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"Swallowed by a Black Hole": The Neglected Impact of Endometriosis in the Workplace

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ABSTRACT

This study examines how endometriosis, as a chronic and cyclical condition, is experienced and managed in contemporary workplaces, and what this reveals about the limits of existing human resource management (HRM) frameworks. Drawing on Feminist Disability Theory (FDT), we conceptualise endometriosis as a form of structurally produced disadvantage shaped by organisational norms of continuous, able-bodied productivity. The study is based on qualitative data from in-depth interviews ($n = 26$) and a focus group ($n = 7$) with employees diagnosed with endometriosis, complemented by open-ended survey responses from HR professionals and managers ($n = 80$) used as contextual insight. Data were analysed using reflexive thematic analysis. Findings identify six interrelated themes that show how workplace practices render endometriosis both invisible and consequential. Extending FDT, we theorise these patterns as systemic neglect, specifying the organisational mechanisms through which marginalisation is enacted, including rigid absence systems, performance-based objectification, and cultures of silence around reproductive health. We further introduce the concept of physiodiversity, reframing chronic and cyclical physiological variation as a legitimate dimension of workforce diversity. The study contributes to HRM scholarship by specifying how able-bodied norms are operationalised in practice and by offering a conceptual foundation for more inclusive approaches to managing chronic health conditions at work.

1 | Introduction

> It was as if I had been swallowed by a black hole. Endless, consuming, and inescapable. The pain pulled me deeper, away from everything normal, leaving me struggling to hold onto the person I was before. Each day felt like fighting to climb out, only to be pulled back in again, with no light, no relief in sight.
>
> (Participant P8, Team Leader in a telecommunications company)

Endometriosis is a chronic health condition affecting 1 in 10 individuals assigned female at birth globally (Maulenkul and et al. 2024). Endometriosis is estimated to cost the UK economy £8.2 billion annually due to treatment expenses, loss of work, and healthcare costs (Jackson and Kapadi 2024). Caused by endometrial-like tissue (tissue resembling the uterine lining, known as the endometrium) growing outside the uterus, it results in chronic inflammation, scarring, and cyst formation (Johnson et al. 2017), leading to severe pain, fatigue, and heavy menstrual bleeding that significantly reduce quality of life (Simoens et al. 2012).

A distinctive aspect of endometriosis is its fluctuating and cyclical nature, with symptoms that vary in intensity across different phases of the menstrual cycle. Pain, exhaustion, and cognitive fog can intensify unpredictably during ovulation or

Practitioner Notes

- What is currently known?
  - Endometriosis affects 1.5 million UK workers yet remains largely absent from HRM policy frameworks
  - Existing absence management tools systematically disadvantage employees with cyclical or episodic conditions
  - Stigma around menstrual and reproductive health discourages disclosure even where workplace protections exist
  - Diagnostic delays averaging seven to 10 years mean many employees remain without organisational support
- What this paper adds?
  - Identification of eight dimensions of systemic neglect through which HRM policies marginalise employees with endometriosis
  - Introduction of physiodiversity as a concept that extends diversity frameworks to include chronic physiological variation
  - Evidence that structural tools such as the Bradford Factor actively disincentivise formalising endometriosis-related absence
- The implications for practitioners
  - For HR managers: existing absence management tools, including the Bradford Factor, should be audited and revised where they disproportionately penalise employees with cyclical health conditions
  - For line managers: reproductive and menstrual health literacy training is needed across all sectors, moving beyond generic wellbeing provision towards condition-specific understanding
  - For HR policy designers: flexible working provisions and reasonable adjustments should not require formal diagnosis as a precondition, in line with the UK Equality Act 2010
  - For organisations: specialist accreditation schemes and free employer resources offered by menstrual health bodies provide accessible, evidence-informed entry points for workplace reform.

menstruation, disrupting daily functioning and creating uncertainty in planning and performance (Horn et al. 2025; Spyrelis et al. 2024). Such cyclical variation forces individuals to continually adapt and self-regulate their work routines, often without adequate organisational awareness or flexibility.

