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Integrating Inequality Regimes and Social Cognitive Career Theory: Female Physicians' Resilience in India

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ABSTRACT

This study integrates Acker's institutional inequality regimes and social cognitive career theory (SCCT) to explore career resilience amongst highly qualified women professionals in a developing country context. Despite women undergraduate students outnumbering men in Indian medical schools, female physicians continue to face systemic barriers to long-term career advancement into executive roles. This research investigates how gendered organizational structures and patriarchal socio-cultural norms impact individual level behaviors, personal goals and circumstances. A thematic analysis of semi-structured qualitative interviews with 30 practicing female and male physicians in northern India highlights a national government policy context of female empowerment or "Nari Shakti". Four themes emerged based on "family first"; "passion first", such as surgery or entrepreneurship; accepting inequities; and developing competencies to cope with and overcome challenges to career advancement. Our research contributes to inequality regimes and SCCT literature by using a holistic, integrated and multi-level approach to understanding career resilience. It applies non-Western centric perspectives to examine career resilience amongst highly qualified professional women. The findings offer nuanced approaches to gender discrimination beyond social cognition related to emotional and physical tensions at various career stages. Finally, this empirical study provides recommendations for policy and practice.

1 | Introduction

This study responds to the call by Bastian et al. (2025, 13) for scholarship in *Gender, Work & Organization* to "tackle organizational misogyny and interrogate hegemonic masculinities' "otherness" while expanding feminist frameworks that prioritize non-Western perspectives". It considers national policy to promote women's empowerment in a highly traditional South Asian patriarchal society which is developing rapidly. Our research focuses specifically on the under-studied challenge of highly educated women's career resilience in a low-middle-income patriarchal context to support national development, economic growth, and well-being. This is a pressing issue following diversity, equity, and inclusion backlash in the United States (Aguinis et al. 2025).

Our research extends inequality regimes and social cognitive career theory (SCCT) literature by adopting a holistic, integrated, and multi-level approach to examining career resilience. To address gaps in gender studies and careers literature, it applies non-Western centric perspectives to explore career resilience approaches in the case of female physicians. Moreover, this qualitative study offers nuanced views of the different bases for gender discrimination related to emotional and physical tensions at various career stages with practical recommendations.

Kossek and Perrigino (2016, 729) characterize resilience as "the ability to adapt to adversity and endure job demands...a trait, capacity, or a process" which include cognitive, emotional and physical challenges. Similarly, London (1983, 621) defines career resilience as "a person's resistance to career disruption in a less than optimal environment". He found that individuals who demonstrate career resilience are typically self-reliant, take risks, develop structure and thrive in situations where outcomes depend on their own behaviors.

India's "Nari Shakti"[1] policy of empowering women as part of its goal to achieve developed country status by 2047[2] contrasts starkly with being ranked 131st out of 148 countries in the *Global Gender Gap Report 2025* (World Economic Forum 2025). Within the medical field in India, the challenges of violence against female physicians (Davies et al. 2024) and their significant under-representation in leadership roles (Gulati et al. 2024) highlight the disconnect between national/personal ambitions and pervasive societal/organizational gender-based discrimination. This is especially the case for women in academic surgery, which Greenberg (2017, ix) characterizes as an occupation literally and metaphorically shaped by "sticky floors and glass ceilings".

To address implementation gaps between national rhetoric and actual female empowerment in the workplace, this paper focuses on female academic physicians in India. We use the term "physician" to include both medical doctors and surgeons, with particular attention to the latter in relation to gender-based discrimination, as women, for example, represent only around 1% of spinal surgeons in India (Jain 2016). We explore female physicians' career resilience in India by integrating the lens of inequality regimes (Acker 2006, 2009) and SCCT (Lent and Brown 2019) to develop meso- and micro-level nuances. Although research on workforce gender inequality is extensive (e.g., Amis et al. 2020; Stamarski and Son Hing 2015), little attention has been paid to professional women's career resilience in low- and middle-income countries (LMICs) where national empowerment goals often fail at the local level.

Indian women's traditional roles as homemakers can constrain their ability to demonstrate their value in professional settings (Nath 2000). Societal expectations of women who manage the "second shift" of unpaid domestic and caregiving duties (Hochschild and Machung 2012) exacerbate their economic vulnerabilities (Badgett and Folbre 1999). In India, there is widespread organizational denial that gender discrimination exists (Gupta 2020) despite constitutional guarantees of equality. To investigate the interplay between government rhetoric and organizational inequalities that are affecting female physicians' social cognition and career resilience, this study uses empirical research from leading northern Indian medical schools. The key research question asks:

> Drawing on the lens of social cognitive career theory in a developing country context of national women's empowerment policies, how do institutional inequality regimes influence the career resilience of highly educated female professionals?

To address this question, we first review relevant literature on empowerment, gender, and careers, and then discuss Nari Shakti and physicians in India. Second, we outline our research methodology and present empirical findings linking patriarchal institutional cultures and individuals' socio-cognitive career perspectives. Finally, we reflect on the theoretical contributions of our conceptual framework and make practical recommendations to address policy–practice implementation gaps.

2 | Empowerment, Gender and Careers

From a macro-level perspective, lack of empowerment is regarded as a pernicious threat to societal well-being (Amis et al. 2020). Cornwall and White (2000) argued for including men in dialog about women's empowerment in society, whereas Agarwal (2001) emphasized participation by those who are disempowered. In the context of empowering physicians within medicine, physicians' jobs are both a vocation and a potential source of burnout when individuals lose their sense of purpose and meaning. Chalofsky (2010, 19) defines meaning in work as "an inclusive state of being" to achieve a subjective sense of purpose in life. Empowerment and meaningful careers are important for employees' mental health and for high-performing organizations. However, burnout is prevalent amongst early career female physicians who work long hours and who report low job satisfaction (Amoafo et al. 2015).

The conceptual framework we propose to adopt to understand empowerment and female physicians' careers combines Acker's (2006, 2009) inequality regimes framework with SCCT using Holland and Gottfredson's (1994) Career Attitudes and Strategies Inventory (CASI). The inequality regimes framework offers institutional level perspectives while a socio-cognitive career perspective complements this view on institutional barriers by highlighting individual-level aspects that advance or hinder professional women's careers.

Within one stream of literature on organizational injustice, Acker's (2006, 2009) inequality regimes framework contextualizes institutional processes. Acker (2006, 443) defines inequality regimes as "loosely interrelated practices, processes, actions, and meanings that result in and maintain class, gender, and racial inequalities within particular organizations". They comprise six dimensions: (1) bases of inequality, (2) shape and degree of inequality, (3) organizing processes which produce inequality, (4) visibility of inequalities, (5) legitimacy of inequalities, and (6) control, compliance, and power. Acker (2009, 206) characterizes the ideal worker stereotype within an inequality regime as a man "who is totally dedicated to the work and who has no responsibilities for children and family demands other than earning a living". By combining inequality regimes with SCCT, we extend our understanding of personal agency and career resilience amongst professional women in deeply gendered societies and institutions.

