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A Qualitative Study of Work-Life Choices in Academic Internal Medicine

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Abstract

The high attrition rate of female physicians pursuing an academic medicine research career has not been examined in the context of career development theory. We explored how internal medicine residents and faculty experience their work within the context of their broader life domain in order to identify strategies for facilitating career advancement. Semi-structured interviews were conducted with a purposeful sample of 18 residents and 34 faculty members representing male and female physicians at different career stages. Using thematic analysis, three themes emerged: 1) the love of being a physician ("Raison d'être"), 2) family obligations ("2nd Shift"), and 3) balancing work demands with non-work life ("Negotiating Academic Medicine"). Female researchers and educators reported more strategies for multiple role planning and management than female practitioners. Interventions aimed at enhancing academic internists' planning and self-efficacy for multiple role management should be investigated as a potential means for increasing participation and facilitate advancement.

Keywords

Social role theory; career development; physicians; women's issues; work stress; retention

Introduction

The Association of American Medical Colleges (AAMC) reported that 38% of physician faculty leave academic medicine within 10 years of entering this career path (AAMC, 2008).

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In a national survey, faculty in academic general and subspecialty internal medicine reported relatively high likelihoods of leaving their organization within 1-2 years (Bunton et al., 2011). Residents and fellows lose interest in academic medicine as their training progresses (Bickel and Brown, 2005; Straus et al., 2006). Notably, female physicians disproportionately drop out of academic careers (AAMC, 2008), contributing to their underrepresentation in senior and leadership positions (Carnes, 2008; Carr et al., 1998; Carr et al, 2003; Tesch et al., 1995). This loss of talent is particularly salient for academic internal medicine where women have accounted for at least 30% of residents for over three decades and which continues to draw over 20% of all graduates from U.S. medical schools (American Board of Internal Medicine, 2009). There is a growing need for conceptually sound models to guide interventions that can reduce the loss of current faculty and retain the next generation of faculty and leaders in academic internal medicine (Lowenstein et al., 2007).

Research has identified numerous contributors to academic physicians' attrition vulnerability including: increased clinical responsibility in response to changes in residency structure; pressure for research productivity coupled with declining federal funding levels; decreased control over the work environment; long work weeks (e.g., > 70 hours); inadequate recognition of clinical service and teaching excellence; and compromised collegiality from the lack of an "academic community" (Aronoff, 2009; Borges et al., 2010; Bunton, et al., 2011; Lowenstein et al., 2007; Pololi et al., 2009; Schindler et al., 2006; Shanafelt et al., 2009). Academic internists have what Hewlett and Luce (2006) refer to as "extreme jobs." Such extremely demanding employment situations can be deleterious to individuals' personal lives, interfering with quality of sleep and eating habits as well as reducing time available to invest in intimate relationships with significant others and children (Hewlett & Luce, 2006). Extremely demanding employment situations exact a high toll on its employees increasing stress which, in turn, may decrease faculty physicians' job satisfaction and can contribute to intentions to leave academic medicine (Shanafelt et al., 2009). Understanding the factors that shape the initial career choices of academic internists, in general, and female academic internists in particular, as well as how they subsequently experience those career choices may provide valuable insight into career junctures where they are likely to leave medicine.

The purpose of this article was to explore the career choices of physicians at different career stages and in different faculty tracks in their current environment of academic internal medicine. We specifically sought to better understand factors influencing male and female academic physicians' choice of medicine and specialty in internal medicine, their perceived sources of social support, and descriptions of a balanced (work and non-work) life. This study is unique for two reasons. First, we explored academic physicians' career experiences using qualitative methods to gain a greater understanding of how physicians experience their work within the context of their broader life (non-work) domain. We adopted a person-oriented approach which focuses on how occupational identities emerge and how individuals experience the objective realities of work (Hermanowicz, 2007) Accordingly, we examined academic physicians' subjective experiences of work and the relationship to non-work life domains and whether these varied by gender across two career stages (resident, faculty) and within three faculty tracks (researcher, educator, practitioner). Second, we applied a career development lens to the cross-over effects of work-family factors and their implications for career commitment. Retention in academic medicine has not previously been examined vis-à-vis career theory. We intended this approach to be useful in suggesting specific targets and methods for intervening on conceptually-derived variables in order to increase the advancement of women physicians pursuing an academic career.

