

The Aspiration-Capability Gap: A Mixed-Methods Study of Structural Barriers to Leadership Among Canadian Female Family Physicians

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Abstract

Despite a female supermajority in Canadian primary care (80%), a demographic paradox persists where women remain severely underrepresented in health authority executive roles. This study investigates the systemic barriers and institutional friction points suppressing the leadership aspirations of female family physicians. Utilizing a pragmatic, sequential explanatory mixed-methods architecture, this study evaluated department-wide survey metrics ($N = 28$) via descriptive statistics and Fisher's Exact Test, alongside deep-dive qualitative interview transcripts ($n = 6$) via inductive thematic analysis within a major regional Canadian hospital authority. Quantitative baselines expose a stark leadership deficit; 60.7% of respondents have never held an administrative position. A distinct mid-career bottleneck (11–15 years of practice) exists where rigid institutional governance schedules (e.g., meetings at 7:30 AM or 5:00 PM) directly clash with intensive caregiving demands, suppressing collective ambition into a medium-aspiration domain (mean: 28.96 ± 3.24). Qualitative themes uncover an uncompensated relational "Deep-Work" Tax that drives career burnout and self-doubt. Crucially, while bivariate analysis indicates that informal mentorship displays no statistical link to elevated career aspirations ($p = 0.636$), qualitative evidence isolates formal executive sponsorship as the vital driver of institutional belonging and self-efficacy. Rectifying this representation gap requires a shift from individualistic deficit models to systemic institutional redesign. Health authorities must execute targeted structural reforms, including restricting leadership meetings to core hours (9:00 AM – 4:00 PM), rewriting promotion frameworks to credit relational labor, and embedding formal sponsorship metrics directly into executive performance criteria.

Keywords: Gendered Organizations, Primary Care, Leadership Aspirations, Mid-Career Bottleneck, Executive Sponsorship, Demographic Paradox, Clinical Housework

1. Introduction

Canadian primary care is dominated by women at the trainee and practitioner levels. Yet, the leadership of medicine is still highly masculinized. In Canada, women now make up the majority of medical trainees, and almost 80% of the health care workforce, with family medicine being one of the most gendered specialties in the country [1]. However, at the top echelons of decision making, this numerical strength is dramatically reduced. In academic medicine, women make up about 50% of the assistant professors, 41% of the associate professors, and 23–28% of the full professors [1]. Likewise, the number of women in executive decision-making roles in hospitals, provincial medical associations and national

physician governing boards is still very low [1,2]. This is a massive demographic paradox, with the workforce feminization and the exclusion of women from leadership positions in institutional decision-making processes that shape policy, resource allocation and organizational redesign, creating a structural imbalance.

This paradox arises at a critical period in Canadian healthcare history. Canada also continues to perform poorly compared to other OECD countries with regard to access to longitudinal primary care, with an estimated 4–6 million Canadians not having a regular family physician or nurse practitioner [3,4]. At the same time, demographic ageing, increasing chronic disease rates and

physician burnout have added to the already challenged primary care system. Recent information from the Canadian Institute for Health Information shows a lack of growth in the number of family physicians and almost one in three of all physicians trained in family medicine is no longer working in comprehensive primary care [5]. Importantly, the loss of women from leadership pipelines is not simply representational but adds to the national retention problem. As women are most of the operational workforce in frontline primary care, leadership structures that do not reflect women lived experiences create organizational conditions that further contribute to professional disengagement, burnout and ultimately exit from the workforce. Institutionalized rigid scheduling norms, undervalued relational care labor, and sustained promotion architectures based on uninterrupted career paths for male physicians continue to be dominant in male-dominated executive systems [6]. This means that when there is no reflective female leadership, the organization continues to create conditions that are detrimental to the very staff Canadian primary care relies on.

The implications go beyond the symbolic issue of equity to measurable system performance outcomes. It has been consistently linked to better efficiency of health care, improved continuity of care and lower mortality rates in health care systems [7]. Similarly, there is some evidence that diversity in leadership enhances institutional responsiveness to patient-centered policy priorities such as maternal health, caring responsibilities, and psychosocial aspects of care provisioning [8]. This loss of women's leadership is thus a structural loss of knowledge gained from the frontline of clinical experience. Mid-career female physicians, especially those in the 11–15-year range of practice or ages 35–54, are at a critical juncture in the organization, where clinical knowledge, relational power, and systems-level knowledge all come together. However, this is where the dreams of leadership are often met with institutional resistance, which can be thought of as an aspiration-capability gap. National data points show overall inequities, but hospital systems in certain areas have highly feminized workforces and distinct micro-dynamics. This study therefore focuses on the role of local leadership cultures in a Canadian regional health network in the context of structural constraints on the executive pathways of women physicians.