This study highlights gaps between everyday sexism, on the one hand, that assumes a prevailing logic of family first for women in a low-income country and, on the other hand, abstract

political rhetoric about female empowerment. The latter contrasts starkly in the context of inequality regimes with an organizational logic that privileges the ideal male "unencumbered worker" (Berns 2002, 5). Future research should consider broader socio-political and emancipatory aims in relation to workplace privilege and penalties. This could enhance realization in the medical workplace of the United Nations Sustainable Development Goals three, five, and eight on gender equality, decent work and economic growth, and good health and well-being.

To capture a complementary perspective on professional female empowerment, we consider career resilience using SCCT (Lent and Brown 2019) in Holland and Gottfredson's (1994) CASI model. This model incorporates nine dimensions related to job satisfaction, interpersonal abuse, work involvement, family commitment, skill development, risk-taking style, dominant style, geographical barriers, and career worries.

Widely used in the literature on career choices and trajectories since 1994 (Lent and Brown 2019), SCCT includes factors such as self-efficacy, outcome expectations, and personal goals (Wang et al. 2022). Studies using SCCT constructs have shown its utility to understand career pathways from both psychological (internal) and social (external) perspectives (Wang et al. 2022). SCCT examines the interplay between an individual's context (e.g., social support) and their behaviors such as the impact of goal setting and actions on their performance and career outcomes (Lent and Brown, 2019). Byars-Winston and Rogers (2019) used the SCCT framework to examine experiential learning which influenced self-efficacy beliefs, outcome expectations, and women's identity in relation to career intentions. The concept of self-efficacy may explain why highly educated professional women persist despite career obstacles including gender-based discrimination while managing multiple work and domestic burdens with little institutional support.

We adopt both institutional and individual perspectives. We draw on Acker's (2006, 2009) inequality regimes framework and the CASI tool for nuanced insights into female physicians' (dis)empowerment in India. This enriches our understanding of the gaps between national rhetoric, personal ambitions, and lived experiences. We, therefore, emphasize the need to take multiple perspectives and to understand the potential for activism in a high-status profession in South Asia. In this context, we suggest that institutions and family attitudes must change to accommodate the pipeline for higher numbers of female medical school students and India's ambitions for universal healthcare. From our literature review, in a patriarchal society we might expect national cultural and gender stereotypes of female physicians' submissiveness and prioritizing family over career within the CASI model related to risk-taking and dominant style dimensions.

In terms of the literature on interventions to empower women, Kaufmann and Derry (2024) argue that line managers must evaluate their own decision-making styles and institutional structures as possible barriers to equitable workplaces. A feminist emancipatory approach in this study allows us to "unpack and delegitimize inequalities in organizations" (Benschop 2021, 3).

3 | The Study's Context: Nari Shakti and Physicians in India

Surprisingly, we have found no high-quality peer-reviewed literature in gender and organizational studies on the phenomenon of Nari Shakti despite its national importance in the world's most populous country. Our aim, therefore, is to deepen an understanding of India's Nari Shakti ideology and interplay of societal, institutional, family, and career dynamics by exploring structural and societal inequalities and career strategies. Indian politics are characterized by centralization in a liberalized market economy with uneven social and economic development based on regional, class, religious and community fault lines (Srinivasulu 2024). Indian governments have used the term Nari Shakti for decades to link female empowerment and national power ("rashtra shakti"). Prime Minister Narendra Modi has pledged to transform India by 2047 into a developed nation. Importantly, a paradigm shift occurred from "women development to women-led development" in 2024 during India's G20 presidency (Government of India 2024) and we argue that it is important to consider its effect in the workplace.

United Nations Women (2024) define women's economic empowerment as "ensuring women can equally participate in and benefit from decent work and social protection; access markets and have control over resources, their own time, lives, and bodies; and increased voice, agency, and meaningful participation in economic decision-making at all levels from the household to international institutions". In India, Nari Shakti has been criticized for its political links to "muscular (Hindu) nationalism" (Banerjee 2010), with women portrayed as empowered in (para)military organizations and the police force to defend themselves and the state against the "other" (Schneider 2022). Central Indian government campaigns like the *#selfiewithdaughter* never present unmarried young women as independent agents (Schneider 2022). It is important, therefore, to critique Nari Shakti.

We chose India for our study because of its high levels of societal and workplace inequality, women's disproportionate burden of care, conservative views, and gender-based violence (GendV Project 2023). According to reports in 2024, the female labor participation rate in India was 32.7% compared with an average of 54% in other emerging markets and developing countries (Chung 2024). A Pew Research Center survey found that nearly 90% of respondents in India agreed that "a wife must always obey her husband" (Evans 2022). Furthermore, a national survey (India Today 2025) reported that only 32% of Indian respondents believed that women should be free to choose the person they marry and in Andhra Pradesh 31% of survey respondents said they were not against domestic violence. However, 93% overall believed that daughters should be encouraged as much as sons to study and 84% of respondents to the survey agreed that female family members should be encouraged to take up a job outside the home.

In the healthcare sector in India, 29% of medical doctors are women, and women hold only 18% of healthcare leadership roles (Dasra 2023; Karan et al. 2019). Women in Indian Medical Association committees (Singh et al. 2024) are under-represented.

For example, only 12.5% of members of the Association of Surgeons of India in 2023 were women (Ghosh 2023).

Moreover, physicians in India are vulnerable in the labor market (Jeffery 2024). Urban middle-class parents encourage their daughters into medicine (Gautam 2015) despite shocking levels of violence (Barhoi et al. 2024). Female physicians must, therefore, find strategies to persist in their challenging jobs despite restrictive local customs in India (Anderson 2024). Extensive research is needed to understand how to dismantle entrenched patriarchal structures and attitudes that perpetuate such inequities and disadvantage highly educated professional women's careers in LMICs like India.