While endometriosis shares some characteristics with other chronic health conditions such as persistent pain and fatigue seen in fibromyalgia, arthritis, or migraine, it differs in several crucial ways. Even among gynaecological conditions, endometriosis presents unique diagnostic and lived challenges compared with polycystic ovary syndrome (PCOS), uterine fibroids, or premenstrual dysphoric disorder (PMDD), as its lesions (abnormal tissue growths that bleed and inflame in response to hormonal cycles but have no route of exit from the body) are internal and not externally visible. The elusive nature of endometriosis, often called the "chameleon of gynaecology" (Harder et al. 2024), contributes to its frequent misdiagnosis and disbelief, leaving many employees struggling to legitimise their symptoms at work (Lindgren and Richardson 2023). Endometriosis also has one of the longest diagnostic delays of any gynaecological condition, averaging seven to 10 years (De Corte et al. 2025). At work, this uncertainty often undermines credibility, as individuals are asked to "prove" a condition that may remain medically unconfirmed for years. Such disbelief reflects a wider gender pain gap, where women's[1] pain is more likely to be dismissed, underdiagnosed, or psychologised (Criado Perez 2019). The normalisation of menstrual pain reinforces this gap, positioning suffering as an expected part of womanhood rather than a legitimate workplace concern.

To move beyond a purely medical reading of these challenges, this study applies Feminist Disability Theory (FDT) to explore how workplace norms and broader social expectations shape the meaning and experience of health and illness at work. FDT problematises the biomedical model by showing that disadvantage arises not only from the body itself but also from the social and institutional contexts that define which bodies are considered normal, capable, and productive (Wendell 1989; Garland-Thomson 2005). In this sense, FDT assumes that chronic illness is not simply an individual or medical issue but is also shaped by organisational and societal arrangements that privilege able-bodied, stable, and continuously productive workers (Wendell 1989; Dirth and Branscombe 2018; Remnant et al. 2023). It further draws attention to how embodied differences that are invisible, cyclical, and gendered are often normalised, dismissed, or rendered unintelligible within professional contexts, particularly where pain and reduced capacity do not fit dominant norms of ideal worker functioning (Jones 2016; Hallström 2024). This framework allows the study to examine how endometriosis interacts with organisational ideals of stability, performance, and able-bodied productivity and how these assumptions shape women's participation in work and their sense of legitimacy within it (Wendell 2013; Hawkey et al. 2022; Hunsche et al. 2023).

While FDT provides the overarching theoretical lens for understanding how endometriosis is socially and organisationally marginalised, it does not by itself specify the concrete dimensions through which such marginalisation is enacted in workplace settings. To address this, we draw on Cetera et al. 's (2024) application of Todres et al.'s healthcare dehumanisation framework to endometriosis care, which discusses eight dimensions through which women's experiences may be diminished within clinical encounters, and adapt these dimensions to the managerial context as forms of systemic neglect.

Although recent HRM literature increasingly recognises chronic illness at work (den Kamp et al. 2024; DeOrsey and Agars 2024; Raque et al. 2024), gendered and reproductive health conditions such as endometriosis have received comparatively limited attention (Innocenti et al. 2024; Swift et al. 2024). Most research on endometriosis in organisational contexts has concentrated on medical management or individual coping, with limited attention to how workplace cultures, HRM practices, and policy frameworks shape these experiences. As such, there remains a conceptual and empirical gap in understanding how endometriosis interacts with organisational structures, expectations of productivity, and gendered workplace norms. Building on this

lens, we aim to 1) understand the workplace experiences of women with endometriosis, particularly the challenges they face in managing their condition while maintaining professional responsibilities; 2) critically examine how workplace policies and practices reproduce able-bodied assumptions that neglect or marginalise employees with chronic and cyclical conditions; and 3) use these findings to develop physiodiversity as a conceptual response that recognises chronic and cyclical physiological variation as a legitimate dimension of workforce diversity. Building on these aims, our contribution is therefore not merely to apply FDT to endometriosis, but to specify the HRM mechanisms through which able-bodied organisational norms become operationalised as systemic neglect.