The literature on career development incorporating the concept of work-family relations has received a great deal of attention in investigations of career-related choice, burnout, and

attrition. The concept of work-family relations, emanating from social role theory, has been articulated within career theory to describe how individuals construct identities from and engage in multiple roles in work and family domains (Cinamon & Rich, 2010). Social role theory acknowledges that the work and family roles provide both stressors and rewards as an individual negotiates the demands from each (Norton et al., 2005). Accordingly, career development researchers have specifically investigated how individuals' anticipated and actual multiple role management relate to work-family conflict, multiple role self-efficacy (confidence), and self-appraised problem-solving effectiveness (McCracken & Weitzman, 1997). These career theory concepts were used to examine the data in this study.

Method

Procedures

This research was approved by the Institutional Review Board at the University of Wisconsin-Madison (UW). We chose a purposeful, stratified sampling strategy to achieve maximum variation in participants' experiences and career stages (Patton, 2002). All physicians were residents or faculty in the UW Department of Medicine. The sample matrix is presented in Table 1. We aimed for at least six participants in each cell as an estimate of the number needed to achieve data saturation (Guest et al., 2006; Miles & Huberman, 1994). Within each group, we randomly selected participants and sent an initial and two follow-up email invitations. All women in the tenure track group were contacted because of their small number.

Participants

Of the 68 (from 134 eligible participants) who responded to the email invitations, 14 declined, 2 were ineligible, and none withdrew for a final interview sample of 52. No participant held a leadership position and all had been in their positions at least two years. Forty-two (16 residents, 28 faculty) of the 52 participants provided additional information in a follow-up questionnaire including age, professional status, weekly work hours, physician specialty, and number of children (see Table 1). None were from underrepresented minority groups (37 of European descent, 5 of Asian descent).

Data Collection

Semi-structured interview questions probed for factors involved in career decision-making, presented in Table 2. Content for interview questions were based on existing literature on the career development of academic internists in particular and female physicians in general. The interviews ranged from 15 to 60 minutes and were digitally audio-recorded, transcribed verbatim, and anonymized through the use of pseudonyms and by collapsing sub-specialties. Each participant reviewed and verified his or her transcript (Glesne, 1999). Research team members were all women and included a senior tenured professor (MC), an experienced qualitative researcher (CI), two second year medical students (RM, AS), all of whom are white, a Native American graduate student (AK), and one career theory researcher who is African American (ABW).

Data Analysis

First, each interview transcript was examined line by line, identifying initial codes, then grouping codes that were conceptually linked into axial codes (Green & Britten, 1998). Finally these concepts were integrated and synthesized into theoretical codes to identify the broad themes to which other categories were related using the constant comparative method in which iterative data collection and analysis occur simultaneously (Bradley et al., 2001; Patton, 2002; Strauss & Corbin, 1998). NVivo 8 (QSR International) textual analysis

software program facilitated coding and analysis (Richards, 2006). Discussion of evolving codes occurred in weekly meetings (CI, RM, AS, MC) until we achieved consensus on a final coding scheme. Coders (RS, AS, CI) independently applied the final coding scheme to four transcripts with 94% intercoder agreement.

Results

The final coding scheme consisted of 37 initial codes which grouped into 12 axial codes and then 3 unifying, emergent themes (see Figure 1): 1) motivating factors for being a physician (“Raison d’être”), 2) family obligations (“2nd Shift”), and 3) the codes that form the tipping point of balancing the demands of being an academic internist with family and personal life (“Negotiating Academic Medicine”). In our conceptual model of these themes, “Negotiating Academic Medicine” is the fulcrum upon which the work roles (“Raison d’être”) and non-work roles (“2nd Shift”) balance as reflected in positive, affirming statements of successful strategies for managing multiple roles (“Balance”), versus negative statements describing ineffective management of multiple roles (“Unbalanced”). We describe the final three themes inserting illustrative text.

Raison d’être—The Raison d’être theme reflected physicians’ work-related mission, passion, motivation and words of wisdom. All participants enjoyed patient care and typically, as one male assistant professor-practitioner reported, “My field is very fun, our patients are fun.” Other motivating factors for choosing internal medicine were the specialty options and the intellectual “sleuthing” that it provides. Male researchers had more text coded in this theme than any group.