We argue unequivocally that the under-representation of female physicians in leadership positions is unacceptable for sustainable development. Female physicians bring unique perspectives to patient care and decision-making and they are essential for addressing diverse healthcare needs (Moak et al. 2020). Studies show that gender diversity in healthcare teams leads to better patient outcomes and more comprehensive care (Gomez and Bernet 2019). However, many women leave medicine due to work–family conflicts when they need to show continuous job devotion and their commitment to work takes second place to their personal life (Blair-Loy 2009). They experience rigid working conditions (Mohsin and Syed 2020) that are compounded by broader societal violence and patriarchal attitudes (GendV, 2023). A leaky pipeline of female physicians results in negative outcomes related to knowledge gaps and delayed diagnoses especially in rural areas (Bhan et al. 2020), inadequate symptom management and patients avoiding medical care. Female physicians quitting the medical profession also leads to lower salaries and stalled career progression for their former colleagues, with broader implications for healthcare delivery and patient outcomes. It is imperative, therefore, to create an environment in medical schools where the best talent in academic medicine is selected regardless of gender (James-McCarthy et al. 2021) to support future generations of female physicians into medical consultant and professorial positions.

Even physicians in formal employment in India experience vulnerability and fear workplace violence (Barhoi et al. 2024; Kunnath et al. 2023). Pandhi (2021) explained that physicians in India experience structural violence from "acutely resource-poor settings, with long hours of working [and] lack of personal or social life, harassment by police [and] politicians". Shockingly, physicians on average die at least a decade before other members of the population. For example, an Indian Medical Association study (Kazi 2017) reported that while average life expectancy in India was 67.9 years and for a Malayali (mixed-ethnic group in India) it was 74.9 years, the mean average age of death for a Malayali doctor was 61.75 years (13 years younger than the Malayali average). This study included 87% male physicians and 27% female physicians amongst a sample of 10,000 during 2007–17 in Kerala. Women exit the healthcare workforce as the government does not enforce gender equality regulations designed to empower women in organizations (Gideon et al. 2024). Structural issues in India include inadequate paternity leave and occupational segregation which reinforce gender norms. The report by Uppal et al. (2024) on female leadership journeys in healthcare organizations highlighted the importance of redistributing care roles in Indian households fairly and promoting transparency by embedding equitable healthcare workplace policies for systemic changes and women's advancement. Another solution is to promote feminist leadership styles (Hawkes and Baru 2024).

Career resilience has been under-researched in the Indian context. Bhaskar et al. (2023, 1507) looked at career sustainability amongst visually impaired people from India and found that those who achieved high career success demonstrated the ability to rebound after rejection to build positive interpersonal relationships and benefited from family support using technology to be "masters of circumstance", adopting an "influence mindset change." Conversely, others with less self-efficacy and career resilience merely accepted what they interpreted as their fate with a skeptical and victim mentality.

4 | Methodology

As the research question sought to understand relationships between national policy to empower women, institutional inequalities, and social cognitive perspectives on female physicians' career resilience, in this study a qualitative approach was adopted to give participants opportunities for reflexivity in natural settings (Bluhm et al. 2011). This enabled the local interviewer to probe and guide responses in semi-structured interviews by developing rapport and to introspect during and after the interviews (Alamri 2019). Data were collected from four tertiary care hospitals (two public and two private) and one nongovernment clinic. The local member of the research team interviewed 30 female and male physicians in AIIMS (All India Institute of Medical Sciences), New Delhi, and in AIIMS, Jammu in the provinces of north-western India along with three individuals from two private and one nongovernment clinic connected to the AIIMS network. All AIIMS in India are elite public sector institutions. AIIMS, New Delhi, is India's first and most prestigious medical school hospital (Ruddock 2021). By illustrating struggles amongst academic female physicians in AIIMS, we assume that we are interviewing some of the country's most able physicians who ought to be able to enjoy decent work, equitable working conditions and career advancement in institutions where there should be sufficient political drive to enact changes that enable female empowerment.

The research team member in India works in AIIMS, New Delhi, and he previously worked with the CEO of AIIMS Jammu. Convenience sampling was adopted with the following inclusion criteria: female and male physicians (MBBS/MD qualified) in a range of specialties (including surgery) at different organizational hierarchical levels and career stages with informal/formal leadership responsibilities. The sample included 16 female physicians (53%) (see Table 1) and diversity in terms of age, educational qualifications, experience, and specialty. In the sample, 97% of the interviewees had a postgraduate medical degree, and they were working in diverse disciplines within clinical (37%), surgical (30%), and paraclinical

TABLE 1 | Interviewees' profiles.

ID Pseudonym	Age	Sex	Education	Experience (years)	Job position	Specialty	Time on leadership (%)
1M Ashwin[b]	40	Male	MD	12	Associate professor	Internal and emergency medicine	20
1W Anika[b]	41	Female	MS	11	Associate professor	ENT	70
2M Bhaskar[b]	48	Male	MS	17	Associate professor	Orthopedics	30
2W Bhavna	44	Female	DM	22	Professor	Neurology	15
3M Chetan[b]	60	Male	MS	30	Chairman	Orthopedics	100
3W Chetana	35	Female	MD	9	Associate professor	Pathology	20
4M Deepak	44	Male	MD	20	Medical officer	Clinical	30
4W Deepa[b]	48	Female	MS	18	Associate professor	Pediatric surgery	40
5M Ravi	47	Male	MD	16	[a]Additional professor	Hospital administration	100
5W Eva	56	Female	DM	30	Professor	Neurology	15
6M Falgun	46	Male	PhD	25	Head of department	Physiotherapy and medical rehabilitation	40
6W Farha	57	Female	MD	35	Professor	Psychiatry	30
7M Gautam	52	Male	DM	28	Professor	Neurology	40
7W Seema[b]	45	Female	MBBS	20	Director	Hospital administration	100
8M Hari	46	Male	MD	22	Professor	Laboratory oncology	30
8W Radha[b]	46	Female	MS	18	Associate dean and head of department	Obstetrics and gynecology	90
9M Ajay	65	Male	MPH	30	Professor and head of department	Community medicine	30
9W Indira[b]	34	Female	MS	5	Assistant professor	Obstetrics and gynecology	40
10M Jit	39	Male	DM	20	Additional professor	Psychiatry	15
10W Jiya[b]	37	Female	MD	8	Head of department	Hematology	70
11M Kush[b]	50	Male	MD	13	Head of department	Hospital administration	100
11W Kamala[b]	39	Female	MD	10	Associate professor	Anesthetics	50
12M Lakhan	44	Male	MD	17	Additional professor	Anatomy	40
12W Leela	44	Female	MS	17	Associate professor	Obstetrics and gynecology	50
13M Mohan[b]	42	Male	MD	14	Additional professor	Pediatric surgery	100
13W Madhura[b]	38	Female	MD	15	Associate professor	Anatomy	60
14M Nitin[b]	47	Male	DM	17	Consultant	Cardiology	25
14W Navina	45	Female	MD	20	Consultant	Radiology	30
15W Oja[b]	40	Female	MS	9	Associate professor	General surgery	50
16W Padma[b]	37	Female	MD	8	Assistant professor	Medical oncology	80

Abbreviations: DM/MD, Doctor of Medicine; MBBS, Bachelor of Medicine, Bachelor of Surgery; MPH, Master of Public Health; MS, Master of Surgery.
[a]Additional professor is above associate professor level.
[b]On-line interview.