A common approach to understanding the underrepresentation of women in medical leadership has been to focus on building their confidence, resilience, negotiation skills, or urging them to “lean in” to leadership, rather than challenge organizational power dynamics. These structures implicitly place women as weak actors who need to be remodeled to fit into existing institutional frameworks. However, Joan Acker's Theory of Gendered Organizations fundamentally challenges this assumption by showing that organizations are not gender-neutral bureaucracies, but rather social systems that are historically based on an implicit masculine “ideal worker” archetype [9]. This type of archetype assumes continuity in time, little domestic involvement, and complete work prioritization. Likewise, maintains that modern professional organizations still reward workers who can carry out unlimited devotion to paid work while shifting care responsibilities

to other people [10]. In health care institutions, these norms are entrenched in the scheduling, promotion, and informal leadership processes.

This gendered organizational logic is particularly apparent in medicine. Executive meetings, committee assignments and networking opportunities are often held at times of the day that clash with the time spent by women physicians on caring for their patients. Such scheduling arrangements are ostensibly neutral, but they favor clinicians who are able to have their domestic work absorbed. However, women family physicians are systematically overburdened with psychosocial counseling, advocacy, and care coordination of relational labor, which are emotionally intensive and time consuming [11]. This labor can be referred to as “clinical housework” or invisible organizational maintenance work, which is not well remunerated and institutionally valued in promotion evaluations [12]. Canadian remuneration analyses also show that activities that are often highlighted in women physicians' practice styles, such as cognitive and relational care, are paid less than procedural medicine, and that gender-based pay differences persist after controlling for specialty, workload, and clinical complexity [13].

However, it is not enough to describe the phenomenon of burnout among female physicians in a personal psychological story. Instead, the organization systems create exhaustion by piling on uncompensated emotional labor, domestic duties, and rigid institutional demands on clinicians already doing frontline care delivery. The downstream impacts of these arrangements are often described in terms of women's confidence or imposter syndrome [13]. Systematic evidence, however, suggests that self-doubt is often a logical strategy to a maternal wall-biased, informal gatekeeping and under-recognition environment [14]. Empathic or collaborative leadership styles can be celebrated for relational competence and yet not be included in the list of strategically authoritative positions [15]. Acker's framework thus reframes the leadership deficit as an institutional production, rather than an individual deficit. Organizational cultures actively obscure the work that maintains health care systems and punish those who do the work most heavily [9,15]. A structural need for institutional redesign in the form of equitable scheduling, recognition of relational labor and flexible leadership pathways is more than simple accommodation.

Some new evidence here indicates that “structured mentorship” and “executive sponsorship” can serve as an important institutional buffer that can overcome that aspiration-capability gap. In academic medicine, mentoring is always linked to better promotion chances, higher research output, higher career satisfaction, and higher retention rates among women faculty [16]. In addition to technical instruction, mentorship reduces professional isolation by symbolically validating and implicitly sharing organizational knowledge. When there are no apparent networks of female colleagues, many mid-career women physicians come to understand that the lack of inclusion is their own fault [17]. Sponsorship can disrupt this process, however, by publicly affirming the leadership

potential of women by active advocacy, strategic introductions, and nominations to high profile positions [18].

From a psychological perspective, Bandura's self-efficacy theory provides a clear understanding of how executive sponsorship works. A sponsor's public exposure and promotion of the junior clinician to the department head, to influential hospital committees, or to national conferences offer vital social persuasion and mastery experiences needed to foster career resilience [18]. This is very clear in high-quality clinical environments, where senior mentors regularly introduce junior female physicians to other prominent scientists, saying explicitly that they should be aware of her research [19]. These actions communicate a strong sense of belonging to the institution that no self-help seminar could ever match. Conversely, a gifted female doctor might always feel like he or she doesn't belong, devalue clinical successes, and never pursue leadership positions at all [20].

Sociologically, sponsorship alters the role of physicians in the network and the institutional status of the network. Sponsors put their own social capital into their protégés [19]. Departments that cultivate and publicly champion a woman are more likely to end up with a woman with these high-profile, revenue-generating committee roles. Departments which engage women actively and publicly are more likely to have women with these high-profile, revenue-allocating committee roles. This significantly increases her sense of agency to shape hospital policy. Empirical research indicates that awareness of a senior leader's active sponsorship of a junior doctor's career raises the likelihood of the junior doctor wanting to take up a leadership trajectory [16,17]. In other words, formal mentorship challenges the internalized story of the gendered organization by shifting the internal standard for the mentee: she is no longer an outsider, but a legitimate insider.