No participants in the entire sample regretted choosing medicine, although they frequently mentioned experiencing career adversity. As one female assistant professor-researcher said, “It’s almost like you (...) have to love it more than anything in the world because you have to endure so much.”

Many of those interviewed (11 of 28 men; 4 of 24 women) had family members who were physicians. This vocational legacy established values of commitment, dedication and historical prestige of internal medicine where internists were:

Revered for their ability to interact with people, make diagnoses, and work on treatments... the ones who were in control and looked up to by the whole community of physicians...that has changed. (male associate professor, clinician-practitioner, generalist)

That last sentence acknowledges the concern expressed by some participants about the future of internal medicine despite their conviction of the appropriateness of their own career choice.

2nd Shift—Both male and female physicians had considerable text devoted to “family” and “children” with the exception of male practitioners who had the least amount of coded text in this theme. Residents anticipated the need for multiple role management with the time commitment required to be an involved parent. One male Post-Graduate (PG) 1 noted that “I don’t want to be that dad that is always missing and can’t make it.” A male associate professor-educator said: “once you have kids, in the end that provides the whole balance.” A male professor-researcher acknowledged gender differences as he would advise his son to, “Make sure that you are balancing [medicine] with your responsibilities at home,” but at the same time when talking about his physician daughter he said, “unfortunately 10 to 15 years from now it’s still going to be a little bit harder [for women].” Notably, 4 of the 18 male faculty (3 professor-researchers, 1 professor-educator) had daughters in medicine while none of the 16 women faculty had daughters pursuing medicine.

Women physicians in this sample contextually evaluated their non-work social role. For instance, a female PG1 stated, “If I have kids I want to be a good mom” reflecting female residents’ common strategizing of their “2nd Shift” roles while male residents more commonly discussed strategizing to protect personal time. A female assistant professor-researcher reported, “having a family affects how you make decisions pretty profoundly.” She later recounted a story about when her husband was reading a book about diversity aloud to their children “and he inserted, ‘it’s OK if your mother’s a [subspecialist]’ (laughter).” Several women reframed social norms about working mothers, as illustrated in the following quote:

My son used to say, I know your patients need you mommy, but I need you too. And I was like, (...) I know but you’ll be alive tomorrow if I leave and they might not be. But it’s hard [for them] to understand so you have to have a lot of inner fortitude I think to get through it (...). When I was pregnant with my daughter I read something that said (...) the main reason you would stay home and not work is so your child can do anything they wanted to with her life. And I said, isn’t it a better example to do what you want with your life rather than to do what you think you should do so they can do what they want with their life? So I think I’m a great role model for my kids, because they know that I love them but they also know that I have a really fulfilled life outside of home. And that’s the kind of life that I want them to live.

A female associate professor-researcher stated, “I don’t think I (...) allowed myself to be devalued (...) I would just say I’m working 75% time, I have kids and that’s what I’m doing- no excuses, nothing, I want to be 75% time.” Later she said, “Thankfully I have a supportive husband who helps out with the kids at home.” These women noted the sacrifices their families made in support of their career, especially their husbands’ who consequentially adjusted to non-traditional gender roles. One female associate professor educator said, “when [my husband] emotionally kind of switched over to thinking ‘OK I’m gonna do meals’ (...) he was able to unstick some of his previous conceptions of how things should go.” At the same time women expressed regret that they themselves “can’t do it all.” This statement by a female assistant professor-researcher summarizes the drive to excel in both career and family: “I’d really like to be able to be the perfect mom and perfect wife and perfect doctor and perfect researcher.”

Negotiating Academic Medicine—“Negotiating Academic Medicine” (figure 1) includes codes for text reflecting “Balance” and “Unbalanced” negotiation strategies or experiences. Notably, male researchers had the least Balance-coded text, and practitioners, particularly women, had the most Unbalanced-coded text.

“Balance”

“Role models” and “mentors” were identified as being important in developing effective strategies for work-life balance with nuanced distinctions between men and women’s text. Male faculty physicians emphasized the effect of their role models’ standards on their attitudes toward professional commitment. Two male educators admired “extraordinary” role models, “because when he was on his death bed he was worried about his patients,” and another admired a physician role model who missed the birth of his third baby because “it was important to him and to [his] institution that he learn all about [procedure].” In contrast, the importance of personal mentoring regarding strategies to balance family – particularly children – and work was evident with female residents, educators and researchers. One female PG3 spoke at length about a female mentor, saying “the amazing thing about her is not only is she supportive professionally, (...) but also support[s] me with my personal life.” A female associate professor-educator described male mentors that taught scientific research

and writing but also female mentors who had provided guidance in multiple role management:

She was pretty frank about the challenges but mostly how rewarding it was. That was the first time I could ever really see balancing both things – career and family. I thought it was either quit or really have a half-time career and have to play at medicine until the kids were older.

