003) set out to determine to what degree lifestyle characteristics, especially those that are controllable, effect the career decision made by graduating U.S. medical students. The study was designed using research from the National Resident Matching Program, the San Francisco Matching Program and the American Urological Association Matching Program from 1996 to 2002. Using log-linear models to develop and examine specialty preference and the specialty's controllability, Dorsey, Jarjoura and Rutecki (2003) found that US medical students' specialty preferences changed significantly from 1996 to 2002. The perfection of controllable lifestyle can account for a majority of the variability in the changing patterns in the career specialty choices for graduating medical students in the United States.

Flexibility is certainly a possible remedy for balancing work-family conflicts, according to Allen, Johnson, Kiburz and Shockley (2013). Allen et. al. conducted a meta-analysis in order to illuminate the nature of the relationship between flexible work arrangements and work-family conflict. In order to do this, the authors deconstruct the flexibility construct, finding that the direction of work-family conflict—including work interference with family and family interference with work—as well as the form of flexibility—including flextime vs. flexplace; use vs. availability—made a significant difference in overall effects on individual work and family roles.

It is uncontroversial that a good work-life balance is considered beneficial to employers and to employees. Almalki, FitzGerald and Clark (2012) unpack the notion of quality of work life (QWL), which has been found to influence the amount of commitment that healthcare professionals have to their jobs. The authors closely parsed the factors that influence the relationship between QWL and turnover intention of primary health care (PHC) nurses in Saudi Arabia by using a cross-sectional survey, and ultimately concluded that creating and maintaining a work-life balance that primary health care nurses can abide is key to reducing turnover by improving work satisfaction. In addition, productivity levels may be enhanced and the outcomes of nursing care could potentially improve as well (Almalki, FitzGerald, & Clark, 2012).

One possible solution to the problem of female work-life balance could be found in the flexible work schedule adjusted for so-called “mommy tenure track” (Drazin, 2004). Many females have difficulty balancing work and family obligations, and junior-level faculty have the most difficult task of maintaining high productivity in their professional setting while raising children. Drazin (2004) focused on the ways in which academic settings and professional institutions can accommodate female professionals while providing generous amounts of work-life balance for those rearing children. The author suggested the implementation of a so-called “mommy tenure track” system in which mothers and caregivers of infants can temporarily postpone their tenure clock.

It is not only female physicians who aim to work less. Norman and Hall (2014) found that there are several factors which predict hospital-based doctors desire to work less, yet the average rates of success in implementing that change are various. Though a survey of Australian doctors, the Norman and Hall (2014) determined that forty-eight percent of doctors preferred to reduce their hours. Most of the doctors who wished to do so were female doctors who worked

forty hours a week. Only thirty-two percent of doctors who wanted to reduce their working hours successfully managed to do so, and many of the doctors who did manage to successfully reduce their hours were older, female and worked more than forty hours per week. Norman and Hall (2014) also found that those who most wanted to reduce their hours were on a U-curve, with younger and older doctors more likely to state their preference.

The modern ideology of females “having it all” is certainly possible, according to Verlander (2004). Verlander focuses on ways to help female medical employees strike the correct balance between work and home life. Verlander’s study touches on issues such as childcare, breastfeeding, maternity leave, pregnancy and choice of specialty. With the number of female medical students and practitioners increasing, the study notes the urgency with which the medical profession should deal with these questions. Also relevant is the increasingly prevalent notion that female physicians should ‘have it all’, namely that they should be able to live fulfilled lives as mothers while balancing a taxing career (Verlander, 2004).

Villablanca, Beckett, Nettiksimmons, & Howell (2011) suggest that the so-called “leaky pipe” phenomenon can be managed by increasing family-friendly policies and institutions. According to Villablanca, Beckett, Nettiksimmons and Howell (2011). This challenge can only be met by balancing life course events with career trajectory. The study, conducted by a survey for UCD’s Schools of Medicine and Veterinary Medicine and College of Biological Science, found that females were more likely to be childless. Documented use of family-friendly policies was low, as was awareness of policies, and both were higher for females than for males. Such policies demonstrate the interest and need of family friendly policies for increase career satisfaction, which is especially important for females in the biomedical sciences.

Jahn (2015) found that, relative to men, females who work as independent agency contractors were more satisfied than permanent employees, as the flexibility of work arrangements allowed females to combine family responsibilities with labor force participation. Though, Jahn (2015) also found that job insecurity is a factor in lowering job satisfaction for both males and females. The paper questions the assumptions that flexible labor is an inherently negative characteristic and leads to low job satisfaction. While contractual agreements differ from workplace to workplace, lower regulations do not necessarily affect all workers negatively.

Management groups perceived few differences in perceptions and benefits of flexible arrangements, but interaction with patients or the immediacy of tasks being performed were potential barriers for managers (Mercer, Russell, & Arnold, 2014). Fifty-two physicians, who were asked about the work-life balance at their large medical centers by Mercer, Russell and Arnold (2014) illustrated how qualitatively driven mixed method design can illustrate differences between stratified groups, such as the four career tracks interviewed here, which included Clinician-Educator, Clinician-Researcher, Clinician-Practitioner and residents. Ultimately, the study found that females and some low-status males did not adequately express strategies in order to successfully negotiate the field of academic medicine within this specific institution.

Lack of flexible work hours can be detrimental to more than just female physicians work hours, but to the larger diversity of the workplace itself. Michielsens, Bingham and Clarke (2013) evaluated the role of flexible work arrangements at play in diversity policies, noting what kinds of barriers to diversity policy these arrangements may or may not impose. A qualitative case study in four large multinational service companies was conducted, and data was collected through interviews and questionnaire given to line managers and senior managers. The findings showed that flexible work arrangements are constrained by management concerns about client

interaction and other organizational imperatives (Michielsens, Bingham, & Clarke, 2013). The study finds that flexible work arrangements are not able to be put in use as a means to greater diversity. Company discourse, often subject to a strictly business focus, highlights the shortcomings of relying upon flexible work arrangements to bring about a changed climate for diversity. The diversity of the workplace is similarly related to the overall health and psychological makeup of the employees at the institution in question.

The health of the institution is always related to the psychological makeup of the institution's employees. Flexible work arrangements can also have an influence on a doctor's psychological health, according to Timms, Brough, O'Driscoll, Kalliath, Siu, Sit and Lo (2015). Timms et. al. (2015) examined the nature of flexible work arrangements, which are often invoked by companies in order to demonstrate organizational sensitivity to difficult interfaces between employees' home and work-life balance. While Timms et. al. expected to find that supportive aspects of organizational culture would increase in tandem with the use of flexible work agreements; the research identified a negative relationship between the use of such arrangements and work engagement over time. The use of flexible work arrangements, according to Timms et al. (2015) is dependent on workplace and cultural norms.

Proposed Solutions to the Work-Life Balance Problem

The studies cited in this literature review note that work-life balance is a problem for those working the medical profession. Aside from Flexible work arrangements, other studies have sought to determine an ideal solution to the problem of maintaining an advantageous work-life balance. These studies will be examined as to how they relate to the problem posed in the

present study, namely the nature of the work-life balance, and how flexible work hours may influence the intention of female physicians at academic medical centers.

The ideology of females “having it all” is reexamined by Ezeedeen and Richey (2009). Ezeedeen and Richey (2009) explored the coping strategies devices by executive females in family relationships in order to maintain an ideal work-life balance while continuing to perform highly at work and advance one’s career. The authors employed a qualitative methodology in which 25 executive females explored career advancement and work-life balance strategies. In conclusion, the analysis of the survey demonstrated that multiple career advancement and career/family balance strategies, including personal support, value system and life course strategies could be used to negotiate support from their spouse and help order the priorities between career and family needs (Ezeedeen & Richey, 2009).

Broader changes in the industry, as evidenced by McGrath, Gay, Salem, Abrahams and Alderman’s (2011) study of the plastic surgery subfield of the medical industry show, are changing the coping strategies and expectations for physicians of both genders. McGrath et. al. took on a question regarding the change in demographics for those entering the field of professional plastic surgery, such as the greater proportion of females and young physicians entering the field. This new demographic creates challenges for work-life balance. In order to assess this changing field the authors of the study sent a self-administered survey to a random sample of American Society of Plastic Surgeons. The survey found that three quarters of the respondents were satisfied with their career, yet only half were satisfied with their time-management between career and personal responsibilities. Females were more likely to be dissatisfied with their work-life balance than males, as well as those who work more than sixty

hours a week, those who have emergency room call responsibilities, and those who have a primarily reconstructive practice (McGrath et. al, 2011).

Different types of training, which improve leadership roles, could also help work-life balance. There is a critical need for preparing healthcare professionals for health system leadership roles. Musick, Harrington, Whicker and DeHart (2013) analyzed the impact of a physician leadership training program involving one hundred and two participants over a five-year period. The Physician Leadership Academy had its participants complete an online, sixteen item anonymous survey. The results of the survey found that eighty percent of all respondents agreed that participation in the PLA was worthwhile, and that it helped improve self-confidence, leadership abilities, and decision-making abilities. The aspects of the program that focused on financial management and teamwork were especially lauded (Musick, Harrington, Whicker, & DeHart, 2013).

Telecommunications and Telecommuting as a Solution

Many studies focus on the flexible practices engendered by telecommuting, which allows employees to work from home or to maintain a flexible work schedule that can be constructed around other personal needs, such as domestic labor. Bélanger, Watson-Manheim and Swan (2013) studied the literature on telecommuting, as it has grown in the past decade it has also shown contradictory results regarding its effect on transportation, management, psychology and information systems. Bélanger, Watson-Manheim and Swan (2013) found that this is due to a conceptualization issue, which needs to be addressed in order to improve the telecommuting research model. In short, telecommuting is both a context and an aspect of work, both a multi-level concept and a time-dependent concept. This means that any study of telecommuting will

have to see it as the condition of labor, rather than its content. Work-life balance cannot simply be managed through organizational means.