Creating these supports as institutional infrastructure as opposed to ad hoc relationships can lead to long-term systems change. Formal mentorship programs offer protected administrative time, leadership development and accountability measures for sponsors [21]. In contrast, programs that neglect to consider internal power dynamics, like providing generic skills workshops, do not influence executive diversification. The opposite happens if sponsorship becomes a part of promotion requirements, where it becomes apparent that the work previously went unnoticed is now being formally recognized [22]. Creating a mentoring culture starts when institutions measure and reward mentoring efforts, breaking the clinical office-housework trap [22]. As executive sponsors gain self-efficacy, it spreads through professional networks over time, which means that mentees will become mentors and so on, fostering an institutional culture in which women leaders become embedded as a strategic priority [23,24].

To address these systemic dynamics empirically, this study explores the precise mechanisms through which gender deeply shapes and constrains the leadership trajectories of female family physicians within the Canadian healthcare ecosystem. The overarching research aim is to investigate the structural, attitudinal, and

institutional factors influencing the leadership aspirations of female family physicians, identifying the friction points where individual professional ambition encounters systemic organizational barriers.

Specifically, this study seeks to answer a vital research question: *What are the perceived institutional obstacles and gendered organizational dynamics that prevent female family physicians from attaining executive and decision-making roles within health authorities?* To address this question comprehensively, this paper pursues three integrated objectives:

- To assess the impact of gendered organizational norms on the professional development of female family physicians.
- To isolate the specific structural factors and temporal bottlenecks that suppress or alter leadership aspirations during mid-career.
- To identify actionable, system-level interventions and formalized mentorship strategies required to support and empower women in their pursuit of leadership positions.

By fulfilling these objectives through an integrated, sequential explanatory mixed-methods architecture, this study shifts accountability from individual female psyches to institutional redesign, offering an empirical roadmap to rectify the primary care demographic paradox.

2. Methodology

The research approach in this study is pragmatic with the aim of exploring the structural barriers and leadership aspirations of female family physicians. Traditional health sciences literature tends to use a strict positivist paradigm, whereas sociological studies tend to use only interpretivism; a pragmatic approach would state that the specific nature of complex organizational issues demands the use of a variety of methodological tools to produce action-oriented and applied solutions that could be applied in the real world [25]. The objective, cross-sectional department trends that are captured quantitatively in this study map out the realities of the situation regarding the demographic trends, structural configurations, and statistical associations; the subjective, lived experiences of the female clinicians navigating these environments are captured qualitatively through the semi-structured inquiry. Pragmatism does not assume that these paradigms are mutually exclusive; instead, it takes both to pinpoint the exact institutional bumps or snags where women's career aspirations collide with structural obstacles and solve a unified research problem.

To implement this paradigm a sequential explanatory mixed methods design (see Figure 1) was used, which consisted of two separate but connected phases: the first was a macro-level quantitative survey phase that served as baseline information on institutional patterns, followed by a deep-dive qualitative interview phase that broke down and contextualized the quantitative survey findings. This structural sequence explicitly responds to the need for a more than quantitative survey, one which is not simply descriptive, but explanatory, and to the need for a more than qualitative structural design, one which is not simply anecdotal, but grounded in the larger organizational realities. The combination of

these tools in a large regional hospital authority ("Hospital X") in Canada creates a unique empirical context. Family medicine is a unique structural position in the Canadian health care system, with the community level becoming feminized at an unprecedented speed yet constrained by institutional development paths shaped

by and rooted in historically male-dominated governance structures. The target population included all active and registered family medicine physicians in the hospital authority (hospitalist and community based), who provide comprehensive primary care within the hospital authority network.