(23%) fields (e.g., laboratories supporting patients but not directly treating them) as well as hospital administration (10%).

Table 1 presents the interviewees' demographics, roles and time spent on leadership activities.

4.1 | Procedure

The study's main aim was to explore the interplay between Nari Shakti policy, organizational inequalities and social cognitive perspectives on career resilience amongst female physicians. A

qualitative approach was deemed appropriate to probe for rich insights into participants' narratives about their career journeys, lived experiences, and aspirations (Creswell and Creswell 2017) as well as critical incidents (Flanagan 1954). The CASI tool (Holland and Gottfredson 1994) informed the semi-structured interview guide (Kallio et al. 2016). Questions were mapped onto Acker's (2006, 2009) six components within inequality regimes and Holland and Gottfredson's (1994) nine CASI dimensions based on SCCT, with female and male physicians interviewed in parallel.

To ensure interviewees' confidentiality, pseudonyms were used, and demographic details were not linked to location. Semi-structured interviews took place during May to July 2023 in participants' work or home to minimize disruption. Note-taking complemented the audio recordings which were subsequently transcribed. The interviewer's semi-insider status (Brannick and Coghlan 2007) in AIIMS, New Delhi, central administration as a senior scientist (nonphysician) facilitated his access to busy and typically difficult-to-access participants and to gain rapport with the interviewees.

4.2 | Data Analysis

Initially, the first two authors thematically and iteratively analyzed the data. We familiarized ourselves with the dataset by (re)reading the transcripts. We highlighted salient excerpts related to social cognitive barriers to female physicians' career advancement as well as societal, institutional, and individual influences. In the second stage, we clustered the excerpts into similar categories which we then coded and recalibrated (Braun and Clarke 2006). Finally, we organized the over-riding themes conceptually and consulted a third member of the research team (a Spanish male general practitioner and OECD health research officer with an MBA in health) to improve the reliability of coding and interpretations (Miles and Huberman 1994) using established methodologies (Gioia et al. 2013; Saldaña 2021) to produce a data structure (see Figure 1). To maintain the integrity of interpretations, both individual and collective reflexivity were applied, grounding the analyses in the data rather than in the researchers' preconceptions. The fourth author subsequently provided insights into gender theory during writing up. We invited constructive feedback to check that our insights

FIGURE 1 | Data structure: influences on female physicians' career resilience.

resonated with practitioners (Motulsky 2021). Additionally, we raised awareness of our research in blogs (Davies and Gulati 2023b; Thompson 2023) as well as in general (Davies and Gulati 2023a) and healthcare practitioner publications in Asia (Gulati et al. 2023).

5 | Findings

The following findings section is structured around the nine facets of the CASI framework (job satisfaction, interpersonal abuse, work involvement, family commitment, skill development, risk-taking, dominant style, geographical barriers, career worries) and Acker's (2006, 2009) inequality regimes. We include illustrative quotes which highlight female physicians' lived experiences related to career resilience.

Figure 1 provides a summary analysis of the data structure and key themes, outlining our findings and including a range of quotes from interviewees, which informed the first order concepts and in turn the second order concepts of the data structure.

Our study revealed inequality based on gender, age (childbearing), marital status, motherhood, and maternity discrimination (Kelan 2014), as well as perceived physical strength, especially for female surgeons. Gender discrimination and female misogyny were normalized in hiring, promotions and development, significantly impacting women's careers. We found evidence of assumptions that female physicians were less committed to their careers due to caregiving responsibilities and that interviewers for recruitment and promotion in India could ask women intrusive personal questions about their family plans:

> I don't think my personal situation with my husband, with my family or my children should have a bearing for me in a job interview.
>
> [1W]

Consequently, the absence of women from leadership and decision-making roles was accepted in gendered occupational hierarchies, particularly in surgery. Examples of organized solidarity among the female physicians was limited to an academic dean who scheduled teaching for female colleagues who had children later in the day.

Female physicians highlighted the need for workplace childcare and family-friendly policies to alleviate mental burdens. Despite some optimism from male physicians regarding women's capabilities, institutional strategies to advance women's careers were largely absent. Female physicians appeared to persist through self-sacrifice, navigating the gap between policy rhetoric of Nari Shakti and everyday workplace practices of being excluded from executive decision making. Female physicians derived meaning from their work and emphasized patient care and teaching over monetary rewards or promotions. One surgeon was particularly interested in entrepreneurship and established her own private clinic. Female surgeons were passionate about their specialty despite active discouragement from some men. They commonly sacrificed their sleep and well-being to accommodate their families and patients, and to write papers and apply for research grants in the middle of the night to further their careers. We found that male physicians in the sample were more strategic, did not mention caregiving or family commitments, and appeared to be more geographically mobile than their female colleagues. Implications from these findings are to support female physicians to be strategic and gain boardroom experiences through mentoring and coaching. Dedicated opportunities to gain skills in difficult procedures and decision-making for promotions, as well financial and other help with (extended) family caregiving responsibilities, international travel opportunities, and safe local travel would be welcome. It is also important to reward teaching and patient satisfaction, which female physicians might prioritize over research networks and board room experiences that can advance their careers. Systems changes are also needed to enable gender equity alongside dedicated careers guidance and support.

5.1 | Key Themes and Dimensions

Male physicians appeared to be able to work long hours and to enjoy geographically mobile careers without having to worry about family commitments. Female physicians we interviewed were not so dissatisfied that they were thinking of leaving but some had taken a back seat in their workplace to juggle their responsibilities and to persist in their careers, even if their specialty was not their first choice. Several female surgeons felt that they had fewer opportunities than their male counterparts for skills and career development.

There was little evidence of risk taking amongst the female interviewees, which may be attributable to acute awareness of dangers for women, particularly in rural postings (Killmer 2018). The norm was for women to follow their husband's job relocations. This gender discrimination was pervasive but not experienced by all the female physicians. Bias against female physicians is largely normalized and visible. In one instance, a female physician who was not allowed to apply for a promotion herself although she was qualified was invited to observe on the interview panel. In another case, a senior female physician told a young colleague that she did not promote female colleagues because childcare meant they would be inflexible.

Clearly implemented policies on reporting and punishing sexist behavior and violence against physicians with zero tolerance would contribute to empowering female academic physicians in elite public sector institutions in India. This requires systemic changes in medical schools and workplaces. However, unprofessional behavior in medicine is pervasive globally, as we see from attempts in Spain to educate medical students about preventing sexism and sexual harassment (Evéquoz et al. 2023).