This notion of telecommuting as the condition of labor is expanded by Kim (2017). While the practice known as telecommuting is often regarded as a travel-demand management strategy, Kim (2017) challenges the narrative that telecommuting reduces travel by taking into account aspects of household travel other than the telecommuter's commute. Rather, Kim (2017) proposes an alternative to estimating the impact of telecommuting on total household travel other than by the sole datum of the actual commute travel. The author stratified two-bit regression analyses show that even without a commute, workers who telecommute are induced to significant travel. The study finds that the benefits of telecommuting are significantly less than anticipated. The stated environmental policy goals are thus nullified (Kim, 2017).

The studies regarding telecommunications are not indicative of how female physicians at academic medical centers are influenced. The present study seeks to expand on this literature by assessing the perceptions of work-life balance as they relate to the expansions of telecommunications technology as well as telecommuting as a practice. The present study will hope to address the gap in research regarding how quality of life and demographic factors influence female physicians as they assess the number of flexible work scheduling programs, such as telecommuting.

Mentoring as a Strategy for Improving Work-Life Balance

While telecommuting and organizational issues are one strategy for improving work-life balance, some studies imply that better mentoring strategies could improve work-life balance. DeFilippis, Cowell, Rufin and Kang (2016) describe solutions to improve mentorship

opportunities for female medical students, taking as its example a program for mentoring female at Will Cornell Medical College. The program aimed to facilitate and institutional need and improve relationship between female medical students and doctors. DeFilippis, Cowell, Rufin and Kang (2016) found that over seventy-one percent of the participants ranked the program as four or five out of five stars. Additionally, seventy-seven percent felt that the program provided opportunities for mentoring, and eighty-two percent felt that it filled an institutional need. The program aims to facilitate relationships between female medical students and doctors.

The question of mentoring could be used in order to place the generational gap outlined above into proper perspective. While the present study seeks to identify the nature of the work-life balance in order to help propose solutions, mentorship provides an opportunity to improve that balance by uniting the disparate groups and expectations within medical communities. Female medical students and doctors are in need of an improvement of relationships, according to DeFilippis, Cowell, Rufin and Kang (2016). The question concerning work-life balance will be answered in the next section, but the studies regarding mentoring will seek to fill the gaps in the research by focusing on the question of workplace demographics and intergenerational dynamics.

Argument for Quantitative Non-Experimental Correlational Study

According to Creswell (2013), the results of a quantitative study are numerical, and can therefore be analyzed statistically to answer the hypotheses of a study. Quantitative researchers aim to discover the objective truth even though there may be multiple interpretations of survey question, and according to Hopkins (2008) the quantitative methodology is suitable for assessing relationship or differences among variables instead of the qualitative research method. For

instance, Mercer, McSorely and Schultz (2016) illustrate how qualitatively driven mixed method design can illustrate differences between stratified groups.

Much of the literature cited in the previous sections of this chapter is qualitative. While qualitative studies focus on the examination of an individual or group of people's experiences (Sinkovics and Alfondi, 2012), a quantitative study will be able to take these accounts and put them into better perspective. According to Barrat, Choi and Li (2011), the increase in qualitative studies in operations management has led to an inability to find consistency in the manner in which the case method has been applied.

Additionally, correlational research design deals with the determination of relationship between variables (Cohen, Manion, & Morrison, 2013). Rottman and Hastie (2014) show that the causal network relies on normative calculations. They found that when normative calculations imply a decrease, judgments tend to go down. And yet, two systematic differences appear, according to this report, namely that people's inferences violate the Markov assumption and that when people's inferences are consistent with the normative calculations they are not sensitive to the parameters and the structure of the network as they should be. In order to determine the relationship between variables, a correlational study is proven to be the most accurate and efficient way to find connections between disparate phenomena. By using a quantitative study, the present work will attempt to fill the gaps in much of the qualitative literature on the correlation between work-life satisfaction and intention to leave among female physicians.

Conclusion

There are increasing numbers of medical students, and the number of females who experience dissatisfaction is increasing (Coulston, Vollmer, Conna, & Malhi, 2012; DeFilippis, Cowell, Rufin, Sansone, & Kang, 2016). The present study aims to fill the significant gap in the research regarding how quality of life and factors affect females' decision to stay in work. In order to undertake this study, a quantitative non-experimental correlational study has been put to use in order to determine the relationship between quality of work life and intention to leave and between work-life balance and intention to leave among female physicians at academic medical centers in the southeastern area of the United States.

The experience of females in the workplace is well documented, as this review of the relevant literature shows. While there have been studies which compare the work-life balance of physicians in countries other than the United States (Fernandez-Crehuet, J. M., Gimenez-Nadal, J. I., & Reyes Recio, L. E., 2016), it is important to note for our purposes no study has taken seriously the nature of work-life balance for female physicians who are trying to enhance their relationship to both their professional and domestic environments. Enhancing the work-life balance is a strategy used by leaders to sustain the workforce and to increase employee stamina. Interest in issues relating to work-family balance has been primarily driven by the presumption that work-family balance provides a comprehensive solution to a wide range of challenges that societies face in the 21st century (Fernandez-Crehuet et al., 2016; Kapasi & Galloway, 2015). S

The literature review has revealed that several studies have established the importance of work-life balance for female employees in the white-collar workforce (Kwong, Chau, & Kawase, 2014; Shanafelt, Ran, Drybye, Sotile Satele, & Oreskovich, 2012; Strong, CeCastro, Sambuco, Stewart, Ubel, Griffith, & Jagsi, 2013; The literature review also provided examples of programs

designed to improve the flexibility of work-life balance in physicians lives (Ezzedeen, R., Richey, K., 2009; Allen, Johnson, Kiburz, & Shockley, 2013; Verlander, 2004; Dorsey, Jarjoura, & Rutecki, 2003). Schollen, Bland, Finstad & Taylor, 2009). Though the nature of the medical profession is rigorous and tough, and no thorough quantitative study of work-life balance as it relates to female physicians' decision to remain in the workforce has been conducted, means that the urgency of the present study should be clear.

As outlined in the first chapter, the purpose of this quantitative non-experimental correlational study is to examine the relationship between quality of work life as well as work-life balance with intention to leave among female physicians. While many qualitative and quantitative studies about the conditions of female labor within the medical profession, no previous study has been able to help organizations develop or enhance their work-life balance policies, especially those that are targeted to females who are committed to both their families as well as their professional growth. Employers can reestablish rules and policies for the effective management of the workplace, more specifically in the healthcare setting, where notions of effectiveness and efficiency are extremely important. As studies by Kiaya and Singe (2013) and Methot and LePine (2015) show, balancing multiple roles, especially for female physicians, should be considered a top priority when flexible work arrangements and continual education and trainings are made available.

A more comprehensive understanding of the nature of flexible work, more specifically in the case of female physicians, will determine if work-life balance is actually achieved and quality of work-life is maximized (Demerouti et al., 2014; Greenberg & Landry, 2013). While the previous literature has proven limited in assessing these issues, the present study will provide empirical evidence based on the experiences of female physicians who are involved in situations

that require them to juggle the demands of being a physician who both works in a professional setting as well as a domestic setting. The present work will provide insights as to how work-life balance and quality of work life is achieved or should be achieved. The results will contribute to growing literature about work-life balance with a specific focus on female physicians.

Chapter III will provide details of the method on how to achieve the purpose and address the gap established in this chapter

CHAPTER III

METHODOLOGY

The purpose of this quantitative non-experimental correlational study is two-fold. First, the purpose is to examine the relationship between quality of work life and work-life balance with intention to leave among female physicians at academic medical centers in the southeastern area of the United States. Second, the purpose is to identify whether flexible working arrangement and other demographic factors (age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan) influence the quality of work life and work-life balance of female physicians at academic medical centers in the southeastern area of the United States. The independent variables are quality of work life, work-life balance, flexible working arrangement, and the aforementioned demographic factors while the dependent variable is intention to leave. A validated survey consisting of three parts will be used to measure the study variables. The demographic part of the study will consist of questions regarding the demographic factors, perceptions of work-life balance, and the presence of flexible working arrangement. The second part will consist of questions derived and modified from Brooks' (2001) Quality of Work Life questionnaire to measure the quality of work life of female physicians. Lastly, the third part will consist of questions from the validated survey of Lu et al., (2005) which will measure the intention to leave of female physicians. Regression analysis will be conducted to determine the relationships between the variables using SPSS Version 24.

This chapter will discuss the proposed methodology. The discussion will include the rationale for the chosen research method and design, target population, sample and sampling procedures, and data collection methods. Instruments in collecting data, validity and reliability

of the instruments as well as the plan for the data analysis will be outlined. Ethical considerations and the summary of the key highlights of the proposed methodology will conclude the chapter.

Research Design and Rationale

A quantitative non-experimental correlational study will be utilized for this study. The quantitative method is the empirical investigation of the research question using scientific methods. The results gathered are numerical, and therefore, can be analyzed statistically to answer the hypothesis (Creswell, 2013). Quantitative researchers aim to discover the objective truth even though there may be multiple interpretations of the survey questions. According to Hopkins (2008), for this type of study in which the variable will be measured numerically and will be tested statistically, the quantitative research method is a suitable approach in assessing relationships or differences among variables instead of the qualitative research method. In short, a quantitative method provides the opportunity to conduct descriptive and inferential statistics needed to determine the relationship of quality of life and work-life balance on the retention of female physicians at academic medical centers.