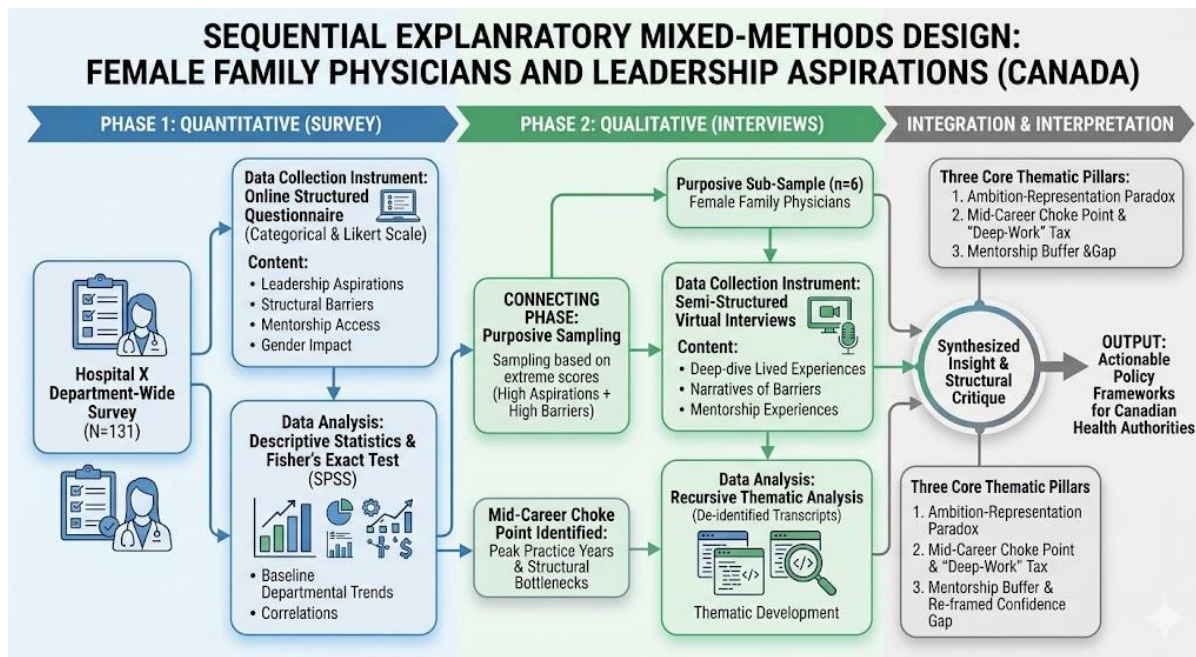


Figure 1: Sequential Explanatory Mixed-Methods design

Phase I began data collection through a department-wide, structured survey using a secure institutional e-mail system. The questionnaire included categorical items, fixed-response items, and Likert scale items across the following targeted thematic areas: leadership aspiration, perceived gender impact, institutional barriers experienced, and mentorship access. This instrument contained no open-ended questions to avoid straining standardization, burdening the respondents, and decreasing the power of the demographic factors. In a similar way, Phase II used a guide for interviews created from critical points identified in the preliminary survey feedback and in the literature in the field of institutional sexism, to explain the trends in the survey. Using purposive sampling, six female family physicians were identified based on the extreme scores (high leadership aspirations and high perceived structural barriers) and were invited to take part in deep-dive, semi-structured interviews. To balance compliance with busy clinical schedules, these sessions were held virtually through secure, encrypted teleconferencing platforms, with a thematic consistency while allowing for conversational divergence about unique administrative constraints. The interviews were audio-recorded, numbered with codes and verbatim transcribed for analysis.

Data analysis was done sequentially, in line with the mixed-methods design, starting with the export of survey data to SPSS

and Microsoft Excel. Workforce demographics, age distribution and leadership concentration measures were calculated to map the workforce, and cross tabulations were used to assess the relationship between categorical variables (e.g. having access to formal mentorship and having higher leadership aspirations). Because of categorical data and sample distribution restrictions, Fisher's Exact Test was used to test statistical significance, and findings were not considered empirical failures, but rather the scientific rationale for which they needed qualitative elucidation. The qualitative interview transcripts were then analyzed using recursive, inductive thematic analysis, in contrast with the quantitative analysis of the surveys. Open coding was then used line-by-line to identify raw units of meaning relating to barriers, then grouped into larger conceptual themes through axial coding, yielding three key thematic pillars: Ambition-Representation Paradox, Mid-Career Choke Point, and Mentorship Buffer.

In the entire sequential process, methodological trustworthiness, validity and reliability were carefully maintained. The quantitative survey instruments were directly aligned to the key objectives of the study and were based on pre-validated organizational measurements ensuring reliability through the provision of unambiguous and standardized scoring criteria in each of the instruments. Trustworthiness was maintained during the qualitative phase by performing an audit trail of coding decisions and

structural triangulation of the survey metrics and the interviews. Both potential interviewer and recall bias were minimized through the use of a standardized semi-structured interview guide and by comparing transcriptions with audio recordings.

In addition, the York St. John University Ethics Committee gave ethical clearance to this study. It was essential to be able to keep the information gathered in this study strictly confidential, as this was a study within one hospital authority and the participants worked within a close-knit professional environment. All primary records were de-identified to protect participants from possible institutional or academic consequences. The respondents were numbered sequentially, and these numbers were used throughout the analysis, transcription and reporting of the final manuscript. Lastly, all raw data files and the audio recordings were securely stored on limited-access, encrypted institutional data storage devices in compliance with the university's data retention policies.