2 | The Organisational Lens on Endometriosis

The professional experiences of women with endometriosis expose critical gaps in workplace policies, which are often developed around the assumption of a fully healthy workforce (Bullo 2020). Women with endometriosis often manage substantial health-related burdens, such as chronic pain, fatigue, and frequent medical appointments, while also attempting to meet workplace demands. These overlapping pressures are intensified when organisational resources are limited, including rigid schedules, insufficient medical leave, and weak support systems (Hansen et al. 2013). Conversely, when resources such as flexible work arrangements and emotional support are available, they can buffer strain, reduce the adverse effects of chronic illness, and enhance wellbeing and engagement (Bakker and Demerouti 2007).

Research shows that women with endometriosis are more likely to encounter stigma and restricted career progression due to the variability of their symptoms (Gupta et al. 2021; Moradi et al. 2014; Seear 2009). Fear of being perceived as unreliable leads many to conceal their condition, limiting access to accommodations and perpetuating absenteeism and presenteeism (Hawkey et al. 2022). The lack of supportive work environments can intensify this resource depletion, placing these women in precarious positions where both their professional and personal lives are adversely impacted (Nnoaham et al. 2011; Guest 2017). Research on disclosure specifically shows that women with endometriosis develop deliberate strategies of selective silence, weighing the risks of visibility against the costs of concealment in performance-driven environments (Krsmanovic and Dean 2022). This pattern of gendered self-protection, in which women manage others' perceptions of their reliability and competence by suppressing evidence of pain, has been documented across qualitative accounts of chronic illness at work (Grogan et al. 2018).

The scale of these workplace consequences is documented by the All-Party Parliamentary Group on Endometriosis (2020), which found that 38% of respondents with endometriosis worried about losing their job due to their condition, while 35% reported reduced income as a direct result. These figures underscore that the workplace consequences of endometriosis are not marginal or individually determined; they are structural and economically significant, reflecting a systemic failure to accommodate a condition that affects a substantial proportion of the workforce. Understanding this failure requires a theoretical lens that can explain how embodied differences become marginalised through organisational norms of productivity, reliability, and presence.

Applying FDT to endometriosis enables a deeper understanding of how able-bodied and masculine norms shape workplace expectations of productivity, stability and presence. By foregrounding the lived experiences of women whose bodies do not conform to these norms, we can reveal how organisational policies reproduce structural inequities through what we conceptualise as systemic neglect. This neglect is not simply a lack of awareness but an institutionalised indifference to forms of embodied diversity that do not fit linear expectations of attendance, performance, or energy. In this sense, FDT can frame endometriosis as more than a medical issue; it is a site where gender, embodiment, and labour expectations intersect, shaping women's participation in the workforce and their sense of belonging within it.

FDT rests on three interrelated theoretical assumptions that guide the analytical approach of this study. First, it rejects the biomedical model's location of disadvantage within the individual body, arguing instead that chronic illness and disability are produced through the encounter between embodied difference and social, institutional, and organisational arrangements that privilege kinds of bodies (Wendell 1989; Garland-Thomson 2005). Disadvantage, in this view, is not a property of the body but an effect of the contexts in which certain bodies are expected to function. Second, FDT foregrounds the gendered dimension of this production: the bodies most consistently rendered abnormal, unreliable, or excessive within professional life are those that deviate from an implicitly male, able-bodied norm (Shildrick 1997, 2019). For women with endometriosis, this means that the cyclical, unpredictable, and invisible character of the condition does not simply make work more difficult; it makes their embodiment structurally illegible within organisations designed around a different kind of body. Third, FDT is epistemologically committed to centring the lived experience of those whose embodiment is marginalised as a legitimate and necessary source of knowledge about social and organisational life (Dirth and Branscombe 2018). In this study, these three assumptions are operationalised through a corresponding set of analytical moves: grounding the analysis in participant accounts as the primary evidential base; reading those accounts through the adapted Cetera et al. (2024) dimensions of systemic neglect to identify how institutional arrangements reproduce marginalisation in HRM practice; and developing physiodiversity as a conceptual response that translates FDT's structural critique into the policy language of diversity and inclusion. Unlike theoretical approaches that treat chronic illness as an individual variable to be managed, FDT locates the source of disadvantage in the organisational arrangements themselves, making it possible to ask not only how women cope, but why coping is required at all.