In contrast, a qualitative method focuses on the examination of an individual's or group of people's experiences, perceptions, or opinions or human observations about a certain phenomenon (Sinkovics & Alfoldi, 2012). Qualitative studies provide a conceptual view of things and thus researchers are able to interpret perceptions, experiences, behaviors, and attitudes of subjects more accurately than quantitative studies (Ibanez-Gonzales, Mendenhall, & Norris, 2014). However, because of the accurateness in data interpretation, qualitative studies are more time consuming as compared to quantitative studies. Though a qualitative method has its own

strengths, it is not appropriate for the proposed study because a qualitative study is an inductive nature that does not require identifying variables and hypotheses beforehand, whereas a quantitative study is deductive nature that requires defining variables and hypotheses before conducting the research (Simon, 2011). A quantitative method allows its findings to be generalized to a larger population, whereas qualitative method only allows its findings to be contextualized on a specific case or phenomenon. Another method that could have been used is the mixed method—a combination of qualitative and quantitative methods that allows the researcher to explain data both subjectively and objectively (Yardley & Bishop, 2015). Though mixed methods combine both qualitative and quantitative methods, it is however not appropriate for the study as the study only involves testing hypothesis and not interpreting information gathered from observations or interviews (Yardley & Bishop, 2015).

A correlational research design deals with relationships between variables (Cohen, Manion, & Morrison, 2013). Correlational research considers the correlations between variables, using statistical tests to make meaningful statements about these correlational relationships, including statements of correlation, non-correlation, moderation, and mediation (Clarke & Collier, 2015). Although correlational designs do not have the ability to make statements of causation, some variables simply cannot be reasonably (or ethically) manipulated by a researcher. Non-experimental designs require significantly less work to implement than experimental designs, and statements of correlation are still meaningful results for policy and future research (Claydon, 2015).

Other research designs were considered but deemed inappropriate for the study. A casual comparative design is appropriate for both the determination of cause and effect relationships between study variables and groups (Nimon & Reio, 2011), which does not apply to this study.

An experimental design is not deemed appropriate because it requires certain variables to be controlled making the analysis of variables look like an artificial environment. The researcher of this study will not control any variables and would like to make the analysis in natural settings as possible. As such, this study will adhere to a quantitative non-experimental correlation research design and utilize the validated surveys to measure the study variables that will be subjected to regression analysis using SPSS Version 24.

Population, Sampling, and Sampling Procedures

The population for the study is the female physicians at academic medical centers. The sample frame includes female physicians at academic medical centers located in the southeastern area of the United States.

The selection of the sample for the study will be conducted using purposive sampling to ensure that only eligible and relevant participants will be included in the study (Haas, 2012; Suen, Huang, & Lee, 2014). According to Brus and Knotters (2013) and Robinson (2014), purposive sampling is a kind of sampling that ensures participants are within the parameters of the study and provides opportunity to select participants who can give richer information to be able to address the objective of the study (Brus & Knotters, 2013; Robinson, 2014).

The computed required sample size for the study was based on four factors: significance level, power of test, effect size, and statistical test to be used. The significance level refers to a type 1 error that indicates the probability of rejecting the null hypothesis given that it is true, which is usually set equal to $\alpha = .05$ (Jia & Lynn, 2015). The power of test refers to the probability of falsely rejecting a null hypothesis. A power of 80% is usually considered in quantitative studies as it is relatively high and at the same time keeps the sample size reasonable

(Rosner & Glynn, 2011). The effect size refers to the degree of the effect of relationships between the dependent and independent variables of the study (Heckmann, Gegg, Gegg, & Becht, 2014). Effect sizes are divided into three categories: small, medium, and large and for the study a medium effect size will followed. According to Haas (2012), a medium effect size strikes a balance between not being too lenient or too strict. Lastly, a linear multiple regression analysis is required to address the research question and hypothesis of the study. Considering a 0.05 significance level, 80% power of test, medium ($f^2=0.15$) effect size, and linear multiple regression analysis with at most 13 predictors, the resulting minimum sample size required for the study will be 131. The researcher will target 150 participants to account for the occurrences of missing data that will be excluded in the final analysis. The sample size for this study was calculated in G*Power (Faul, Erdfelder, Buchner, & Lang, 2013).

Procedures for Recruitment, Participation, and Data Collection

Participants will be randomly selected from a list obtained from the administrators of the medical centers. After receiving Central Michigan University IRB approval, the data collection will be done during a 45-day period from August 1 to mid-September 2017. Letters introducing the study and the requirements of participation will be distributed via email to physicians along with the survey link hosted through Research Electronic Data Capture (REDCap), an on line commercial survey service widely used in the academic community. Participants will be directed to a link to the anonymous survey generated from REDCap. The completed anonymous questionnaires will be submitted online. Sampling will be continued until a minimal goal of 150 participants is reached. The entire survey can be completed in 15-20 minutes. Reminder emails

will be sent to those who have not responded in two weeks. When the minimal sample size is reached, the web survey will be closed.

All data will be downloaded onto Microsoft Excel to be examined and properly coded for Statistical Package of the Social Sciences (SPSS Version 24.0). The survey information and results will be stored through a password protected private computer and flash drive, which can only be accessed by the researcher. Data and relevant analysis will be made available to the CMU dissertation committee upon request.

Instrumentation and Operationalization Constructs

The survey for this study will consist of three parts. The first part consists of questions that aim to collect the demographic data of the physicians as well as their work-life balance perceptions and presence of flexible working arrangements. The demographic data that will be collected include age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan.

The second part of the survey will consist of the modified questions from Brooks' Quality of Work Life Questionnaire developed originally for the nursing profession and a change of the use of 6-point Likert scale to a 5-point Likert scale. A 5-point Likert scale will be used for responses to questions on the survey instrument. The Cronbach's alpha coefficient of the original scale is 0.83. Factor analysis revealed structural validity. The scale consists of 4 subscales with Cronbach's alpha coefficient ranges from $r= 0.24$ to $r=0.68$ and correlation coefficients for each sub-dimension were between $r=0.50$ and 0.90 .

Intention to leave of female physicians will be measured by questions adapted from previous research by Lu et.al. (2005). Each item will have a 5-point Likert scale matching the scales used for the Quality of Life survey.

Data Analysis Plan

Descriptive and inferential statistical analyses will be conducted using the SPSS software Version 24.0. Descriptive statistics will be used to report the demographical data using frequencies and percentages. Inferential statistics will be used to address the hypotheses of the study using linear multiple regression analysis. The data set for the study will be screened so that no missing data will be included in the final data set. Participants with missing data will be excluded from further analysis. Pearson's correlation and Chi square analysis will be used to test for statistically significant relationships. Cross tabulation may be used to test relations between the categorical variables and minimize error.

The following research question along with three hypotheses will guide this study:

RQ: Is there a relationship between female academic medical center faculty intention to leave employment and work-life balance, quality of work life, and availability of flexible work schedules?

HO1₁: There is no statistical relationship between female academic medical center faculty intention to leave and their perception of quality of work life.

HO1_n: There is a statistical relationship between female academic medical center faculty intention to leave and their perception of quality of work life.

HO2₁: There is no statistical relationship between female academic medical center faculty intention to leave and their perception of work-life balance.

HO2_n: There is a statistical relationship between female academic medical center faculty intention to leave and their perception of work-life balance.

HO3₁: There is no statistical relationship between female academic medical center faculty intention to leave and the availability of flexible work schedules.

HO3_n: There is a statistical relationship between female academic medical center faculty intention to leave and the availability of flexible work schedules

In hypothesis 1, the independent variable is the perception of quality of work life while the dependent variable is intention to leave of female physicians. In hypothesis 2, the independent variable is the perception of work-life balance while the dependent variable is intention to leave of female physicians. In hypothesis 3 the independent variables are the presence of flexible working arrangements and demographic variables (age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan) and the dependent variable is the quality of work life and work-life balance of female physicians.

Ethical Procedures

Permission to conduct the study will be obtained from the Institutional Review Board (IRB) at Central Michigan University and the selected academic medical centers included in the study before any data commences. After receiving IRB approval and permission has been secured from all medical centers, eligible participants for the study will be provided a participant

letter. The letter will inform the participants of the objectives of the study, how the researcher plans to ensure confidentiality, withdrawal procedures and any possible risks for participation in this study. Consent will be implied with participation in the study and completion of the survey.

The retention period of all data whether in hard or soft copies will be five years starting from the submission of the final copy of this study. The participant may personally request the information they provided even after the analysis has been conducted. Only aggregate and statistical information of the data may be forwarded to other people seeking to further evaluate the raw data. All data files will be stored on a personal computer in which the researcher has sole access. The personal computer will reside in the researcher's office. All data files will be stored for five years and will be destroyed after that period.

Revision of Survey Instrument and Process

In the explanation provided above regarding the survey instrument, the proposal states that questions for this section of the questionnaire were to be modified from Brooks (2001) Quality of Nurses' Work Life to measure the quality of work life. Permission to use the Brooks Nurses Quality of Work Life questionnaire was not granted as the author felt that the survey was specifically designed for nurses and could not be successfully modified to serve as a measurement for female physicians. Since the validated study could not be used, the researcher developed a set of questions for the study based on the dimensions of quality of work life identified in previous studies of work-life quality (Lowenstein, Fernandez, & Crane 2007; Linn, Cope & Leake 1985). These common dimensions of work quality and work balance (Appendix A) along with others not listed, and intent to leave are noted in previous studies and often used in various combinations or varying terminology to identify or formulate questions for surveys

regarding the predictors of quality of work life and work-life balance. Also with permission of author Paul Spector (1997), questions from his validated job satisfaction survey were included since job satisfaction is a dimension of quality of work life (Appendix A). The newly developed quality of work-life questions were inserted into the study questionnaire. Five female physicians at an academic medical center took the survey and their input was used in finalizing the questions for the study questionnaire.