3. RESULTS

3.1. Quantitative Findings

3.1.1. Participant Demographics and Institutional Baseline

The macro-level baseline context of this study was established by evaluating the institutional workforce distribution at the regional health authority ("Hospital X"). The total departmental baseline for family medicine at this institution comprises 131 active clinicians. Structurally, the department exhibits an apparent surface-level feminization, consisting of 76 female physicians (58.0%) and 55 male physicians (42.0%). In terms of operational environments across the network, the distribution shows that 106 clinicians are positioned within urban or town-based family medicine centers, 10 serve as specialized hospitalist physicians, 4 operate as clinical assistants, and 11 are dispersed across three distinct rural settlements. From this institutional baseline, the primary data collection yielded a survey sample size of N = 28 after data scrubbing and verification. A notable divergence emerged regarding institutional engagement by gender: the response rate among female physicians reached 29.0% (22/76), whereas the male response rate sat substantially lower at 10.9% (6/55). Consequently, the final quantitative analytical sample is heavily weighted toward female clinicians, who comprise 78.6% (n = 22) of the respondents, compared to 21.4% (n = 6) for male physicians.

The domestic and workload baselines of the respondents underscore significant competing demands. The surveyed clinicians report a mean of 1.77 children, with an average child age of 11.75 years.

Crucially, 57.1% of the respondents are actively managing the care of young children under the age of 10. Professionally, family medicine specialists within this health authority work a mean of 42.54 hours per week, with annual incomes densely clustered around a mean baseline of C\$264,815.

3.1.2. Leadership Profiles and Aspiration Index Distributions

Evaluating institutional advancement histories revealed a profound current leadership deficit within the department. A substantial 60.7% (17/28) of the total sample have never held a formal leadership position within the hospital authority, despite the majority possessing extensive clinical tenure ranging from 6 to over 21 years of practice. Conversely, only 39.3% (11/28) of respondents currently hold or have previously occupied institutional leadership roles. These roles are primarily restricted to lower-tier administrative or advisory functions, concentrated among Committee Chairs (14.3%) and Clinical Directors (10.7%). Leadership ambition was measured using a pre-validated, 9-item Likert aspiration matrix with a composite score ranging from a minimum of 9 to a maximum of 45. Following the omission of one statistical outlier, the mean leadership aspiration score for the sample sits just below the mathematical midpoint at 28.96±3.24. Individual aspiration scores are tightly clustered between 21.00 and 35.00. The vast majority of female family physicians fall squarely within this medium-aspiration domain, demonstrating a notable reservoir of latent interest that remains unrealized.

3.1.3. Perceived Systemic Barriers and Gender Bias Metrics

The cross-sectional metrics reveal that perceived structural friction is prominently linked to gender. Specifically, 40.7% (11/27) of respondents agree or strongly agree that their professional development tracks have been negatively impacted by their gender, whereas only 22.2% perceive gender as a positive factor in their career progression. Furthermore, an explicit advocacy imbalance was recorded: 33.3% (9/27) of female family physicians report having to advocate significantly harder for training allocations, resource distribution, and career promotion than their male counterparts. This structural imbalance is mirrored in assignment bias metrics, where 33.3% of respondents agree that gender directly influences institutional task allocations (such as high-burden, low-visibility committee work), while 22.2% remain neutral. When asked to isolate specific operational challenges hindering leadership acquisition, respondents identified clear structural and psychological constraints:

Rank	Identified Institutional Obstacle	Sample Percentage (%)
1	Inflexible Administrative Meeting Schedules	60.7%
2	Self-Doubt and Internalized Competence Anxiety	57.1%
3	Limited Availability of Institutional Leadership Training	32.1%

Table 1: Perceived Institutional Obstacles and Structural Constraints Hindering Leadership Acquisition among Female Family Physicians (N = 28)

Additionally, environmental mapping illustrates a distinct spatial mismatch: female family physicians are disproportionately concentrated within solo private practices across the authority's geography, whereas institutional decision-making positions remain heavily clustered within urban group practices and centralized hospital governance boards.

3.1.4. Visibility of Equity Policies and Support Frameworks

The quantitative data uncovers an extensive policy visibility gap within Hospital X. A commanding 63.0% majority of surveyed physicians maintain a completely neutral stance regarding whether formal policies promoting gender equity in leadership actively exist within their workplace. Only 22.2% can definitively confirm the presence of such frameworks, meaning that nearly four out of five practicing clinicians (77.8%) operate in an environment where active gender-equity initiatives are either missing, invisible, or poorly implemented. In terms of institutional professional development, the organization demonstrates formal compliance, with an 85.7% combined agreement rate (57.1% agree, 28.6% strongly agree) that equal access to leadership training is theoretically available to all genders. However, this formal availability conflicts with actual operational feasibility: 42.9% of respondents explicitly disagree that flexible scheduling is provided within their workplace to make leadership roles viable, compared

to only 32.1% who view their schedules as sufficiently flexible. Regarding organizational support infrastructure, 51.9% (14/28) of physicians' existing formal mentorship or sponsorship pathways as highly effective, 44.4% rate them as moderately effective, and 3.7% view them as entirely ineffective.