Endometriosis, although not always officially recognised as a disability, fits within a broader critique of how chronic and invisible conditions are marginalised in both medical and professional contexts (Jones 2016). FDT questions binary categorizations of "abled" versus "disabled" by showing how people with chronic conditions may be denied recognition and support precisely because their embodied limitations do not conform to

conventional disability categories (Wendell 2013; Dirth and Branscombe 2018; Remnant et al. 2023). Hallström (2024) similarly emphasises the significance of social recognition in the lived experience of endometriosis, particularly how the condition is often overlooked or misunderstood in professional settings. This lack of recognition forces women to engage in continuous body work to navigate symptoms and fit into workplaces that remain organised around able-bodied norms. Shildrick's (1997) concept of the "leaky body" is particularly relevant here, as symptoms such as heavy bleeding and severe pain, and bodily unpredictability are often treated as incompatible with professional ideals of control, composure, and reliability. The effort to conceal these symptoms can produce internalised shame, drain personal resources, and deepen women's sense of alienation at work (Bobel and Fahs 2020; Przybylo and Fahs 2020; Hawkey et al. 2022; Hunsche et al. 2023).

Recent scholarship has begun to explore how endometriosis is lived and navigated alongside employment through explicitly feminist theoretical lenses, offering important points of dialog for the present study. Williams et al. (2025), drawing on Hallström's (2024) foundational theorisation of endo time, alongside Shildrick's (2019) concept of neoliberal embodied precarity and Kafer (2013), (2021) concept of *crip time*, develop *endo time* as an endometriosis-specific non-normative temporality situated within the context of employment. Their analysis demonstrates how the regularly irregular rhythms of endometriosis create a fundamental incompatibility with linear, continuous productivity demands, leading some women to seek precarious or flexible employment as a paradoxical form of bodily accommodation. Their findings on appearing well at work, rigid absence policies, managerial disbelief, and the relief afforded by flexible working resonate closely with the experiences described by our participants.

This feminist theoretical work sits alongside a broader empirical literature that consistently documents the workplace consequences of endometriosis. Quantitative studies demonstrate substantial absenteeism and presenteeism, alongside longer-term impacts on labour force participation and earnings (Estes et al. 2020; Rowlands et al. 2022; Soliman et al. 2017), while qualitative research highlights diagnostic delay, symptom uncertainty, stigma, and the need for ongoing self-management (Ellis et al. 2022; Sun et al. 2022). Studies of disclosure further show how workplace environments shape whether and how women make their condition visible, often leading to strategic concealment and self-regulation (Krsmanovic and Dean 2022; Eitze and Reinhardt 2025). Emerging organisational research points to the value of flexibility and managerial support, but also to the absence of consistent and embedded policy responses (Armour et al. 2022; Howe et al. 2025).

However, this literature has primarily focussed on documenting the consequences and lived experiences of endometriosis, rather than specifying the organisational mechanisms through which these patterns are produced and sustained. In particular, there remains limited understanding of how everyday HRM practices, including absence management systems, performance expectations, managerial discretion, and disclosure cultures, translate cyclical and invisible conditions into structural workplace disadvantage.

Our study builds on and extends this body of work in two ways. First, rather than focussing primarily on how women adapt to or circumvent unaccommodating organisational structures, we identify the specific institutional mechanisms through which their marginalisation is reproduced, drawing on Cetera et al. 's (2024) framework of clinical dehumanisation to map the dimensions of systemic neglect in HRM practice. Second, we develop physiodiversity as a policy-level reframing, arguing that cyclical and chronic embodiment should be recognised within diversity and inclusion frameworks rather than managed as individual deviation from an able-bodied norm. This positioning inform the analytical focus of the study: to examine how endometriosis is made difficult to disclose, accommodate, and legitimise within everyday organisational life, and to situate this analysis within critical HRM debates on workplace dehumanisation, where cultures that privilege productivity over holistic wellbeing can marginalise employees whose embodied needs disrupt assumptions of stable performance (Pfeffer 2018; Bal et al. 2022; Gip et al. 2023; Li et al. 2024; Alvesson et al. 2022).