One female associate professor-educator reported “when my kids were sick but not that sick I would bring them to work and have them color in my office and sleep under the desk;” this was a 2nd shift strategy she learned from a senior female physician that when on call would “put [children] in sleeping bags in the back of a station wagon and drive to the hospital.”

These personal pragmatic daily strategies were particularly important as they often affected career choices. A female associate professor-educator said, “I’ve made a lot of choices that have allowed me a lot of flexibility- taking protective teaching roles...when you’re 100% patient care it’s a little bit hard; it’s arrange-able but not without consequences.” Patient care constrains the time of most of these women; however, one female assistant professor-researcher’s position gave her more control, “you can do more at night; it’s more flexible, you do your writing, your meetings, e-mails, whenever it works out -so that gives me more flexibility that I can see my kids more.”

“Unbalanced”

“Balance” themes were often used in conjunction with “Unbalanced” themes, with the latter often focused on time issues including initial codes such as “juggling roles,” “uphill struggle,” “control of schedule” and “worry about the future of medicine.” Male faculty, predominantly practitioners, emphasized practical strategies for the “control of schedule.” One male associate professor-practitioner said, “you really have to outline a schedule and stick to it the best you can and meet your responsibilities on a daily basis (...) you just have to say no [because] you just can’t do it all...you have to reserve time for yourself.” Another male associate professor-practitioner alluded to the resident work hour restrictions:

Patient care demands are the 600 lb. gorilla. They always take precedence.... Prior to 1976, if a resident complained of being tired, the attending would look at them and just say if you can't handle it, drop out – it's your problem. Deal with it. We did it. Suck it up. Be a man (...) or a woman. The culture has changed a bit but no one is dealing with the attending issue.

Similarly, a different male associate professor-practitioner decried the “old boy system [where] you worked 100% of the time”:

You never have the concept of anybody working less everybody just had to work more. I think medicine has too long had this sort of hero feeling that (...) there’s more to be done, I’ll go do it. To the point that they didn’t do it well.

The subject of hospitalists was positively discussed by five (3 male, 2 female) clinician-practitioners. One male associate professor-practitioner acknowledged the benefits of having a work week reduced from, “70 hours down to 40 and getting rid of the night call.” A female associate professor-practitioner said:

Hospitalists have changed dramatically (...) the way that you can structure your life because when we take call (...) you never have to leave your house. Nobody’s going to say you need to come in here and leave your children (...) and I think that’s changed a lot the way people can look at their careers and say I can do medicine.

The greatest amount of “Unbalanced” text came from female practitioners, primarily generalists, who also had the least amount of text coded with “strategies.” These women were clearly motivated in their career pursuits *and* particularly challenged in work-life negotiations, as supported by statements that they “enjoy doing it all [inpatient care] but it came at a very high price in terms of never seeing my family, being on call, being tired, being overworked, being totally stressed (...) [with the need to] be perfectly friendly and perfectly knowledgeable, perfectly perfect.”

All participants described the “adversity” of academic medicine consistent with the description of “extreme jobs”, using phrases such as “a constant battle,” “a struggle,” “hard on our family,” “constantly working,” “huge commitment.” Female residents were already making choices about the realities of managing multiple roles as one female PG1 who is a mother stated, “For my eventual career I don’t want to have to do inpatient work so I can see my son, who is the light of my life.” In contrast, male professor-researchers typically chose work over family time. One stated “my life is my professional life – period (...) my life is not balanced at all – I am extremely comfortable with it.” Another stated that, “My kids are a source of distraction which is extremely important when things are not going well professionally.”