3.1.5. Bivariate Analysis: Fisher's Exact Test

To evaluate the statistical association between organizational support structures and individual intent, a cross-tabulation was conducted between Leadership Aspiration Levels (categorized as Low/Medium versus High) and Formal Mentorship Access (categorized as Accessed versus Not Accessed). Given the categorical constraints and the small sample size distribution (N = 28), Fisher's Exact Test was deployed. The analysis revealed no statistically significant relationship between baseline mentorship access and leadership aspiration levels (p = .636, two-tailed, where p > .05). This non-significant quantitative result suggests that the mere presence or absence of a flat, nominal mentorship variable cannot statistically account for variations in leadership ambition. Consequently, this statistical limitation highlights the critical need to transition to qualitative narratives to unpack how the underlying quality, gender dynamics, and structural configuration of mentorship operate in practice.

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2- sided)	Exact Sig. (1- sided)
Pearson Chi-Square	.491 ^a	1	.484		
Continuity Correction ^b	.031	1	.861		
Likelihood Ratio	.527	1	.468		
Fisher's Exact Test				.636	.447
Linear-by-Linear Association	.473	1	.492		
N of Valid Cases	27				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.67.

b. Computed only for a 2x2 table

Table 2: Statistical Association Between Formal Mentorship Frameworks and Executive Ambition Index

4. Qualitative Findings

4.1. Strategic Drivers of Latent Leadership Ambition

The qualitative deep-dive interviews with six female family physicians clarified that the "medium-aspiration" scores captured in the survey do not reflect a lack of intrinsic motivation. Rather, individual ambition is driven by a desire to rectify clinical operational deficiencies and establish gender representation. Participants repeatedly stated that their motivation to enter

leadership stems from firsthand frustration with primary care delivery models. As Participant 4 noted:

"I was bothered about issues in primary care, and I wanted to do something about it."

Similarly, the narratives emphasize that female leadership development is cyclical and relies on visibility. The presence of women in executive boardrooms acts as a visual catalyst that transforms a clinician's perceived capability into active career

intent. Participant 1 explained this relationship between visibility and systemic efficacy:

"My desire for improvement in the system and that females see something that can be fixed even though they can be perceived as having less power but they can help... more female leaders will create more female leaders because if you see somebody, you will think that you can do it."

Conversely, when institutional hierarchies lack visible female representation, it creates a psychological barrier that suppresses leadership interest before it can materialize. The absence of relatable role models restricts career imagination, framing the executive tier as a foreign space. Participant 6 summarized this dynamic simply:

"It is hard to imagine what you could do if you don't see it."

Motherhood, Rigid Infrastructures, and the Temporal "Time Tax"

The interviews reveal that the temporal bottleneck identified in the survey, clustering around peak mid-career years is defined by a structural collision between rigid hospital governance and family caregiving responsibilities. The qualitative data demonstrates that the institutional architecture of Hospital X applies an explicit penalty to the biological and maternal realities of female physicians. Participant 4 recounted an instance of overt institutional gatekeeping that directly linked maternal status to leadership exclusion:

"No, you cannot do that [leadership role] because you are pregnant/breastfeeding."

Because hospital administrative structures fail to provide flexibility during child-rearing years, female family physicians face a compounding "time tax" that delays their career advancement. The narratives show that women are forced to split or postpone their leadership ambitions, creating a staggered career trajectory that does not match the linear progression of their male colleagues. Participant 2 and Participant 4 both corroborated this mid-career stall, stating:

"I had to do part-time leadership work during the years of raising my kids... Doing my leadership now is easier than 10 years ago when my kids were younger."

This temporal friction is not an individual time-management failure; it is an unyielding systemic boundary. The organization requires simultaneous devotion to continuous full-time clinical practice, evening executive meetings, and domestic management baseline that is structurally unviable for mid-career mothers. Participant 1 detailed this exhausting three-way friction point, identifying time as an institutional barrier:

"You cannot do all three at the same time, family, leadership, and practice. Time is the biggest commodity that I don't have enough of."

4.2. Demanded Structural Interventions and System Redesign

When asked to identify the specific institutional transformations needed to bridge the aspiration-capability gap, participants rejected superficial solutions, calling instead for a complete structural overhaul of primary care practice funding and maternity integration. To alleviate the uncompensated administrative and psychosocial burdens that drive mid-career burnout, participants demanded that health authorities reconfigure the daily clinical

workflow by integrating allied health professionals. Participant 1 outlined an operational framework to decouple clinical care from structural isolation:

"The province should look at setting the number of patients to be seen per day and provide office support like LPN [Licensed Practical Nurses] or Nurse Practitioners (NP)."