Both male and female physicians said that they would like to be more involved in medical leadership as they felt since the COVID-19 pandemic that physicians rather than nonclinical administrators ought to have more institutional power to improve physicians' job satisfaction. Female physicians were passionate about their specialties (e.g., pediatric surgery,

hospital management, and teaching) and their regions. Several had gained confidence from mentors, by completing an MBA and other leadership development programs. Physicians also talked about personal growth through participating in international conferences, establishing a new department, managing accreditations, commissioning hospitals, handling overseas operations, multitasking, and developing strong support systems.

5.1.1 | Job Satisfaction

Several women regretted prioritizing societal expectations over personal interests, as reflected in Leela's lament about forgoing surgery for gynecology:

> I wanted to be a surgeon, but I didn't choose general surgery. I went into gynaecology because at that point in time females or patients only thought that if she's a woman doctor then she can be a good gynaecologist.
>
> [12W]

Traditional gendered specialties like pediatrics were seen as safer career options for women:

> I would say that in departments which have a very fair share of both men and women like paediatrics, the working environment is better than if you go to extreme specialties like orthopaedics.
>
> [2W]

Bhavna's experience of being overlooked for promotion and interviewing a male successor exemplified systemic biases that undermined overall satisfaction:

> I lost a promotion opportunity. They made me interview a man and they hired him as they assumed as a woman, I wouldn't be able to manage people. They didn't even give me an opportunity. So that's when you lose confidence and become more demotivated.
>
> [7W]

5.1.2 | Work Involvement

Passion for helping students was mentioned by female physicians which helped to account for their career resilience despite entrenched gender discrimination:

> I have a passion for teaching. Basically, I left everything and joined AIIMS only because I wanted to teach. And I'm a good surgeon.
>
> [8W]

Physicians like Radha emphasized a commitment to teaching and surgery. She viewed medicine as a vocation rather than as just a job. Balancing professional career peaks and personal milestones in their 30s posed distinct challenges for female physicians, as Anika highlighted:

> Work-life balance is a bit challenging and taxing because two things happen simultaneously if you're a doctor—like your professional peak and expectations to settle down in your 30s.
>
> [1W]

There was very little evidence of female physicians being involved in or leading on executive decisions. Ashwin [1M] believed that "*women leaders are really important in our health system*" but socio-economic and political reasons hold them back. Falgun [6M] felt that women in India are:

> overloaded with the additional and primary responsibility of home care childcare [so] their attention is divided, and it is hard for them to excel in academic, research and clinical domains.

He felt that childcare leave should be offered to male employees.

5.1.3 | Skill Development

Opportunities for skills development were hindered by senior male surgeons excluding female colleagues from complex cases (especially in surgery) and decision-making, as noted by Chetana and Deepa:

> Generally, seniors don't involve juniors in decision-making processes.
>
> [3W]

> Women surgeons sometimes don't get adequate exposure or opportunities to learn complicated surgical cases.
>
> [4W]

Anika mentioned gender stereotyping:

> The general perception in our system is that you can't be a woman surgeon. ... My skills might be on a par with my male colleagues, but in patients' first few interactions with me they have a level of insecurity.
>
> [1W]

Male colleagues like Bhaskar [2M] perpetuated gender stereotypes by comparing orthopedics to carpentry. He suggested that the specialty deterred women without acknowledging how artificial intelligence (AI) and robotics are changing surgery. Ajay [9M], however, called for more female representation in public health teams, recognizing their multitasking capabilities and ability to access hard-to-reach female patients. He admitted that female physicians:

> Are sometimes more competent than male doctors because they are born multitaskers.
>
> [9M]

5.1.4 | Dominant Style

Many women faced exclusion from leadership roles due to male-dominated networks and so they were only able to show informal leadership. Bhavna noted the mainly male power dynamics in boardrooms:

> You see the power of male dominated clinical networks in boardroom meetings. They can bypass the system to get things done.
>
> [2W]

> Men in the boardroom think women can be easily moulded so being a woman in male dominated big meetings can be a disadvantage.
>
> [2W]

Farha described the extra efforts required for female physicians to gain credibility as (younger) men tend to ignore women:

> I have to work twice as hard as men. I don't have the kind of rapport men have in old boys' clubs. Whenever I can, I put myself in a position so that others say, "OK, she means business, she's good".
>
> [6W]

Nevertheless, Kush [11M], a male head of department, was very positive about many highly performing female physician leaders. He wanted women to be included in selection interviews for leadership roles. The dominant style we discerned in the interviews, however, for most female physicians was doggedness, self-reliance and self-sacrifice while caring for their families, patients, patients' caregivers and colleagues. They lacked time and resources for careful career planning and any geographical relocations were based on following their husbands. Women were disempowered by having to accommodate male norms and various forms of inequalities, despite more female than male medical school students now entering the profession (The Indian EXPRESS 2024).

5.1.5 | Career Worries

Social expectations and gender biases frustrate many female physicians' careers, including lack of boardroom clout. Radha felt that women internalize societal expectations which hinders career progress:

> In the Indian system, we expect men to do much better than women. But that's just because we have our own social taboos that are holding us back.
>
> [8W]

Anika noted that acceptance of women in surgical leadership positions requires exceptional dedication when faced with gender stereotypes yet she offered some hope:

> I think there's still a long way to go for women to be accepted as the lead surgeon. Once male colleagues know you as a person and know your worth as a surgeon, gender is irrelevant.
>
> [1W]

5.1.6 | Interpersonal Abuse

Female physicians in India are accustomed to interpersonal abuse. Although female physicians in the public sector benefit from relatively generous childcare leave, this is held against them. Chetana acknowledged:

> Sexism always exists, I think. People don't like women taking childcare leave and all that. They say that women are getting two years off.
>
> [3W]

Indira noted discriminatory attitudes to young women in authority:

> When they see a young female head of department, the first impression is "How's she going to do anything?"
>
> [9W]

Seema noted that single young women in leadership faced ageism and pay disparities:

> In that region, they don't accept any women leaders who are young and unmarried. Single women are paid less.
>
> [7W]

> Men, but not women, receive a salary hike when they have children.
>
> [7W]

Ravi acknowledged broader societal influences, including caste and religion:

> Social associations, status, region, religion, caste play a significant role in a country like ours while reaching the pinnacle of leadership.
>
> [5M]

5.1.7 | Family Commitment

The interviewees indicated that childcare responsibilities and assumptions that mothers are highly committed to their families disproportionately impacted female physicians' career advancement. Anika highlighted colleagues' resentment about women taking time off for childcare:

> When it comes to asking for leave for personal and family reasons, the administration isn't very supportive. But ironically, it's not the case for male colleagues.
>
> [1W]

Kamala added:

> Nobody's concerned if a male colleague is absent from his work for family reasons.
>
> [10W]

Anika discussed her mental health as a mother and physician working anti-social hours without employer support for childcare:

> I was on-call at night and my child used to sit awake until I returned. If I know at work there's something that will take care of my mental baggage, I can work more freely. There should be a hospital creche.
>
> [1W]

Bhavna blamed society for these pressures:

> Boys' upbringing, their social conditioning, is the root of the problem.
>
> [2W]

Indira had no time for self-care:

> I'm the only woman in my home. The male family members like my husband can't cook food. In a male dominated society, there's a mindset that only women should do certain things.
>
> [9W]

Radha, like others, accepted that their lives were constantly focused on balancing family and work commitments. Nevertheless, Radha mentioned activism to resist entrenched gender discrimination:

> I'm a good multitasker. Gender biases are always there in our social system. We can fight it.
>
> [8W]

These attitudes demonstrate that female physicians are keen to persist in their careers and to change structural and systemic sources of disadvantage.

5.1.8 | Risk-Taking

There appeared to be little appetite for risk-taking amongst the female physicians we interviewed (see also Killmer 2018) as they were so busy caring for others and not their personal projects. One woman recounted her pioneering role as a surgeon and entrepreneur, although personal challenges led to her clinic's closure:

> I'm the first woman surgeon from XX province. I started my own centre in XX along with my husband. You can say that I was one of the very few women entrepreneurs in the XX region. I started a Centre for Paediatric Surgery and Intervention. But because of some personal reasons we had to shut down that centre in 2021. Afterwards, I joined medical college and now I'm at AIIMS XX.
>
> [4W]

Deepak suggested that some women are discouraged from applying for leadership positions in their careers because they fear they will have to:

> Sign policy papers without knowing the technicalities, which can attract problems, and they could lose their jobs.
>
> [4M]

5.1.9 | Geographical Barriers

Finally, using the CASI model dimensions, we found that relocations were driven by husbands as Barhate et al. (2021) suggest happens in India. Indira relocated with her husband to escape departmental politics:

> I moved from XX to XY because of toxic politics in the department there.
>
> [9W]

Chetana felt empowered to return home after medical school, a joint decision with her physician husband:

> When my husband and I left ABC for medical education, we were clear that we would return to our home state and develop the specialty here.
>
> [3W]

In the following section, we discuss the findings and offer a conceptual framework to understand macro-level factors and inequality regimes at a meso-level which interact with an individual's social cognition and career resilience.

6 | Discussion

Overall, the CASI constructs complement inequality regimes by providing a useful framework to organize insights into personal, institutional, professional and societal factors which influence women's career resilience and empowerment in the medical workforce in India. Clearly, there are multiple sources of inequalities based on gender, perceived physical strength, childbearing age, motherhood, marital status, domestic arrangements and medical/surgical specialty compounded by a lack of organizational support to empower women in their careers. The findings in our qualitative study extend literature on gender segregation in medical (Pelley and Carnes 2020) and surgical specialties (Lim et al. 2021) and on gendered microaggressions against female physicians (Myers et al. 2023).

Our sample included female mainly academic physicians who felt sufficiently empowered to continue working in India's top public sector medical institutions. We found evidence of female

physicians' personal agency, self-efficacy, positive outcome expectations, goal setting and adapting to circumstances highlighted in the CASI model. Several male colleagues admired female physicians' multitasking abilities and contributions. However, societal norms, gender biases, and structural and cognitive barriers continue to hinder equitable career advancement.

Women expressed dissatisfaction with being confined to gendered specialties and excluded from conducting difficult operations and decision-making. They are constantly pressured to prioritize their (extended) family and domestic commitments over their careers and self-care. Some men recognized these challenges, advocating for systemic changes, particularly as they would also like more free time to spend with their families. However, the gap is huge between the rhetoric of India becoming a developed country by 2047 and everyday lived experiences as indicated in our study. The United Nations Global Compact Women's Empowerment Principles tool is one potential mechanism to mobilize local action.

The CASI framework has been useful in illustrating social and cognitive challenges with institutional and family attitudes typically failing to support national ideology and female physicians' personal ambitions. Women's empowerment to achieve Nari Shakti policy relies on dismantling inequality regimes and on providing social and cognitive support that is inclusive and impactful. Practical interventions can include structural reforms, mentoring and coaching, leadership training, supportive policies, such as flexible work and reporting on discriminatory conduct, funding for research conferences and research assistance, supportive workplace cultures that address discrimination, representation in leadership roles such as professional body committees, networking opportunities, and boardroom experiences. These can help female academic physicians to advance in their careers and build on positive experiences about making connections with patients and students, enjoying surgery and making a difference in society.

Importantly, there is a perfect storm in India as less than a third of doctors and under a fifth of healthcare workers in leadership positions are female (Dasra 2023) while there are more female than male medical student enrollments. It is inconceivable that India could become an economic superpower without significantly advancing female physicians' careers and achieving equity in medicine although it is interesting that Japan had 23.6% female physicians in 2022 (Nippon.com 2024), the lowest in the OECD and lower than India.

Our study, therefore, contributes to literature on female empowerment using social cognitive career perspectives at the individual level and institutional perspectives during a critical historical point in the world's most populous country. Nari Shakti for nation building provides a macro-level backdrop; however, our findings indicate there is scope for greater political will to implement this policy in India's leading medical institutions.

Figure 2 illustrates the conceptual framework developed in our multi-level study. This helps us to understand the interplay between macro-level factors and inequality regimes at a meso-level which interact with an individual's social cognition and career resilience.

Figure 2 highlights four themes of family first, passion first, accepting inequities, and resilient competences. The framework reflects physicians in the sample who are particularly concerned with family commitments first and develop resilience to juggle work and nonwork responsibilities, especially for child and eldercare. This approach reflects Mainiero and Sullivan's (2005) conceptualization of a kaleidoscope career where the primacy of careers, life balance, and authenticity shift over time. In this model in the West, early career women may prioritize career goals and challenges over work–life balance and authenticity, whereas mid-career women shift their priorities to balance family issues. However, if in India women are expected to marry and have children earlier than in the West during their 20s, their primary career roles in families start when their careers should be taking off. This means that mid-career married women with children in India may be ready to make their careers their primary focus in their 40s, but by then it is too late. This scenario results in a loss of executive female talent as organizations fail to account for work–family conflicts in medicine and other sectors.