A change was made in the platform for delivery of the survey and collection of data. Because RedCap was only in use as a pilot at Central Michigan University, a change was made to use the secure confidential option of Survey Monkey (no IP addresses collected or identified) to deliver the survey and collect data. These two changes were the only revisions made to the initial methodology as stated in this chapter for the study.

Summary

The purpose of this quantitative non-experimental correlational study is two-fold. First, the purpose is to examine the relationship between quality of work life and intention to leave and between work-life balance and intention to leave among female physicians at academic medical centers in the southeastern region of the United States. Second, the purpose is to identify whether flexible working arrangements and other demographic factors (age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan) influence the quality of work life and work-life balance of female physicians at academic medical centers in the southeastern area of the United States. The independent

variables are quality of work life, work-life balance, flexible working arrangement and the aforementioned demographic factors while the dependent variable is intention to leave.

A validated survey consisting of three parts will be used to measure the study variables. The demographic part of the study will consist of questions regarding the demographic factors, perceptions of work-life balance and the presence of flexible working arrangements. The second part will consist of questions derived and modified from previous quality of life and work-life balance studies to measure the quality of work life and work-life balance of female physicians at academic medical centers. The third part will consist of questions adapted from previous studies on organizational balance and intent to leave by Lu et.al. (2005) that will measure the intention to leave of female physicians. Regression analysis will be conducted to determine the relationships between the variables using SPSS Version 24.0.

CHAPTER IV

RESULTS

The purpose of this quantitative non-experimental correlational study was two-fold. First, the study was set out to examine the relationship between quality of work life and intention to leave and between work-life balance and intention to leave among female physicians at academic medical centers in the southeastern United States. Second, the study was to identify whether flexible working arrangement and other demographic factors (age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan) influenced the quality of work life and work-life balance of female physicians at the three academic medical centers. The independent variables are quality of work life, work-life balance, flexible working arrangement, and the aforementioned demographic factors while the dependent variable is intention to leave. A survey questionnaire consisting of three parts will be used to measure the study variables. The demographic part of the study will consist of questions regarding the demographic factors, perceptions of work-life balance, and the presence of flexible working arrangement. The second part will consist of questions derived and adapted from previous studies on work quality and work balance for the questionnaire to measure the quality of work life and work-life balance of female physicians. Lastly, the third part will consist of questions adapted from the previous research of Lu et al. (2005) that will measure the intention to leave of female physicians. Regression analyses were conducted to determine the relationships between the variables using SPSS Version 24.

This chapter will discuss the results of the analyses and their implications. The descriptive statistics and the inferential statistics will both be discussed to answer research questions and if the research hypotheses are supported.

Research Question and Hypotheses

RQ: Is there a relationship between female academic medical center faculty intention to leave employment and work-life balance, quality of work life, and availability of flexible work schedules?

HO₁: There is no statistical relationship between female academic medical center faculty intention to leave and their perception of quality of work life.

HO_{1n}: There is a statistical relationship between female academic medical center faculty intention to leave and their perception of quality of work life.

HO₂: There is no statistical relationship between female academic medical center faculty intention to leave and their perception of work-life balance.

HO_{2n}: There is a statistical relationship between female academic medical center faculty intention to leave and their perception of work-life balance.

HO₃: There is no statistical relationship between female academic medical center faculty intention to leave and the availability of flexible work schedules.

HO_{3n}: There is a statistical relationship between female academic medical center faculty intention to leave and the availability of flexible work schedules.

Results

The survey was launched on the online platform Survey Monkey for data collection. There were a total of 146 respondents, and of the total respondents, 21 were missing significantly

data points. After eliminating the missing respondents from the final analysis, a total of 125 participants were included in the study. Of the 125 respondents, the average age was 42.57 with a standard deviation of 10.21. The youngest participant was 27 years old and the oldest participant was 73 years old at the time of study. The average years of experience for the participants were 9.62 with a standard deviation of 8.96. For the participants who reported hours worked weekly, the average was 52.57 with a standard deviation of 12.12. The mean of the number of children for the participants was 1.12 and the standard deviation was 1.07 (Table 1).

Table 1. Descriptive Statistics for Study Variables

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness
Age	124	27.0	73.0	42.573	10.2133	1.011
Years of experience	124	.5	43.0	9.617	8.9577	1.591
Hours worked weekly?	123	12	80	52.57	12.121	-.194
Number of children	125	1.00	3.00	1.1120	1.0659	.357
Valid N (list wise)	1					

For the responses in a categorical nature, frequencies and percentages were summarized in Tables 2, 3 and 4. The majority of the participants were White, and less than 15% of the participants were of other races including Black, Asian, and Hispanic (Table 2). Marital status (Table 3) is also significantly one-sided with the majority of the participants being married and about 15% unmarried. Table 4 summarizes the rank distribution of the participants. There were 43 (34.4%) associate professors, 52 (41.6%) assistant professors, 13 (10.4%) professors, and 8 (6.4%) instructors.

Table 2. Racial Background of the Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
White	107	85.6	86.3	86.3
Black	3	2.4	2.4	88.7
Hispanic	1	.8	.8	89.5
Asian	10	8.0	8.1	97.6

Table 2. Racial Background of the Participants (continued)

	Frequency	Percent	Valid Percent	Cumulative Percent
Other	3	2.4	2.4	100.0
Total	124	99.2	100.0	
Missing	1	.8		
Total	125	100.0		

Table 3. Marital Status of the Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Single	12	9.6	9.6	9.6
Married	106	84.8	84.8	94.4
Significant Other	5	4.0	4.0	98.4
Divorced	2	1.6	1.6	100.0
Total	125	100.0	100.0	

Table 4. Job Ranks for Participants

	Frequency	Percent	Valid Percent	Cumulative Percent
Associate Professor	43	34.4	37.1	37.1
Assistant Professor	52	41.6	44.8	81.9
Professor	13	10.4	11.2	93.1
Instructor	8	6.4	6.9	100.0
Total	116	92.8	100.0	
Missing	9	7.2		
Total	125	100.0		

Hypothesis 1 evaluated the relationship between quality of work life and the turnover intention. A Pearson's correlation was conducted to examine the potential relationship. Table 5 summarizes the results from the analysis, and based on those results ($r = -.585$, $p < .001$), there is a significant and negative correlation between the quality of work life and the turnover intention. The results indicate that the higher the perceived quality of work-life score, the less likely an individual is to think about leaving the position.

Table 5. Correlation between Quality of Work-Life and Turnover Intention

	QWL	Turnover
Pearson Correlation	1	-.585**
Sig. (2-tailed)		.000
N	116	113
Pearson Correlation	-.585**	1
Sig. (2-tailed)	.000	
N	113	120

** . Correlation is significant at the 0.01 level (2-tailed).

Hypothesis 2 evaluated the relationship between perceived work-life balance and the turnover intention. The Pearson’s correlation results show that there is a significant negative correlation between the perceived work-life balance and the turnover intention in the participants ($r=-.278, p=.003$). This indicates position (Table 6).

Table 6. Correlation between Work-Life and Intention to Turnover

	Work-life balance	Turnover
Pearson Correlation	1	-.278**
Sig. (2-tailed)		.003
N	119	115
Pearson Correlation	-.278**	1
Sig. (2-tailed)	.003	
N	115	120

** . Correlation is significant at the 0.01 level (2-tailed).

Hypothesis 3 discussed the relationships between the flexibility in the workplace and the turnover intentions. For this hypothesis, the turnover intention was examined in two ways – job change and leaving the field. Job change indicates leaving the current employment to seek employment elsewhere in the same field; whereas leaving the field indicates abandoning the field of medicine altogether and not practicing in the medical profession any longer. The determining factors were examined in two ways – whether the position was demanding (such as surgeons and

trauma-care doctors) or not, and whether flexibility of scheduling was made available in the workplace.

Tables 7, 9, 11, and 13 summarized the cross-tabulation between the four variables in this study; while tables 8, 10, 12 and 14 summarized the significance of the relationships between each pairs of variables. According to the data in the tables, there had been no significant relationship between the area of practice, the flexibility of scheduling and the intentions to turnover (both job change and leaving field). Therefore, hypothesis 3 was not supported, and the area of practice and availability of flexible scheduling were not related to the intentions for medical professionals' turnover intentions.