Furthermore, the qualitative data shows that addressing the mid-career bottleneck requires normalizing maternity leave within institutional promotion tracks. Participants emphasized that health authorities must eliminate the subtle professional marginalization that follows family leave, ensuring that taking leave does not permanently disrupt a physician's advancement path. Participant 4 explicitly identified this requirement for systemic equity:

"Return to work after a maternity leave without the unspoken punishment attached to this."

5. Discussion

The integration of these quantitative and qualitative findings provides an empirical validation of Joan Acker's Theory of Gendered Organizations within Canadian primary care [9]. It exposes the structural mechanisms that maintain the primary care demographic paradox. By evaluating the data through an organizational lens, we can see that the systematic underrepresentation of women in executive seats at Hospital X is not born from an individual deficit in capability or drive. Instead, it is actively manufactured by an institutional architecture configured around a masculine "ideal worker" archetype [10]. The descriptive data establishes that while women comprise a clear 78.6% supermajority of the responding workforce, their representation in formal leadership stalls at 39.3%, primarily limited to low-tier committees. This layout perfectly reflects Acker's assertion that organizational hierarchies use ostensibly "neutral" rules to obscure gendered power distributions [9]. The fact that 63.0% of the physicians remain neutral regarding the existence of gender-equity policies prove that formal organizational statements on diversity are largely decoupled from daily operational realities at Hospital X, operating as symbolic rhetoric rather than actionable infrastructure [2,26].

This structural friction explains the non-significant finding generated by Fisher's Exact Test ($p = .636$). In a traditional positivist health sciences paper, a non-significant p-value is often interpreted as an empirical failure, suggesting no relationship between the variables. However, under a pragmatic paradigm, this non-significant result is highly instructive. It demonstrates that simply tracking nominal, ad-hoc mentorship access cannot explain variations in leadership aspiration. The qualitative narratives clarify this statistical discrepancy: mentorship is not a uniform resource. When mentorship is informal and uncoupled from institutional power, it functions merely as a psychosocial sounding board. While this support helps reduce immediate isolation, it cannot dismantle the rigid barriers built into hospital operations [16,27]. As shown by the interviews, for mentorship to alter career aspirations, it must shift toward formal, executive sponsorship. Sponsors must actively invest their social capital by creating visible, high-visibility structural pathways for their protégés [19,22].

The findings also provide a structural re-framing of the "confidence gap" that dominates individual deficit models in medical literature [1,13]. While 57.1% of survey respondents identified self-doubt as a major barrier, the qualitative data proves that this imposter syndrome is an institutional product rather than a personal psychological flaw [14]. When a mid-career female physician looks at an executive boardroom and sees zero female representation, her resulting self-doubt is a rational response to an exclusionary environment [6,20]. This isolation is reinforced by what the data identifies as a gendered "Deep-Work" Tax. Female family physicians disproportionately absorb the time-intensive, cognitive, and relational care work of the clinic—such as psychosocial counseling and complex care coordination [11,15]. Because Canadian fee schedules structurally undervalue cognitive, relational labor relative to procedural interventions, these clinicians are hit with a double penalty: they face a 16% to 37% annual pay gap, and their emotional labor remains entirely uncredited in traditional, volume-driven promotion metrics [12,13,28]. This invisible "clinical housework" exhausts their cognitive and temporal bandwidth, leaving mid-career female family physicians with no remaining capacity to navigate a masculine promotion architecture [12,15].

Furthermore, this study identifies a distinct temporal bottleneck: leadership aspirations stall precisely during the 11-15 years of practice window (ages 35–54). This bottleneck represents a volatile intersection where peak clinical competence collides with intense domestic caregiving responsibilities and rigid institutional scheduling [5,6]. The survey shows that 60.7% of physicians identify inflexible work schedules as their primary operational obstacle. The interviews contextualize this metric, showing that scheduling mandatory administrative and governance meetings at 7:30 AM or 5:00 PM enforces the "ideal worker" logic [9,10]. These schedules assume a disembodied clinician who has no domestic responsibilities and can completely prioritize the organization [9]. For a mid-career mother managing young children under 10 (who comprise 57.1% of the sample), these meeting times function as a structural barrier that forces a protective withdrawal from leadership paths [12,28]. This reality challenges individualistic "lean-in" theories [1]. The data shows that female family physicians do not opt out of leadership due to a lack of ambition; rather, they are structurally locked out by an inflexible organizational ecosystem that treats maternal and caregiving realities as professional liabilities, [4,20].