Our research aim was to enhance our multi-level understanding of how institutional inequality regimes influence the career resilience of highly educated female professionals in a context of national empowerment policies to empower women using an SCCT lens. The findings draw on Acker's (2006, 2009) inequality regimes framework related to deep-rooted inequality based on gender, (childbearing) age, marital status, motherhood, as well as perceived physical strength and medical/surgical specialty. Our study did not ask intersectional questions related to caste, religion, or socio-economic status.

The study highlights discriminatory processes in recruitment interviews when women are asked intrusive family questions and being excluded from decision-making and complex surgical procedures. Our insights confirmed that female surgeons may have fewer opportunities to develop their skills (Thompson-Burdine et al. 2019) than their male counterparts. Moreover, our findings supported gender stereotypes reported in the literature that women lack appropriate leadership styles (Kaatz and Carnes 2014) and that an authoritative masculine style is most appropriate in surgery (Minehart et al. 2020; Stephens et al. 2020). Our findings resonate with observations that risk-taking male norms of heroism and physical strength (Ainsworth and Flanagan 2020) and masculine behaviors such as autonomy, power, and agency (Lombarts and Verghese 2022) are pervasive in surgery.

Female physicians were mainly dissatisfied with the lack of institutional support for their medical leadership development. The over 30-year-old Executive Leadership in Academic Medicine Program for Women in the United States (Jagsi and Spector 2020) offers one example. Female physicians must also contend with patriarchal attitudes in their own households which result in considerable self-sacrifice on their part. The interviews showed female physicians' dissatisfaction with intensive workloads, stress, unsociable hours and long shifts,

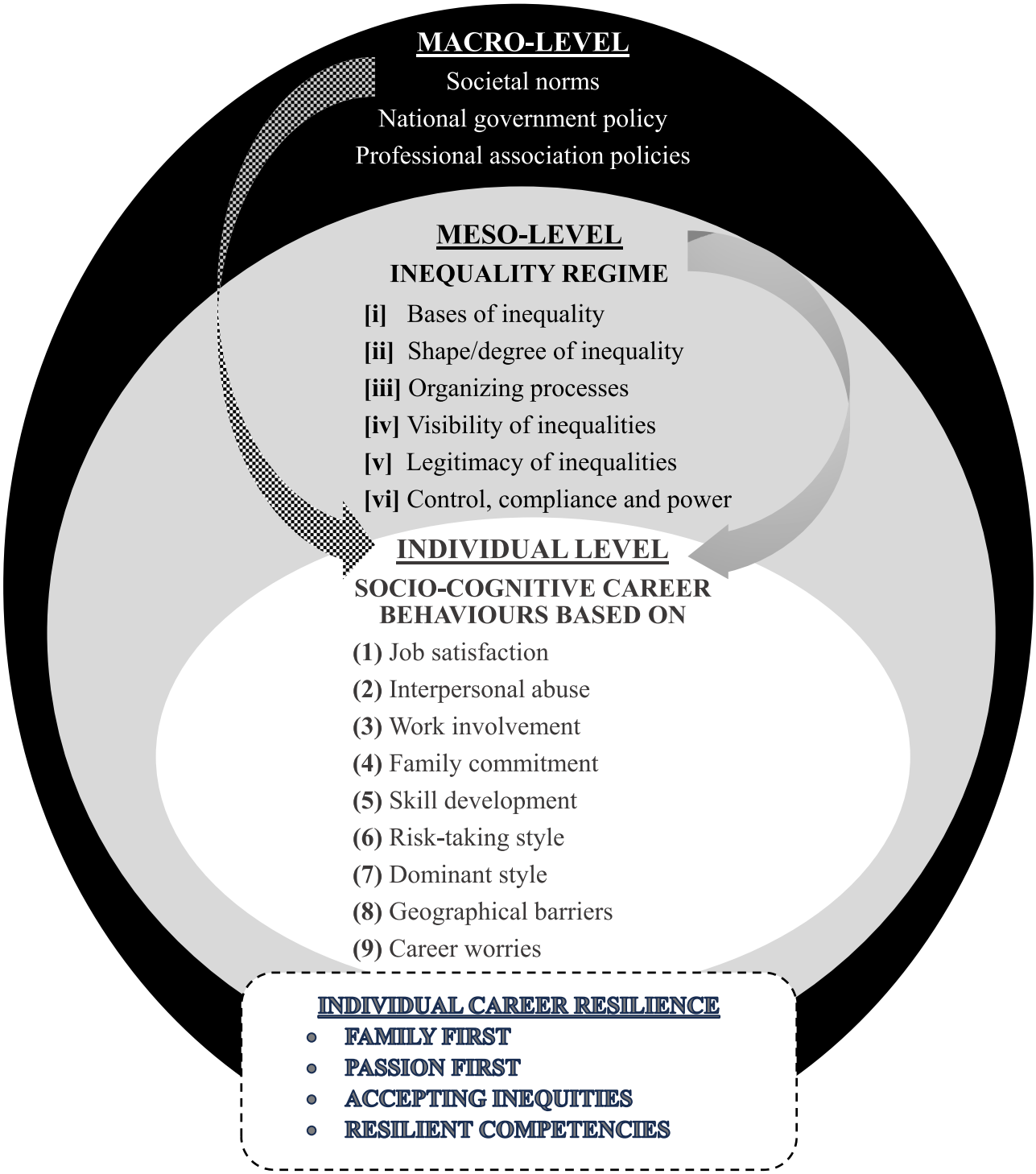

FIGURE 2 | Conceptual framework of factors influencing female professionals' career resilience. Acker (2006, 2009) and Holland and Gottfredson (1994).

which can result in burnout and intentions to quit (Walsh 2013). The literature suggests that female physicians can be more empathetic than men and spend longer with patients (Linzer and Harwood 2018); however, this leads to greater burnout for female physicians, compounded by various facets of inequality regimes (Acker 2006). Evidence in the study illustrated female physicians' concerns for patients and students and family members. The male physicians were particularly interested in boardroom decision-making and rarely mentioned family responsibilities. This echoes the ideal of the "unencumbered worker" (Berns 2002, 5).

Our respondents did not mention high rates of sexual harassment that are generally experienced by female surgeons (Begeny et al. 2023). They did, however, refer to others' resentment about female physicians' pregnancy and childcare responsibilities

(Granek et al. 2024). Interviewees were aware that women in academic medicine are not promoted because of gender stereotyped assumptions, which policy changes alone cannot easily rectify (Kaatz and Carnes 2014).

When applying our conceptual framework (Figure 2), we found significant policy implementation gaps. Female physicians were struggling to advance in their careers because of others and internalized expectations about their lack of geographical mobility and family first priorities in South Asian cultures. The elite medical schools in our study are clearly sites where societal inequalities and inequality regimes are (re)produced (Acker 2006, 2009), detrimentally impacting female physician's careers.