Both male and female faculty “worry about the future of medicine”, but overall, male faculty held onto the belief that medicine “comes far ahead of your own life”:

I think internal medicine is falling apart completely (...). It’s become shift work and with a lack of vigilance and dedication to the patients far more than it ever was. I don’t personally believe that you can have a career in medicine without being dedicated to medicine exclusively. The idea of balance is a euphemism for not actually applying yourself in a medical career (...) you’ve taken the vows that I think all of us take to support, serve and to be dedicated to patients, that’s the priority that comes far ahead of your own life, your own sort of happiness and enjoyment or balance. (Male professor-educator)

This statement made by a female associate professor-educator about a hypothetical instance in which her daughter would be medicine-bound may clarify some of the unspoken conflict,

Medicine is still often dictated by the rules and ideals of men. (...) The career of medicine has been successful for both genders but it’s still a man’s world.

(...) It’s changing, but it is certainly true that men still dictate what happens in the field of medicine because they are in the roles of being the chairperson and the roles of being section leader.

Discussion

In this article, social roles were salient in participants’ pursuit of and adjustment to academic medicine careers: in how they defined, reframed, and managed societal norms for women and men in work and family domains. Social role theory, articulated within career theory, describes how individuals’ involvement in multiple roles in work and family domains may relate to their career commitment behavior (McCracken & Weitzman, 1997; Norton et al., 2005). Moreover, social role theory acknowledges that work (Raison d’être) and family (2nd shift) roles provide both stressors and rewards as an individual negotiates the demands from each (Norton et al., 2005). In our research, negotiating these roles required strategies to maintain equilibrium (Balance) in the face of stressors (Unbalanced). Our discussion centers on social role construction and multiple role management and how this may influence physicians’ career commitment, advancement and potential vulnerability to attrition.

Although both men and women had strong social expectations for gendered behavioral norms (Eagly & Karau, 2002), they varied somewhat in their conceptions about responsibilities and life priorities that men and women should adopt. Male researchers had the most focus on “Raison D’Etre” themes and had the least amount of Balance- or Unbalanced-coded text. They described their scientist role as unencumbered by family, yet some observed their physician daughters struggling with negotiating multiple work-family roles. Ironically, these men viewed multiple role planning as necessary for their daughters despite not actively doing so themselves. This irony may stem from the role models for many male faculty who taught them that professional commitment required prioritizing work over family and anything less reflected a lack of professional commitment. Although these standards were derived from previous generations of male physicians, these male researchers were proud of their physician daughters and their emulation of the professional commitment standards of their fathers. We found support for an enhancing effect of family roles on work satisfaction for some participants, male and female, an effect found in other research to be associated with fewer intentions to leave one’s organization (Wayne et al., 2006).

Previous research identifies professional mentors and role models as being influential in guiding career decisions (Sambunjak et al., 2006). Similarly, evidence emerged from our analysis that senior female physicians who taught strategies for negotiating life-work roles facilitated the strong multiple role self-efficacy beliefs and problem-solving skills to negotiate academic medicine. Although residents had the least negative text of all groups even while working almost 80 hours per week, female residents were already planning for multiple roles, and had similarities to female faculty text that illustrated a broader interpretation of their social roles. For instance, our findings supported prior research that female physicians are more likely to feel guilty and inadequate in their roles as both doctor and mother (“being perfectly perfect”) while male physicians may express regret about the lack of time they give their families (Parsons et al., 2009). Yet, our female faculty reframed their performance to mitigate the social threat that they are either uncommitted physicians and/or inadequate mothers or spouses (Carli, 2001; Heilman, 2001; Heilman & Okimoto, 2008). They also highlighted changes to their family social roles as a result of their career; findings not found in the male participants’ text and not previously identified in research on the changing workforce in internal medicine (Jovic et al., 2006). Although the pressure for research productivity may discourage some physicians from considering academic medicine (Schindler et al., 2006), our female researchers discussed the convenience of having the flexibility that research time affords for accomplishing their 2nd shift roles in contrast to the difficulty of doing so with full-time patient care.

Consistent with other research, our female researchers and educators, despite their demanding roles, enjoyed the flexibility of their schedule as a type of Balance strategy (Borges et al., 2010). Overall, female researchers and educators had more “strategy” text than did female practitioners. Perhaps female practitioners have less access to those who can show them successful strategies for negotiating career and family; notably the department from which the sample was drawn has no formal mentoring programs for the practitioner track.