Finally, applying Bandura's self-efficacy theory to the qualitative data reveals the mechanism through which formal institutional sponsorship can bridge this aspiration-capability gap [18]. As Participant 1 and Participant 6 noted, individual self-efficacy is co-produced by social persuasion and vicarious mastery experiences. When a healthcare institution formalizes sponsorship as an integrated piece of infrastructure—guaranteeing protected administrative time, moving committee meetings to core clinical hours (9:00 AM – 4:00 PM), and embedding mentoring success into executive performance metrics, it directly dismantles the office-housework trap [21,22]. Active executive sponsorship

reinvests institutional capital into mid-career women, shifting their internal narrative from isolated outsiders to legitimate stakeholders [17,19]. This systematic re-allocation of power is essential to resolve Canada's broader primary care retention crisis [3,5]. Because health authorities face massive clinician shortages, they can no longer afford to maintain patriarchal governance models that burn out and alienate the female supermajority delivering frontline care [1,6]. Shifting accountability from individual female psyches to structural institutional redesign is a pragmatic mandate to build a sustainable, resilient, and reflective healthcare leadership pipeline [2,7,8].

6. Conclusion

This study has empirically investigated the precise mechanisms through which gender shapes, constrains, and alters the leadership trajectories of female family physicians within the Canadian healthcare ecosystem. By adopting a sequential explanatory mixed-methods architecture, this paper successfully addresses its overarching research question regarding the specific institutional obstacles and gendered organizational dynamics that prevent a workforce majority from attaining executive, decision-making roles within health authorities. In addressing the first objective, assessing the impact of gendered organizational norms, the empirical data reveals that healthcare systems are not gender-neutral bureaucracies. Instead, they remain structurally anchored in Joan Acker's masculine "ideal worker" archetype [9]. This manifestation is evident in the gendered "Deep-Work" Tax, where female physicians disproportionately absorb low-visibility, time-intensive "clinical housework," such as psychosocial counseling and complex care coordination [11,15]. This relational labor remains undervalued by Canadian fee schedules and unrewarded by promotion architectures, reinforcing a 16% to 37% annual physician pay gap and actively manufacturing professional burnout [12,13].

Regarding the second objective of isolating specific structural factors and temporal bottlenecks, the findings locate a volatile mid-career choke point occurring between 11 and 15 years of practice (ages 35–54). This bottleneck represents a severe collision between rigid organizational governance and intensive caregiving responsibilities, characterized by the fact that 57.1% of the sample manage young children under the age of 10. Quantitative metrics indicate that 60.7% of clinicians identify inflexible scheduling as their primary barrier. The qualitative narratives contextualize this, showing that scheduling mandatory executive meetings at 7:30 AM or 5:00 PM enforces an exclusionary logic that punishes maternal realities and pushes female aspirations into a protective, medium-level stagnation [20,28].

Finally, in line with the third objective, while bivariate analysis (Fisher's Exact Test, $p = .636$) demonstrated that nominal, informal mentorship access alone cannot statistically alter leadership aspirations, the qualitative deep dives established the precise mechanism of formal sponsorship. Grounded in Bandura's self-efficacy framework, the study proves that formal, institutionalized executive sponsorship provides the vital social persuasion and

structural advocacy needed to bridge the aspiration-capability gap, shifting female clinicians from isolated outsiders to legitimate stakeholders [18,19].

Policy Implication

To dismantle the primary care demographic paradox and build a sustainable leadership pipeline, Canadian health authorities must transition from individualistic "deficit models" to systemic institutional redesign [1,2]. First, health authorities must mandate equitable scheduling frameworks, prohibiting the scheduling of core administrative, governance, and strategy meetings outside the core clinical hours of 9:00 AM to 4:00 PM. This simple structural modification removes the systematic barrier faced by physicians with domestic caregiving responsibilities [9,12]. Second, the structural undervaluation of relational care must be rectified. Health departments should overhaul promotion criteria and performance metrics to formally recognize, credit, and reward "clinical housework," organizational maintenance, and diversity, equity, and inclusion (DEI) service [15,22]. Nationally, provincial funding frameworks should integrate allied health professionals such as Licensed Practical Nurses (LPNs) and Nurse Practitioners (NPs) into family medicine environments to cap daily patient volumes and relieve the uncompensated cognitive load on frontline clinicians.

Third, health authorities must formalize mentorship into an institutionalized sponsorship infrastructure [21]. This requires embedding sponsorship metrics directly into the performance evaluations of department chairs and senior executives, ensuring that the advancement and nomination of qualified mid-career female physicians to revenue-allocating "power committees" is treated as a core strategic mandate rather than an optional accommodation [19,22]. Finally, human resource frameworks must establish standardized, penalty-free maternity reintegration pathways, eliminating the subtle professional marginalization that historically disrupts continuous promotion tracks [28]. Restructuring healthcare organizations around these evidence-based policy pillars is a pragmatic necessity to retain the female supermajority sustaining Canada's frontline healthcare delivery [3,6].

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