Table 7. Cross Tabulation between Area of Practice and Thoughts about Job Change

	What area of medicine do you practice?			Total
	Demanding	Non-Demanding		
Count	19	31		50
Expected Count	20.1	29.9		50.0
Count	20	27		47
Expected Count	18.9	28.1		47.0
Count	39	58		97
Expected Count	39.0	58.0		97.0

Table 8. Chi-Square Results for the Relationship between Area of Practice and Thoughts about Job Change

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.209 ^a	1	.648		
Continuity Correction ^b	.062	1	.803		
Likelihood Ratio	.209	1	.648		
Fisher's Exact Test				.683	.401
Linear-by-Linear Association	.207	1	.649		
N of Valid Cases	97				

Table 9. Cross Tabulation between Area of Practice and Thoughts about Leaving the Field

		What area of medicine do you practice?		Total
		Demanding	Non-Demanding	
Count		28	36	64
Expected Count		28.8	35.2	64.0
Count		22	25	47
Expected Count		21.2	25.8	47.0
Count		50	61	111
Expected Count		50.0	61.0	111.0

Table 10. Chi-Square Results for the Relationship between Area of Practice and Thoughts about Leaving the Field of Medicine

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.102 ^a	1	.749		
Continuity Correction ^b	.016	1	.899		
Likelihood Ratio	.102	1	.749		
Fisher's Exact Test				.847	.449
Linear-by-Linear Association	.101	1	.750		
N of Valid Cases	111				

Table 11. Cross Tabulation between Flexibility of Scheduling and Thoughts about Job Change

		Flex		Total
		Yes	No	
Count		26	24	50
Expected Count		28.9	21.1	50.0
Count		30	17	47
Expected Count		27.1	19.9	47.0
Count		56	41	97
Expected Count		56.0	41.0	97.0

Table 12. Chi-Square Results for the Relationship between Flexibility of Scheduling and Thoughts about Job Change

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.389	1	.239		
Continuity Correction ^b	.947	1	.331		
Likelihood Ratio	1.394	1	.238		

Table 12. Chi-Square Results for the Relationship between Flexibility of Scheduling and Thoughts about Job Change (continued)

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Fisher's Exact Test				.305	.165
Linear-by-Linear Association	1.375	1	.241		
N of Valid Cases	97				

Table 13. Cross Tabulation between Flexibility of Scheduling and Thoughts about Leaving the Field

	Flex		Total
	Yes	No	
Count	34	31	65
Expected Count	34.5	30.5	65.0
Count	25	21	46
Expected Count	24.5	21.5	46.0
Count	59	52	111
Expected Count	59.0	52.0	111.0

Table 14. Chi-Square Results for the Relationship between Availability of Flexible Scheduling and Thoughts about Leaving the Field of Medicine

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.045 ^a	1	.832		
Continuity Correction ^b	.000	1	.985		
Likelihood Ratio	.045	1	.832		
Fisher's Exact Test				.849	.493
Linear-by-Linear Association	.045	1	.833		
N of Valid Cases	111				

The only significant relationship shown in the results was between the flexibility of work and the hours worked weekly for participants. The negative correlation result indicated that the participants in this study worked less hours if their work offered and supported flexible scheduling.

Table 15. Correlation Matrix for Relationships between Flexible Scheduling and Background Variables

	Flex	Age	Years of experience	Hours worked weekly?	Children
Pearson Correlation	1	.060	.112	-.288**	.049
Sig. (2-tailed)		.511	.219	.001	.585
N	124	123	123	122	124
Pearson Correlation	.060	1	.842**	.046	-.317**
Sig. (2-tailed)	.511		.000	.613	.000
N	123	124	123	122	124
Pearson Correlation	.112	.842**	1	.078	-.276**
Sig. (2-tailed)	.219	.000		.391	.002
N	123	123	124	122	124
Pearson Correlation	-.288**	.046	.078	1	-.019
Sig. (2-tailed)	.001	.613	.391		.838
N	122	122	122	123	123
Pearson Correlation	.049	-.317**	-.276**	-.019	1
Sig. (2-tailed)	.585	.000	.002	.838	
N	124	124	124	123	125

** . Correlation is significant at the 0.01 level (2-tailed).

Table 16. Cross Tabulation for Relationship between Flexibility Scheduling and Race

	Race		Total
	White	Other	
Count	61	9	70
Expected Count	59.8	10.2	70.0
% within Flex	87.1%	12.9%	100.0%
% within Race	57.5%	50.0%	56.5%
% of Total	49.2%	7.3%	56.5%
Count	45	9	54
Expected Count	46.2	7.8	54.0
% within Flex	83.3%	16.7%	100.0%
% within Race	42.5%	50.0%	43.5%
% of Total	36.3%	7.3%	43.5%

Table 17. Chi-Square Table for Relationship between Flexibility Scheduling and Race

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.357 ^a	1	.550		
Continuity Correction ^b	.116	1	.734		

Table 17. Chi-Square Table for Relationship between Flexibility Scheduling and Race
(continued)

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Likelihood Ratio	.354	1	.552		
Fisher's Exact Test				.612	.365
Linear-by-Linear Association	.354	1	.552		
N of Valid Cases	124				

Table 18. Cross Tabulation Table for Relationship between Flexibility Scheduling and Rank

	What is your rank / job position?				Total
	1.0	2.0	3.0	4.0	
Count	27	32	3	3	65
Expected Count	24.3	29.4	6.8	4.5	65.0
% within Flex	41.5%	49.2%	4.6%	4.6%	100.0%
% within Rank	62.8%	61.5%	25.0%	37.5%	56.5%
% of Total	23.5%	27.8%	2.6%	2.6%	56.5%
Count	16	20	9	5	50
Expected Count	18.7	22.6	5.2	3.5	50.0
% within Flex	32.0%	40.0%	18.0%	10.0%	100.0%
% within Rank	37.2%	38.5%	75.0%	62.5%	43.5%
% of Total	13.9%	17.4%	7.8%	4.3%	43.5%

Table 19. Chi-Square Table for Relationship between Flexibility Scheduling and Rank

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	7.250 ^a	3	.064
Likelihood Ratio	7.323	3	.062
Linear-by-Linear Association	4.300	1	.038
N of Valid Cases	115		

Table 20. Cross Tabulation Table for Relationship between Flexibility Scheduling and Marital Status

	Married		Total
	Yes	No	
Count	60	10	70
Expected Count	59.8	10.2	70.0
% within Flex	85.7%	14.3%	100.0%
% within Married	56.6%	55.6%	56.5%
% of Total	48.4%	8.1%	56.5%

Table 20. Cross Tabulation Table for Relationship between Flexibility Scheduling and Marital Status (continued)

	Married		Total
	Yes	No	
Count	46	8	54
Expected Count	46.2	7.8	54.0
% within Flex	85.2%	14.8%	100.0%
% within Married	43.4%	44.4%	43.5%
% of Total	37.1%	6.5%	43.5%

Table 21. Chi-Square Table for Relationship between Flexibility Scheduling and Marital Status

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)
Pearson Chi-Square	.007 ^a	1	.934		
Continuity Correction ^b	.000	1	1.000		
Likelihood Ratio	.007	1	.934		
Fisher's Exact Test				1.000	.566
Linear-by-Linear Association	.007	1	.934		
N of Valid Cases	124				

The correlation and the Chi-square analyses showed that there was also one pair of significant relationship between variables. Similar to the results concluded for research question 3, the only pair of significant relationship for this research question was between work-life balance and the hours worked weekly for participants. This also indicated that if an individual perceived high work-life balance, he/she was more likely to be working less hours per week.

Table 22. Correlation Matrix for the Relationship between Work-Life Balance and Background Variables

	Work-life balance	Age	Years of Experience	Hours worked weekly?	Childre n
Pearson Correlation	1	-.156	-.146	-.379**	-.138
Sig. (2-tailed)		.092	.114	.000	.136
N	119	118	118	118	119
Pearson Correlation	-.156	1	.842**	.046	-.317**
Sig. (2-tailed)	.092		.000	.613	.000
N	118	124	123	122	124

Table 22. Correlation Matrix for the Relationship between Work-Life Balance and Background Variables (continued)

	Work-life balance	Age	Years of Experience	Hours worked weekly?	Childre n
Pearson Correlation	-.146	.842**	1	.078	-.276**
Sig. (2-tailed)	.114	.000		.391	.002
N	118	123	124	122	124
Pearson Correlation	-.379**	.046	.078	1	-.019
Sig. (2-tailed)	.000	.613	.391		.838
N	118	122	122	123	123
Pearson Correlation	-.138	-.317**	-.276**	-.019	1
Sig. (2-tailed)	.136	.000	.002	.838	
N	119	124	124	123	125

** . Correlation is significant at the 0.01 level (2-tailed).

Table 23. Cross Tabulation Table for Relationship between Work-Life Balance and Race

	Race		Total
	White	Other	
Count	68	13	81
Expected Count	68.7	12.3	81.0
% within WLB	84.0%	16.0%	100.0%
% within Race	67.3%	72.2%	68.1%
% of Total	57.1%	10.9%	68.1%
Count	33	5	38
Expected Count	32.3	5.7	38.0
% within WLB	86.8%	13.2%	100.0%
% within Race	32.7%	27.8%	31.9%
% of Total	27.7%	4.2%	31.9%

Table 24. Chi-Square Table for Relationship between Work-Life Balance and Race

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.168 ^a	1	.681		
Continuity Correction ^b	.019	1	.892		
Likelihood Ratio	.172	1	.678		
Fisher's Exact Test				.789	.455
Linear-by-Linear Association	.167	1	.683		
N of Valid Cases	119				

Table 25. Cross Tabulation Table for Relationship between Work-Life Balance and Rank

	What is your rank / job position?				Total
	1.0	2.0	3.0	4.0	
Count	31	35	7	3	76
Expected Count	27.6	34.5	8.3	5.5	76.0
% within WLB	40.8%	46.1%	9.2%	3.9%	100.0%
% within Rank	77.5%	70.0%	58.3%	37.5%	69.1%
% of Total	28.2%	31.8%	6.4%	2.7%	69.1%
Count	9	15	5	5	34
Expected Count	12.4	15.5	3.7	2.5	34.0
% within WLB	26.5%	44.1%	14.7%	14.7%	100.0%
% within Rank	22.5%	30.0%	41.7%	62.5%	30.9%
% of Total	8.2%	13.6%	4.5%	4.5%	30.9%

Table 26. Chi-Square Table for Relationship between Work-Life Balance and Rank

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	5.733 ^a	3	.125
Likelihood Ratio	5.417	3	.144
Linear-by-Linear Association	5.290	1	.021
N of Valid Cases	110		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 2.47.