3 | Methods

This study is designed as an employee-centred qualitative inquiry into the impact of endometriosis in workplace settings. Following qualitative HRM research that distinguishes between primary analytical data and supplementary contextual material (Diefenhardt et al. 2025), the employee interviews and focus group constitute the main body of data in this study, while the employer survey responses are used as complementary organisational context. Ethical approval was obtained from the authors' university research ethics committee.

3.1 | Overview of Data Collection Procedures and Participants

Data collection comprised two components. The primary component consisted of in-depth interviews and a focus group with employees diagnosed with endometriosis; these constitute the main analytical basis of the study. The secondary component consisted of open-ended survey responses from HR representatives and managers, used selectively to contextualise the organisational conditions within which employees' experiences unfold. The employer responses are not treated as an equivalent dataset, nor as a means of validating employee accounts; their role is complementary and contextual throughout. Table 1 provides an overview of each data source, its scope, and its contribution to the study.

The interviews provided individual-level perspectives on how employees experience and manage endometriosis at work, with a particular focus on embodiment, coping, and disclosure decisions. The focus group extended these insights through collective reflection and shared meaning-making, allowing participants to elaborate and challenge one another's accounts of policy gaps and workplace silence. The employer survey provided an organisational perspective on managerial awareness, support and policy gaps, relating to chronic health conditions such as endometriosis. These responses helped situate the employee findings within the organisational conditions that shape disclosure, support and accommodation practices.

TABLE 1 | Sequential data sources and their analytical purpose.

Phase	Data source	Type of data	Sample/scope	Analytical purpose	Contribution to the paper
Phase 1 Employee lived experience	In-depth semi-structured interviews via microsoft teams	Interview transcripts capturing lived experiences of managing endometriosis at work	26 full-time employees diagnosed with endometriosis across sectors and job roles	To examine participants' diagnostic journeys, physical and psychological symptoms, disclosure decisions, coping strategies, and experiences of workplace support	Primary analytical dataset; formed the foundation of the reflexive thematic analysis and identified key patterns around workplace legitimacy, stigma, and structural neglect
Phase 2 Collective employee reflection	Focus group discussion via microsoft teams	Group discussion transcripts on policy, disclosure, and the burden of proof	7 participants drawn from the interview cohort	To explore shared experiences of navigating workplace flexibility, disclosure dilemmas, and the absence of formal policy support; to surface collective insights on possible reforms	Secondary primary source; deepened understanding of stigma and the relational and institutional dimensions of endometriosis management at work
Phase 3 Complementary organisational context	Open-ended survey via prolific	Written narrative responses on awareness, policies, and organisational responses to chronic health conditions	80 HR representatives and managers with supervisory or policy responsibilities	To contextualise the organisational landscape within which employees' experiences unfold; to capture employer awareness and attitudes towards chronic illness and endometriosis-related disclosure	Treated as complementary context rather than an equivalent dataset; used selectively to illuminate the structural and policy conditions shaping employee experiences

Note: The three phases reflect a sequential mixed-qualitative design. Phases 1 and 2 constitute the primary analytical dataset. Phase 3 are used selectively as organisational context.

3.2 | Data Collection

Because this study focuses on endometriosis as a gendered and cyclical condition, all methodological decisions, including how participants were chosen and how the data was analysed, were made to highlight the specific nature of this condition rather than to make generalisations about other chronic illnesses. The focus on full-time employees was intentional to examine how endometriosis is managed within the structural constraints of continuous, full-schedule employment, settings where organisational expectations of attendance and performance are most rigid. Each participant, whether in interviews, the focus group, or the open-ended survey, received a consent form with study information and an overview of the interview protocol. As a token of appreciation, each participant was given a £20 incentive for their time and contribution to the study.