6.1 | Theoretical Contributions

We offer three theoretical contributions to the field of gender studies in organizations related to (1) a holistic, integrated, and multi-level approach to career resilience by combining inequality regimes and social cognitive career theory, (2) non-Western centric perspectives on highly qualified professional women in a developing country, and (3) nuanced approaches to gender discrimination beyond social cognition related to emotional and physical tensions at various career stages.

First, by integrating Acker's (2006, 2009) inequality regime framework and SCCT, researchers and policymakers can better understand and address complex dynamics that shape how professional women demonstrate career resilience. A combined meso-level systemic structural approach and a micro-level individual perspective offers a nuanced, holistic, and robust multidimensional framework to understand gendered career structures and career resilience amongst professional women in specific cultural contexts drawing on social and psychological insights into institutional and individual considerations and how these intersect.

Second, we conceptualize career resilience by extending inequality regimes and social cognitive career theory to include macro-level contingencies in a non-Western developing country context which has been under-researched (Healy et al. 2011). Historically entrenched patriarchal norms influence individual agency for highly educated women who persist successfully in "greedy occupations" (Goldin 2024) characterized by disproportionate burnout amongst women (Yeluru et al. 2022). This is despite active discouragement from peers, gender biases, exclusion from executive decision-making, and family commitments (notwithstanding commonplace arrangements for live-in domestic help) that require high levels of self-sacrifice and forbearance.

Third, building on Kossek and Perrigino's (2016) review of occupational resilience, we observe the importance of emotional (family and nonwork) and physical demands (surgery, long hours, and overwork) as well as career stages (coinciding with marriage and motherhood) which nuance our understanding of gender discrimination and the need for different types of career resilience to navigate structural inequalities beyond social and cognitive perspectives.

6.2 | Implications for Policy and Practice

We offer a robust framework for support and interventions with complementary models. In the context of India, our study contributes to the case for strengthening medical leadership capabilities (Davies et al. 2025; Gulati et al. 2025) from gendered, systemic, structural, social, and cognitive perspectives. We contribute to studies of professional women's careers by using qualitative research methods to understand experiences of highly educated professional female employees in South Asia. This responds to the recommendation by Wang et al. (2022) to extend SCCT beyond the usual quantitative studies on careers amongst university students in developed countries. We also contribute to literature on physicians' careers beyond medical school and training which have been overlooked (van Leeuwen 2023) in non-Western settings.

Our study examines mainly academic physicians who are often overlooked in literature on workplace gender disparities and higher education careers. We argue that if societal, institutional and cognitive barriers to female academic physicians' career advancement are not addressed, they will perpetuate working life and health inequalities. In the context of India, arguably, Nari Shakti is a useful national framework to adopt institutionally for positive impact in advancing women's careers through enabling equal pay and opportunities to balance family and work responsibilities while also advancing national progress toward developed country status.

This study illuminates female empowerment using social cognitive career perspectives at the individual level and structural institutional perspectives in the world's most populous democratic country. Nari Shakti for nation building provides an interesting macro-level backdrop. Our findings indicate there is scope for greater political will to implement this policy in India's leading medical institutions. Mainiero and Sullivan (2005) suggest that a kaleidoscope career model would benefit from line managers being accountable for their direct reports' career advancement goals. They advocate work being redesigned to accommodate work–nonwork demands with new career paths and working schedules that are more flexible. Performance management and reward systems should be based on outcomes and a supportive culture in this approach. Waterman et al. (1994, 89) argue that an organization "must help people explore opportunities, promote lifelong learning, and, if it comes to that, support no-fault exits". They suggest that career resilience programs can help employees to assess their interests, skills, temperaments and values and regularly benchmark and update their skills to help them to understand how they can excel and remain competitive in the labor market.

7 | Conclusion

Our research sought to explore the impact of institutional inequality regimes on the career resilience of highly educated female professionals in a developing country context of women's empowerment (Nari Shakti) drawing on SCCT. The findings illustrate the bases and extent of gender disparities in organizational processes which are normalized in a patriarchal society.

These are linked to individual-level orientations about career advancement such as gendered assumptions in South Asia about female employees' family commitments, risk taking and leadership styles and lack of geographical mobility. This article introduces Nari Shakti as a novel phenomenon in gender and organizational studies and in the field of higher education careers in academic medicine. Clearly, our findings demonstrate entrenched patriarchal behaviors and attitudes in households and organizations that frustrate national and personal career ambitions in India. This is despite Nari Shakti discourse even in elite academic medical institutions like AIIMS. Nevertheless, female physicians persist with passions such as surgery and entrepreneurship.

Future research might adopt longitudinal, participatory and comparative approaches by examining the effectiveness of appropriate interventions to support gender equity and careers, with insights into religion, caste, intergenerational, and international differences. Further studies might also explore changes in traditional extended and nuclear families in South Asia and how professional working women can realize their full potential while avoiding burnout, especially in roles as sandwiched caregivers when they support their children and parents simultaneously (Jacobs and Gerson 2004).

As the number of female medical students in India exceeds the number of male students (Temkin et al. 2024), it is important that these approaches are culturally sensitive in an LMIC context to stimulate collective efforts to achieve gender equity and a female leadership pipeline in academic medicine (Dharanipragada et al. 2024; Heru 2005). We recommend radical mechanisms to translate national ideology on female empowerment into everyday reality. These might include adopting the UN Women's Empowerment Principles, gender equality action plans linked to enforcing regulations, funding, and accreditations such as the Athena SWAN Charter (Rosser et al. 2019). Finally, we argue that a robust evidence base and inclusive feminist medical leadership development are required to support medical careers and the well-being of physicians, healthcare institutions, and nations by addressing workplace gender inequalities.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data will be made available on request.

Endnotes

[1] "a term used to symbolize women taking charge of their own lives. Derived from Sanskrit, Nari means "women" and Shakti means "power"..... "Nari Shakti or women power is reflective of the renewed power of women that came to the fore in 2018. ... Nari Shakti is a movement involving both men and women, and a reminder that we need to keep fighting the good fight." Oxford Dictionaries Team, India. Source: https://global.oup.com/news-items/archive/Nari_Shakti?cc=gb [accessed:15/1/2025].

[2] On 19 December 2023, Prime Minister Modi launched Viksit Bharat @2047. "Viksit" means "advanced" and "Bharat" is the official Hindi name for India. This vision aims to transform India from a developing to a developed country by focusing on human capital. It includes Nari Shakti for developing women beyond being full-time homemakers (Patil 2024).

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