Table 27. Cross Tabulation Table for Relationship between Work-Life Balance and Marital Status

	Married		Total
	Yes	No	
Count	69	12	81
Expected Count	68.7	12.3	81.0
% within WLB	85.2%	14.8%	100.0%
% within Married	68.3%	66.7%	68.1%
% of Total	58.0%	10.1%	68.1%
Count	32	6	38
Expected Count	32.3	5.7	38.0
% within WLB	84.2%	15.8%	100.0%
% within Married	31.7%	33.3%	31.9%
% of Total	26.9%	5.0%	31.9%

Table 28. Chi-Square Table for Relationship between Work-Life Balance and Marital Status

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.019 ^a	1	.890		
Continuity Correction ^b	.000	1	1.000		
Likelihood Ratio	.019	1	.890		
Fisher's Exact Test				1.000	.545
Linear-by-Linear Association	.019	1	.890		
N of Valid Cases	119				

CHAPTER V

CONCLUSION

The problem guiding this study is that it is not known how quality of work life, work-life balance, and flexible work hours influence the intention of female physicians at academic medical centers (Mercer, McSorley, & Schultz, 2016; Strong et al., 2013). To help solve this problem, this quantitative non-experimental correlational study had a twofold purpose. First, it examined the relationships between the quality of work life or work-life balance and intention to leave and between work-life balance and intention to leave among female physicians at academic medical center in the southeastern United States. Second, the study sought to identify whether flexible working arrangement and other demographic factors including age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan influenced the quality of work life and work-life balance.

This research used a self-administered questionnaire delivered to participants via email with a link to the survey within the Survey Monkey platform. The survey instrument consisted of questions randomly delivered to respondents. The first part of the survey was a simple demographic questionnaire that sought to assess the relevant demographic as enumerated above. The second part of the survey used items developed from other research and input from pre-survey evaluations of five female physicians. This part of the instrument assessed quality of work life and work-life balance. Finally, the third part of the survey comprised a set of items adapted from previous research on organizational design and intent to leave by Lu et al. (2005), modified to be on a 5-point Likert scale. Together, the survey instrument measured demographic

factors, work-life quality, work-life balance, flexible working arrangements, and intention-to-leave of the female in the study.

The study was guided by one primary research question:

RQ: Is there a relationship between female academic medical center faculty intention to leave employment and work-life balance, quality of work life, and availability of flexible work schedules?

The analysis consisted of descriptive statistics, Pearson's correlation coefficient, and Chi-squared tests. Chapter IV consists of a detailed report on the analysis of these data. The study included data from 146 participants, but only 125 of these participants completed the entire survey and were included in the study. Descriptive statistics suggested that the females participating in the study were of the average age of 46, with nearly 10 years of experience and one child. The participants worked on an average of 56 hours per week, which is deemed to be high compared to the traditional 40-hour workweek.

In terms of correlation testing, the analyses provided results that were in support of the hypotheses for the research question. Both work-life balance and perceived quality of work life had statistically significant negative correlations with intentions to leave. Those who perceived a good work-life balance or who perceived themselves as having high work-life quality were less likely to have intention to leave the academic medical centers. With regard to flexible working arrangements, only two of the demographic variables included in the survey predicted either work-life quality or work-life balance. A participant's average weekly hours worked significantly and negatively predicted work-life balance. Of the demographic variables, only hours worked per week was meaningfully correlated with flexibility in terms of work schedule. The significance of these results, how they fit into the existing body of literature, and their

implications are discussed in the next section. Following that, limitations and caveats of the study can be made based on the results of this study.

Discussion and Implications of Results

This section is divided in accordance with the research question that guided the study. For the research question and each hypothesis, the results are considered and discussed in the context of the literature. Overall, the results of the study are relatively strong in terms of supporting the hypotheses and answering the research question.

Quality of Work-Life and Intention to Leave

Quality of work life is understandably one factor that the literature supports as predicting intention to leave (Krooks, 2013). Although the present study is merely correlational and cannot establish causation based on its results, there is a clear potential underlying causal relationship that may be understood here. When work-life quality is low, a person may grow dissatisfied with their position and therefore wish to leave it.

H01_n: There is a significant negative relationship between the perception of quality of work life and intention to leave of female physicians at academic medical centers in the southeastern area of the United States.

The predicted relationship was negative because work-life quality was measured on a positive scale; better work-life quality corresponded to a more positive score. Intention to leave was also measured on a positive scale; meaning participants who were more likely to quit would score higher. Therefore, the expected result that poor work-life quality would be correlated with an increased chance of intending to quit constituted a negative relationship between the relevant variables. This hypothesis was supported by the statistical analysis, which found a Pearson's $r=-$

0.585 at a significance level of $p=0.01$. Pearson's r is a value between -1 and 1 whose absolute value reflects on the strength of the relationship. The r -value found in this study represents a moderately strong relationship.

The expected result that poor work life quality would be correlated with an increased chance of intending to quit fits with the expectations set forth by the literature. Almalki, et al. (2012) found that in female workers, quality of work-life was a significant predictor of job commitment. By improving work-life quality, the researchers suggested that not only could commitment be increased, it also increased the related factors of job satisfaction and overall performance. Krooks (2013) also found that low work-life quality may drive females to leave their positions in the medical field. However, most researchers have not focused on work-life quality explicitly; instead, more research has focused on work-life balance. As a result, even with the conclusion that work-life quality negatively predicts a female's intention to leave being somewhat commonsense, this study contributes to a somewhat lightly researched area in the literature, providing further support that work-life quality in addition to work-life balance is a meaningful factor that can predict female's intention to leave academic medical centers.

Work-Life Balance and Intention to Leave

Work-life balance might arguably be considered an aspect of work-life quality. Regardless of this, the construct of work-life balance in particular has seen considerable attention in the literature as a predictor of a female's intention to leave (Strong et al., 2013). This issue affects both females and males, but may be more severe in the case of females for several reasons. Females may have more physical demands from the life side of the balance through the maternity process and be more likely to suffer from negative effects of a poor work-life balance

such as sleep deprivation (Gander et al., 2010). Second, the timeframe in which females complete medical school means that many females enter the medical profession just prior to or shortly after having had a child; relevantly, the female in the study had one child on average, and a majority was married. Thirdly, females are a continually increasing portion of the medical profession; as a result, the issue of work-life balance becomes increasingly relevant to them. While the traditional workweek is around 40 hours, the participants of this study worked an average of 56 hours a week, demonstrating why female medical workers may have more issues with work-life balance than individuals in many other professions.

Based on all of this, the following hypothesis was proposed for part two of the research question:

HO_{2n}: There is a significant negative relationship between the perception of work-life balance and intention to leave of female physicians at academic medical centers in the southeastern area of the United States.

As was the case with the first hypothesis, a negative relationship was expected because both work-life balance and intention to leave were measured as positive variables. Also, in addition to being supported by the literature, there was a commonsense justification for this expectation. Faced with a situation wherein work and life are being poorly balanced, leaving one's place of employment is generally an easier and more acceptable way of solving the problem than is abrogating one's familial responsibilities especially since other places of employment may potentially offer a better work-life balance. Again, as in the first research question, the statistical analysis supported this hypothesis. At a significance level of $p=0.01$, the Pearson correlation coefficient between work-life balance and intention to leave was $r= -.278$. As noted above, the Pearson coefficient indicates the strength of the relationship.

It is of interest that the correlation in this study was significantly weaker for work-life balance than for overall work-life quality. However, there is unquestionable support in the literature for this relationship. For example, Degen and Angerer (2015) suggested that the high rates of attrition found in practitioners of academic medicine are a direct consequence of poor work-life balance and a general poor management of conflicts between work and life. Ariely and Lanier (2015) also studied these issues and concluded that the relationship may be causal and mediated by burnout. Burnout can be defined as a dysfunctional impairment that includes emotional exhaustion, loss of empathy, cynicism and general dissatisfaction (Ariely & Lanier, 2015). Poor work-life balance, in this view, leads to burnout on the part of female academic physicians, which in turn leads them to be unable to cope with their job and have a higher intention to leave. The results of this study are in line with the literature, although the relatively low strength of the relationship is somewhat surprising.

Flexible Working Arrangements and Intention to Leave

Little is known about utilization of flexible working arrangements in the medical field, but the final hypothesis provides further insight into flexible work hours.

HO3_n: There is a statistical relationship between female academic medical center faculty intention to leave and the availability of flexible work scheduling.

Implicit in the quality of work life and work-life balance part of the research question is an assumption based in the literature that demographic factors on both the work and life sides of the work-life equation drive the work-life conflicts described in the existing research. The final part of the research question regarding flexible working arrangements seeks to test these assumptions by exploring a variety of demographic factors and how they serve to impact work-

life quality and work-life balance. In addition, no prior research has considered the potential impact of flexible working hours on work-life quality or work-life balance for practitioners of academic medicine, and therefore the ability to choose flexible working hours was included alongside demographic variables. The other demographics were: age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan.

Each of the above demographics was included in the study because it was either a basic demographic covariate (age, ethnicity, education, length of employment) or because it had at least some support in the literature. Hours worked per week was perhaps the most natural of the demographics to consider because it is a clear potential predictor of conflict between work and life. As the number of hours worked per week goes up, so does the percentage of available time used by work, prompting increased potential for conflict. Marital status is a basic demographic characteristic, but being married also creates a significantly higher potential for work-life conflict on account of marriage being an expansion of the life side of the issue and increasing the likelihood of children (DeFilippis et al., 2016). Children, in turn, are included as a potential predictor because more children could mean more domestic responsibilities and therefore an increase in the demands of life.