A semi-structured interview guideline was developed, informed by Cetera et al. 's (2024) framework of clinical dehumanisation and aligned with FDT's emphasis on embodied experience and structural neglect. In practice, this meant that the interview guide was designed to explore not only participants' symptoms and coping strategies, but also how workplace norms, policies, and expectations shaped the legitimacy and management of endometriosis at work. The guide covered diagnostic journeys, physical and psychological symptoms, workplace coping strategies, disclosure decisions, organisational support, and perceived policy gaps. In addition, the open-ended survey for HR and managerial respondents explored awareness, existing policies, and organisational responses to chronic health conditions, including endometriosis.

3.2.1 | In-Depth Interviews and Focus Group Discussions With Employees

In the first phase, in-depth, semi-structured interviews were conducted with 26 full-time employees diagnosed with endometriosis (see Table 2 for participant characteristics). The interviews focussed on participants' personal experiences of managing endometriosis at work, including physical and psychological symptoms, diagnostic journeys, treatment approaches, workplace support and disclosure decisions. All interviews were conducted via Microsoft Teams within a qualitative, interpretive design that foregrounded participants' lived experiences and the meanings they attached to them (Creswell & Poth, 2016).

TABLE 2 | Research participant characteristics.

Participant	Job title	Time since diagnosis
Interview participants (n = 26)		
P1-I	Senior research midwife	1 year
P2-I	Consultant researcher	8 years
P3-I	Clinical engagement project officer	2 years
P4-I	Teacher of chemistry	8 years
P5-I	Engagement advisor	1 year
P6-I	Product technician, medical device industry	1 year
P7-I	Risk manager, financial services	3 years
P8-I	Team leader, telecommunications company	7 years
P9-I	Deputy head of news, newspaper	10 years
P10-I	Disability advisor	17 years
P11-I	Pharmacist	6 months
P12-I	Specialist mental health, drugs and alcohol midwife	3 years
P13-I	Nursery practitioner	4 months
P14-I	Lecturer in psychology, sole trader	6 months
P15-I	Delivery manager, charity sector	2.5 years
P16-I	Head of sociology in secondary education	1 year
P17-I	Programme manager, university	2 years
P18-I	Senior E-commerce manager	3 years
P19-I	Software implementation specialist	1.5 years
P20-I	Deputy service delivery manager	1.5 years
P21-I	Environmental specialist	6 months
P22-I	Health and safety manager	5 years
P23-I	Account manager	1 year
P24-I	Primary education teacher	1 year
P25-I	University lecturer	3 years
P26-I	Psychological practitioner	1 year
Focus group participants (n = 7)		
P1-FG	Retail worker	4 years
P2-FG	Transport for London Employee	14 years
P3-FG	Wealth manager	8 years
P4-FG	Marketing professional	4 years
P5-FG	Veterinarian	3 years
P6-FG	Veterinary nurse	2 years
P7-FG	Social worker	3 years

Note: All participants in Phase 1 held full-time employment and had a confirmed diagnosis of endometriosis. Focus group participants (Phase 2) were drawn from the interview cohort. Pseudonymous codes are used throughout.
Abbreviations: FG = focus group; I = interview.

Following the individual interviews, a focus group was conducted with 7 participants who shared their insights on how workplace policies, or lack thereof, impacted their ability to manage endometriosis at work (see Table 2 for focus group participant details). The discussion focussed on disclosure, workplace flexibility, and the burden of proving their illness, allowing participants to reflect collectively on shared experiences and possible policy reforms. This generated additional insight into the relationship between endometriosis, stigma, and workplace practices.

3.2.2 | *Complementary Organisational Context: Open-Ended Survey of HR Representatives and Managers*

This complementary perspective involved a survey of 80 HR representatives and managers (Table 3). These respondents

TABLE 3 | Employer survey participant characteristics.

Category	n	%
Education level		
University degree	38	48%
High school or equivalent	33	41%
Master's level	9	11%
Number of direct reports		
0 to 10	36	45%
11 to 30	32	40%
31 to 80	8	10%
81+	4	5%
Formal EDI training		
Yes	70	88%
No	10	13%
Gender		
Male	48	60%
Female	32	40%
Experience supervising employees with chronic health conditions		
Yes	62	78%
No	18	23%
Total	80	100%

were recruited independently from the employee interview and focus group participants and were not drawn from the same organisations. Eligibility for this stage required participants to hold HR or managerial responsibilities involving employee supervision, workplace support, or policy implementation. They were not required to confirm prior direct experience of managing an employee with endometriosis.