As other research affirms, long work weeks (e.g., > 70 hours) (Aronoff, 2009; Borges et al., 2010; Bunton, et al., 2011; Lowenstein et al., 2007; Pololi et al., 2009; Schindler et al., 2006; Shanafelt et al., 2009) caused by changes in residency structure leads to decreased control of time, which is a primary source of work dissatisfaction (Lowenstein et al., 2007; Straus et al., 2006). Male practitioners expressed the most dissatisfaction with these structural changes that affect their “control of time”, rarely concerned with managing multiple roles. Female practitioners were also dissatisfied with these structural changes;

their comparatively smaller amount of strategy text may explain their lack of advancement. Relative to female researchers and educators, female practitioners appeared to lack multiple role planning for work-family involvement, multiple role self-efficacy, and problem-solving skills to balance work and family demands (Norton et al., 2005).

Our findings suggest that interventions aimed at enhancing academic physicians' planning and confidence for engaging in multiple role management may be one strategy to investigate for advancing within academic medicine. This would include recognition of the complexities and stressors associated with simultaneous work and family involvement and the subsequent need for deliberate planning to manage the demands from work-family domains. The processes by which multiple role plans and related self-efficacy develop, however, remain unknown (McCracken & Weitzman, 1997) and thus represents a direction for future research with academic physicians.

Social role theory helps explain how the centrality of a given role changes over time, especially due to the stress and rewards individuals experience in those roles (Norton et al, 2005). Increased stress in a role, work or family-related, can decrease the commitment to and importance placed on that role. Thus, academic internists who do not actively identify and implement strategies for balancing simultaneous career and family demands may be most vulnerable to career attrition. Results suggest the need for multiple role planning for ascension through the career ranks of academic medicine. Research questions such as the following might guide further inquiry: How does multiple role planning interface with physician internists' commitment to an academic career? How can multiple role self-efficacy be enhanced through interventions and are such interventions similarly effective for both female and male physicians?

Limitations

All participants were at one institution, none were ethnic/racial minorities, and none had left academic medicine. However, in support of our work Levine, Lin, Kern, Wright, and Carrese (2011) also found that a lack of role models for combining career and family responsibilities was a predominant theme for female physicians in academic medicine.

Conclusions

This research suggests that interventions aimed at enhancing academic internists' planning and self-efficacy for multiple role management should be investigated as a potential means to facilitate career advancement in academic medicine. Although female practitioners may be most in need of such interventions, such investigations would do well to examine male and female physicians as men are increasingly active in family roles and therefore managing work-family balance demands.

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Figure 1.
Code development from initial codes (bulleted) to emergent themes (within bolded lines)

Table 1

Participant demographics of residents and faculty in academic internal medicine

Participant Group	No.	Training Level or Rank	Subspecialist (SS) Generalist (G)	Median Age [*] (range)	Median Hours/Week [*] (range)	Median No. of Children [*] (range)
Male Residents	10	5 PG1, 5 PG3		29 (14)	80 (20)	.00 (2)
Female Residents	8	3 PG1, 5 PG3		30 (5)	80 (20)	.00 (1)
Male Researchers	6	5 Prof, 1 Assoc	6 SS	56 (25)	70 (40)	2.0 (2)
Female Researchers	4	1 Assoc, 3 Asst	4 SS	47 (14)	50 (20)	2.0 (1)
Male Educators	6	2 Prof, 4 Assoc	6 SS	52 (9)	70 (40)	3.0 (3)
Female Educators	6	1 Prof, 5 Assoc	2 SS 4 G	55 (14)	50 (20)	2.0 (4)
Male Practitioners	6	4 Assoc, 2 Asst	3 SS 3 G	52 (24)	50 (40)	2.5 (3)
Female Practitioners	6	1 Prof, 3 Assoc, 2 Asst	2 SS 4 G	52 (8)	30 (40)	1.5 (2)
Total	52		23 SS/11 G	46 (41)	70 (60)	2.0 (5)

Abbreviations: PG1 = residents in first postgraduate year (interns); PG3 = residents in third postgraduate year; Prof = Professor; Assoc = Associate Professor; Asst = Assistant Professor.

* 42 participants responded to a follow-up questionnaire for data in these columns.

Table 2

List of interview questions posed to faculty and residents

• What factors influenced you to choose medicine and your specialty?
• What role models/memorable situations influenced your career decisions?
• What are the consequences of the choices you have made?
• Who provides you support personally and professionally?
• Describe a balanced life in medicine.
• What advice would you give a son or daughter who was following your career path?