Similarly, caregiver responsibilities represent a non-traditional but increasingly prevalent source of domestic work as the current generation of older adults live longer and require more support from the younger generations, thereby increasing the amount of time required by life (Krooks, 2013). Job position, work schedule, tenure track, and career plan also are factors on the job side of the equation. These factors could potentially serve to worsen work-life conflicts by

increasing the demands of the work side. This is especially true given that tenure track in the field of academic medicine is notably slower than in other, comparable academic fields (Geraci & Thigpen, 2017) and that career plans may require meeting certain promotion goals which in turn require more work to earn promotions. Whether the relationship was positive or negative depended on the nature of the variable, but based on the literature increasing either the demands of work or life were expected to hurt both work-life balance and work-life quality.

Somewhat surprisingly, only two of the demographic variables emerged as significant: flexibility and weekly hours worked. In the case of weekly hours worked, the statistical analyses suggested that it was significantly and negatively correlated with both work-life balance and flexibility. Flexibility itself was only correlated with weekly hours worked and not work-life balance or work-life quality. This conflicts with the literature with regard to all the other demographic variables, as the literature contained as least some support—as well as commonsense support—for a host of factors that increase either workload or life-related responsibilities as being detrimental to work-life balance. However, the association between hours worked and work-life balance is both natural and well supported (Strong et al., 2013). Furthermore, as the results in this study were only univariate, it is possible that the data contains subtler effects of the other demographic factors that were not captured in the analysis; this possibility is discussed further in the limitations section below.

The lack of any meaningful results with regard to flexibility is somewhat disappointing. The results do suggest that those who have the chance to take flexible hours are more likely to work less hours a week, suggesting a potential indirect effect on work-life balance in a causal model, but this would be contingent on causality being both proved for the hours worked relationship to work-life balance and causality being proved in the case of flexibility and hours

worked. Overall, the results of the study fail to meaningfully extend the state of knowledge regarding flexibility of scheduling and its relationship on intent to leave or work life quality and balance in the field of academic medicine.

Implications

Along with the existing literature, the results of this study have implication for both theory and practical reality. This section discusses those implications and provides the foundation for the recommendations section. However, these implications must be carefully considered in light of the study's limitations so as not to overstate their relevance.

Implications for Theory

This study was theoretically grounded in gendering organization theory and work enrichment theory. Acker's (1992) Gendering Organization Theory, which defined gendered processes as the advantage and disadvantage, exploitation and control, action and emotion, meaning and identity, which are patterned through and in terms of a distinction between male and female, masculine and feminine. Given that this study focused on exploring the experiences of females in academic medicine, the study as a whole contributes to the gendered understanding of academic medical centers. The results from research questions three and four also cast some doubt on the current state of gendered understanding in this context. Based on the literature regarding females in academic medicine, or medicine in general, a host of demographic factors such as marital status, children, caregiver responsibilities, and tenure track were expected to influence work-life quality and balance. Not all of these factors are explicitly gendered, but many were described in the literature as being both relevant and having a specifically female dimension. Since only the factor of hours worked per week is not related to specific gender and

emerged as significant, the results suggest a challenge to the existing understanding of the role of these gendered factors. However, it is possible that these factors played a subtler role and therefore simply did not emerge clearly in the analysis.

The other half of the study's theoretical grounding was Work Enrichment Theory (Hackman & Oldham, 1980). The Work Enrichment Theory highlights the importance of both home and work, particularly the interdependence of each from one another. Based on this model, experiences at home impact work and vice versa (Hackman & Oldham, 1980). Therefore, the results of the study are partially in support of the theory; poor work-life balance or work-life quality was found to negatively influence whether or not a participant exhibited intention to leave. Of the factors considered in the analysis of research questions three and four, only a work-factor was able to predict work-life balance. This suggests that the appropriate home factors influencing work as suggested by the theory were not considered in this study, and raises the potential question of what other factors in the home lives of practitioners of academic medicine might have the same magnitude of effect on work-life balance as that seen from the number of hours worked.

Implications for Practice

The results of the study present a clear picture: those females who work long hours in academic medicine have worse work-life balance. In turn, those without worse work-life balance are more likely to quit. While this study cannot report a causal link, the results suggest that work-life quality and balance should be monitored as predictors of attrition. In academic medicine, attrition is both prevalent and costly due to the high amount of effort and expense that goes into training a replacement (Waldman et al., 2004). Thus, a poor quality of work-life or a

poor balance between work and life should be a cause for concern. Other researchers have suggested that the link is in fact one of causality; even if this is not the case, the results of this study suggests that understanding work-life balance and quality for females in academic medicine centers may allow the administration to focus on and better serve a population that is more likely than others to contribute to costly turnovers.

The relevance of perceived work-life quality is well supported in the literature, especially for female medical workers. Even as the number of females in medicine continues to increase, the number of those who are satisfied and perceive a good work-life quality is decreasing (Coulston et al., 2012; DeFilippis et al., 2016). The conclusion found in both the literature and this study suggesting that work-life quality is strongly related to commitment and/or to intention to leave suggests that the medical field may struggle going forward if this issue is not addressed. Research suggests that the problem is complicated in the case of females by the fact that they do not advance as easily as males (Carr et al., 2015). This problem may further confound the issue, as slow advancement means that females in academic medicine may have to work harder, further worsening their work-life quality and balance, in attempt to advance—but in turn, if there truly is the expected causal relationship between work-life quality/balance and intention to leave, these decreases in work-life quality and balance in turn worsen the female's probability of remaining in her position, much less advancing.

Limitations

The results of this study were limited in several regards. Most prominently, this study was expressly non-experimental and correlational. While it is possible to hypothesize causal links between the correlated study variables based on the correlation and support in the literature,

the results of the study demonstrate only that the two variables are linked such that changes in one are linked to changes in the other. Although this could result from a causal link, it could also result from a common cause between changes in both the variables.

Second, the study's results are limited by the bivariate analyses employed. Although the correlational approach employed was appropriate for answering the research questions, these methods are also limited to capturing only certain effects. The bivariate analysis using Pearson's r only considers individual relationships between the variables and not larger, more complex relationships such as mediation or moderation. For example, it is possible that one of the other, non-significant demographic variables included in the analysis might have moderated the effect of average number of hours worked weekly on work-life balance or work-life quality. In addition, a multivariate analysis could have potentially determined whether or not work-life balance moderated a relationship between the average number of hours worked weekly and intention to leave. Therefore, the results of this analysis do not support the hypotheses that expected correlations involving more demographic variables, but the analyses were not undertaken with sufficient strength as to provide truly compelling evidence against these variables' involvement.

Third, the study's results are limited by the measurement of certain demographic variables. For example, flexibility might have emerged as a more important predictor of work-life balance or work-life quality if a more involved measure of flexibility had been utilized, as opposed to a simple yes-no measure. Similarly, variables such as career plan may be too complex to have been meaningfully captured in a simple demographic survey and accordingly the results with respect to these variables may not be fully indicative. Further research might

serve to focus on these individual factors and gain a better understanding of what role they play, if any.

Finally, by design the study was limited to centers of females working in academic medicine in southeastern area of the United States. While there is no reason to believe that the population of the centers is significantly different from that in other U.S. regions, it is possible that the results were in some way influenced or determined by contextual factors unique to this region. Accordingly, care should be taken when seeking to generalize these results to a broader context. However, the lack of much influence by demographic factors in the analysis suggests that these contextual factors may be of limited importance.

Recommendations and Conclusion

Recommendations for Research

Based on the results of this study, several directions for future research are suggested. First, it would be ideal to strengthen the correlational conclusions found in this study into causal ones. As actual experimentation in this context would be unethical, such research might be pursued using a similar research design but in a longitudinal study. Additionally, it might also be achieved through a qualitative study focusing on the same population and exploring the participants' reasons for having intention to leave.

Second, further research should examine issues of flexibility. As this was the first study of how flexible scheduling may affect the work-life balance of females in academic medicine, it drew upon a rather simplistic measure. Future research could develop a complete quantitative measure of flexible scheduling. Alternatively, qualitative research could focus on exploring

perceptions of flexible scheduling and how it does or does not contribute to maintaining better work-life balance or work-life quality.

Third, research should re-examine the demographic factors that were found to be insignificant in this study. These factors were supported in the literature and might potentially have more complicated statistical effects such as moderation or mediation that were not captured by the bivariate analysis used herein. Such studies would use similar measures of the variables but a more thorough statistical analyses such as structural equations modeling.

Recommendations for Practice

Two recommendations for practice are made based upon the results of the study:

1). Centers of academic medicine should not neglect the importance of work-life quality and balance.

The results of the study demonstrate that work-life quality and balance at the very least can predict the intention to leave. Given the high rate and cost of attrition in this field, such predictive factors cannot be ignored. Results in the literature from similar situations suggest the correlation may in fact be causation.

2). Centers of academic medicine should consider the average hours worked per week when addressing issues of work-life balance.

As the only demographic factor included in the study with statistical significance, the average hours worked each week by females in academic medicine may be a valuable predictor when trying to target those who are at higher risk for work-life conflict, and who may be more likely to hold turnover intentions.