The survey examined employer attitudes, awareness, and workplace policies relating to chronic health conditions like endometriosis. The open-ended questions were informed by previous research on chronic illness in the workplace and the translation of medical practices of dehumanisation into the concept of systemic neglect in the workplace (Cetera et al. 2024; DeOrsey and Agars 2024; Grogan et al. 2018; Krsmanovic and Dean 2022). These questions were designed to gather qualitative insights into policy implementation and into how respondents understood disclosure-related challenges and support needs in relation to chronic health conditions. Prolific, an online recruitment platform, facilitated participant recruitment, targeting individuals involved in policy oversight and management. In the present paper, these responses are used more selectively to provide organisational perspective rather than as a dataset equivalent in depth to the interview and focus group material.

3.2.3 | *Role of Researchers and Reflexivity*

The researchers' backgrounds and experiences were an important part of the study, especially because the first author has personal experience with endometriosis. This connection helped build empathy and understanding with participants, but we also took steps to remain reflexive and analytically careful (Finlay 2002; Berger 2015). After each interview or focus group, the two researchers discussed the conversation and took notes on initial impressions and possible assumptions. We also held peer discussions to check our interpretations and made sure that voices from different job roles and sectors were represented in the analysis. These steps helped strengthen credibility of the findings and ensured that no single perspective dominated (Guba and Lincoln 1994; Morrow 2005).

3.3 | Data Analysis

We analysed the data using Braun and Clarke's (2019, 2022) reflexive thematic analysis. This approach enabled us to identify patterned meanings across employee and employer context while remaining attentive to context, researcher interpretation, and the broader organisational conditions in which endometriosis was experienced. Throughout the analysis, reflexivity was important in recognising how the researchers' assumptions, positions, and experiences could shape interpretation (Finlay 2002; Berger 2015; Doucet and Mauthner 2008).

The analysis involved several iterative steps. After each data collection, the two researchers reviewed the transcripts independently, noted initial impressions, and then met to discuss emerging ideas and potential assumptions. This was followed by open, line-by-line coding to identify key concepts within participants' accounts. Codes were first generated inductively from the data, while also being sensitised by key ideas from the literature and theoretical framework, such as stigma, systemic neglect, disclosure, and flexibility. These initial codes were then refined through team discussions into a final coding framework that guided theme development. We then grouped related codes into broader themes that captured patterns across the employee interviews and focus groups, while drawing more selectively on the employer survey to contextualise organisational awareness, support, and policy gaps. As this process advanced, the emerging themes were refined through sustained engagement with both FDT and the adapted Cetera et al. (2024) dimensions, which served as interpretive lenses for examining how structural marginalisation was enacted in workplace practice. Table 4 presents the complete analytical framework, mapping preliminary inductive codes onto second order themes, key empirical patterns, theoretical dimensions, and their FDT anchors.

As Table 4 illustrates, FDT informed the broader theoretical interpretation of endometriosis as a gendered, embodied, and structurally marginalised condition, while the adapted Cetera et al. (2024) dimensions served as interpretive categories for examining how that marginalisation was enacted in workplace practices and policies. This analytic approach enabled us to organise employee responses into a coherent thematic structure while still allowing space for variation in individual experience. Employer survey responses were reviewed separately and used only where they provided relevant contextual insight into organisational awareness, policy gaps and support practices (Braun and Clarke 2014; Clarke and Braun 2017; Joffe 2011; Nowell et al. 2017). Figure 1 complements Table 4 by visually summarising the progression from inductive codes to aggregate

TABLE 4 | Analytical framework: From inductive codes to theoretical dimensions.