Conclusion

This quantitative non-experimental correlational study had a twofold purpose. First, it examined the relationships between the quality of work life or work-life balance and intention to leave and between work-life balance and intention to leave among female physicians at academic medical centers in the southeastern United States. Second, the study sought to identify whether flexible working arrangements and other demographic factors including age, ethnic background, education level, length of employment, hours worked per week, marital status, number of children in household, caregiver responsibilities, job position, work schedule, tenure track, and career plan, influenced the quality of work life and work-life balance. To serve this purpose the study was carried out through quantitative surveys, using Pearson's r and chi-squared analyses. The results suggested that females with poor work-life balance or work-life quality are significantly more likely to hold intentions to leave. Furthermore, those who worked longer hours on average each week were at significantly higher risk of having poor work-life balance.

APPENDICES

APPENDIX A

DIMENSIONS, COMPONENTS AND QUESTION NUMBERS FOR SURVEY

Dimensions of Quality of Work Life (QWL) and Question Numbers in the Survey Questionnaire

Dimensions of QWL	Components	Question Number
Demographics	Age, job position, children in home	1,2,3,4,5,6,7,8,9,10,11,12,13
Job Satisfaction	Resources, Emotional Exhaustion	38, 40, 48, 58, 66
Organizational Culture	Leadership	27
Relationships	Other Faculty, staff	34,45,46,59
Compensation	Pay, Fringe Benefits	36,47
Rewards and Recognition		37,49,50,57,60
Work environment	Decision input, Communication	32,33,35,44,54,63
Autonomy	Control over schedule	56,
Career/Professional Development	advancement, continuous education to stay current in field	26,39,41,53,55,61

Dimensions of Work-life balance and Question Numbers in the Survey Questionnaire

Dimensions of WLB	Components	Question Number
Work Load	Hours, Volume of Work	15,28,51,52
Organizational Culture	Paid Family Leave, Child Care, Elder Care	19,42,43,65,72
Satisfaction with Family/Leisure Life	Time for family activities, emotional exhaustion at end of work day,	64,68,69
Work Life Interference	Doing work at home, receiving text, pages at home	29,30,31,62,67,70

Dimensions of Flexible Work Arrangements in the Survey Questionnaire

Dimensions FWA	Components	Question Number
Optional Work Schedules	Part time, Job Share, Reduced Load	23,25
Organizational Culture	Support to work flex schedule	17,18,20,22
Work-life balance	Optional work schedules	14,71
Career	Personal Career Plan, Tenure, Grants and Committees	16,21,24

Dimensions of Intent To Leave

Dimensions ITL	Components	Question Number
Leave the Job	Leave current position or medical center	73,74,76
Stay on the job	Remain in current position or medical center	75,77
Leave Medical Profession	leave practice of medicine	78

APPENDIX B

PARTICIPANT INFORMED CONSENT AND QUESTIONNAIRE

September 8, 2017

Dear Participant:

My name is Elaine Purdy and I am a graduate student at Central Michigan University. For my dissertation research, Dr. Steven Berkshire, principal investigator and I, as co-investigator, are examining the quality of work life, work-life balance and flexible working arrangements and their influence on the retention of female physicians working at an academic medical center.

Since you are a female physician working in an academic medical center, I invite you to participate in this study that takes 10 minutes of your time to complete. There is no compensation for responding nor is there any known risk. Participation is strictly voluntary and you may refuse to participate at any time.

If you choose to participate in this research, please answer each question as honestly as possible. In order to ensure that all information will remain confidential, please do not include your name.

This is an anonymous study managed through Survey Monkey and records of this study are strictly confidential. SSL (Secure Sockets Layer) will be used to prevent IP address tracking and no personally identifiable information will be included.

Completion of the questionnaire will indicate your willingness to participate in this study. If you require additional information or have questions, please contact me at the number listed below.

If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the Institutional Review Board by calling 989- 774-6401, or addressing a letter to the Institutional Review Board, 104 Foust Hall, Central Michigan University, Mt. Pleasant, MI 48859.

Thank you for taking the time to assist me in my educational endeavors. The data collected will provide a better understanding of the medical center working environment for female physicians and identify factors that affect work life quality, work-life balance, flexible working arrangements and the intent to leave their position. This information could be valuable for workforce management that better supports the recruitment and retention of female physicians.

If you would like a summary copy of this study, send email to elaine.purdy@vanderbilt.edu. Put in the subject line of the email: dissertation survey results requested. Results will be sent to you by reply email.

Sincerely,
Elaine Purdy

Contact information for researchers

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Demographic Information

1. Which race/ethnicity best describes you? (Please choose only one.)

- American Indian or Alaskan Native Asian / Pacific Islander
- Black or African American Hispanic
- White / Caucasian
- Multiple ethnicity / Other (please specify)

2. In what year were you born? (enter 4-digit birth year; for example, 1976)

3. What is your marital status?

- Single
- Married
- Divorced
- Widowed
- Significant Other

4. Do you have children in the home age 5 and under?

- No
- Yes

Please enter the number of children in the home under age 5:

5. Do you have children in the home between age 6 - 12?

- No
- Yes

Please enter the number of children in the home between age 6 - 12:

6. Do you have children in the home over age 12?

- No
- Yes

Please enter the number of children in the home over age 12:

7. What is your rank / job position?

- Instructor
- Assistant Professor
- Associate Professor
- Professor
- Other (please specify)

8. How many years have you worked in an academic medical center?

9. What area of medicine do you practice?

- Primary Care, Internal Medicine
- Specialty
- Emergency Medicine
- Female's Health
- Pediatrics
- Behavioral Health, Psychiatry
- Other (please specify)

10. How many hours on average do you work weekly?

11. What is your contracted work commitment?

- Full time
- Part time (29 hours or less)
- Reduced load (30 - 39 hours)

12. What areas are included in your contract?

- Research, clinical, education
- Research, education
- Research, clinical
- Research only
- Clinical only
- Clinical, education

Please read each statement and indicate your level of agreement or disagreement.

Note: Flexible working arrangements refer to reduced load, part-time, job sharing, seasonal schedule changes, a variation of scheduled hours for school holidays, and other exceptions for a change of standard work hours.

13. Flexible work arrangements are an important work option to support work-life balance.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
14. Physician workloads in my academic medical center provide an opportunity for work-life balance.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
15. Utilizing flexible working arrangements will negatively affect my career.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
16. My medical center provides flexible work schedule options when family demands change.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

17. The overall culture of my academic medical center is not supportive of individuals who utilize flexible work schedules.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
18. My academic medical center has work life policies (FMLA, job sharing, part time employment, reduced load, etc.) that are communicated clearly to all employees.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
19. My department supports the use of flexible working arrangements.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
20. The “tenure clock” should be paused for the physician if flexible working arrangements are utilized.
- Strongly Disagree
- Disagree
 - Neutral
 - Agree
 - Strongly Agree
21. In my organization, promotions are not likely for individuals working a flexible schedule.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

22. If offered, I would job share with another physician.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
23. In my organization, committee membership and grant awards are not likely for individuals working a flexible schedule.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
24. I can work a reduced load with less pay if I chose to do so.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
25. I do not have many opportunities for career advancement.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
26. I am satisfied with my department chair's leadership.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

27. I feel that Grand Round, On Call or rotating coverage schedules negatively affect my life.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
28. I usually do some work outside of normal business hours.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
29. I put personal life on hold for work.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
30. I miss personal activities because of work.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
31. I often feel I do not know what is going on in the organization.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

32. Communication within my organization is good.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
33. I like the people I work with.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
34. Many of our rules and procedures make doing a good job difficult.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
35. There are few rewards for those who work here.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
36. I have too much paperwork.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

37. There is really too little chance of promotion on my job.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
38. I feel a sense of pride in doing my job.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
39. I am satisfied with my chances for promotion.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
40. My organization provides childcare facilities.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
41. My organization provides resources to assist with elder care for my family.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

42. I have opportunity to participate in decision making for my department.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
43. I feel that I am part of a work family in my department.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
44. I enjoy good working relationships with my colleagues.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
45. My compensation is fair & adequate.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
46. Red tape often blocks my efforts to do a good job.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

47. I do not feel I receive appreciation for the work I do.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
48. When I do a good job, I receive the recognition that I should.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
49. I feel torn between demands of work life and personal life.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
50. I do not feel I work an excessive number of hours per week.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
51. I am able with resources provided by my department to obtain needed education to stay current in my field.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

52. I have the needed support staff for my practice.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
53. I want a more personalized career path than I have now.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
54. I have adequate control over my work schedule.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
55. My chair equally rewards and recognizes faculty for their work.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
56. My chair ensures support and resources are available to faculty.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

57. My department has a strong sense of community among all staff.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
58. My department equally recognizes and rewards clinical, teaching and research efforts.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
59. My department provides adequate professional development.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
60. My family activities are interrupted by work related phone calls or pages.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
61. My work environment is highly motivating.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

62. With my current position, I can balance work and family successfully.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
63. My department is accommodating of time off requests for family-related needs.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
64. At the end of most workdays, I am emotionally exhausted.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
65. I often bring work home and work late into the night to complete.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
66. My personal life suffers because of work.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

67. I am happy with the amount of time I have for non-work activities.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
68. I miss personal activities because of work.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
69. I have successfully used flexible work options to balance work and family.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
70. Maintaining work-life balance is encouraged at my medical center.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
71. I often think about quitting.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

72. It is likely that I will actively look for a new job next year.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
73. I do not intend to leave my present position.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
74. I often think of changing my job.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
75. If I leave, it will be for retirement.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree
76. At times, I think about leaving the medical profession.
- Strongly Disagree
 - Disagree
 - Neutral
 - Agree
 - Strongly Agree

Thank you for your participation

Thank you for taking the time to participate in this survey. We value your insight to further understand the working environment for female physicians in an academic medical center.

If you would like a summary copy of this study, send email to elainepurdy@comcast.net. Put in the subject line of the email: dissertation survey results requested. Results will be sent to you by reply email.

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