Themes	Key empirical patterns	Cetera et al. (2024) dimension	FDT link	Analytical summary
Primary analytical data: Employee interviews (n = 26) and focus group (n = 7)				
Theme 1: Embodied pain and performing normality	• Cyclical, unpredictable pain during menstruation and mid-cycle • Self-surveillance and pressure to appear competent and reliable • Informal coping: Heat packs, rescheduled meetings, discreet medication • Formal support rare, inconsistent, manager-dependent	**Objectification**	Compulsory able-bodiedness (Wendell 1989); the ideal worker norm renders fluctuating embodiment professionally illegible	Employees concealed pain to meet performance expectations that organisations took for granted. The absence of any formal acknowledgement of cyclical health needs meant self-management was the only available strategy.
Theme 2: Institutional barriers and rigid policies	• Sick leave frameworks designed for acute, not cyclical, illness • Bradford factor penalising episodic absences • Repeated documentation demands discouraging leave-taking • Annual leave used to conceal flare-ups; financial penalties incurred	**Passivity and dislocation**	Institutional arrangements privilege stable, able-bodied workers; organisational structures reproduce rather than mitigate inequality (Dirth and Branscombe 2018)	Employees described feeling penalised by systems that could not accommodate unpredictability. Rigid absence policies and documentation requirements actively deterred leave-taking, reinforcing presenteeism even during severe flare-ups.
Theme 3: Silenced voices and disclosure dilemmas	• Strategic concealment to protect professional credibility • Stigma around menstrual and reproductive health in professional settings • ~80% would not use menstrual leave even if legally available • Silence as self-protection, but at significant emotional cost	**Isolation and loss of meaning**	Gendered self-protection in performance-driven environments; the leaky body (Shildrick 1997) as a source of professional shame; invisible conditions rendered unintelligible	Employees weighed the risks of visibility against the costs of concealment. Even hypothetical formal protections were rejected out of fear of stigma, illustrating that policy provision alone, without cultural change, is insufficient.
Theme 4: Exhaustion and career trade-offs	• Cyclical fatigue distinct from burnout, with no predictable recovery phase • Avoided promotions, leadership roles, and new project responsibilities • Downward career adjustment framed explicitly as survival • Professional capability judged through the lens of health	**Loss of personal journey**	Chronic conditions quietly truncate career trajectories; organisations designed for linear productivity exclude those whose capacity is cyclical (Remnant et al. 2023)	Employees did not choose stalled careers; they were structurally constrained into them. The cumulative toll of working through pain without adequate support foreclosed ambition that organisations never registered as lost.

(Continues)

TABLE 4 | (Continued)

Themes	Key empirical patterns	Cetera et al. (2024) dimension	FDT link	Analytical summary
Theme 5: Emotional labour and mental health	• Constant emotional regulation to perform wellness at work • Guilt, anxiety, and shame around absences and team disruption • Internalised sense of professional failure and unreliability • Psychological exhaustion mirroring and compounding physical fatigue	**Objectification and reductionist views of health**	Employees reduced to performance metrics; Price's (2015) body-mind (physical and psychological wellbeing) inseparable; emotional labour as a gendered organisational expectation	The effort to appear well was experienced as equally draining as the condition itself. Organisations that addressed only physical absence, through documentation and sick leave, entirely missed the psychological dimension of the burden employees carried.
Theme 6: Organisational cultures of silence	• Reproductive health treated as taboo in professional contexts • Male-dominated sectors sustaining institutional silence • Pain trivialised by managers: Everyone has bad days • Unsupportive responses from female managers also reported	**Homogenisation, objectification and dislocation**	Uniform professionalism norms render cyclical embodiment invisible; organisational cultures as sites of structural exclusion (Garland-Thomson 2005)	Silence was institutionally produced, not individually chosen. Where managers did listen and offer flexibility, employees experienced meaningful relief, confirming that the problem lies in organisational design, not in the condition itself.

Note: Themes were identified through reflexive thematic analysis (Braun & Clarke, 2019) applied to employee interview and focus group data. The Cetera et al. (2024) framework of clinical dehumanisation was subsequently used as an interpretive lens to theorise how each theme reflects a distinct dimension of systemic neglect in organisational practice.
Abbreviation: FDT = Feminist Disability Theory.

themes, while also showing how the employer survey responses were used as contextual insight.

3.3.1 | *Emergent Themes From Data Collection*

The core themes presented below were developed from the employee interviews and focus group, and the interpretation of participants' narratives was guided by the framework of clinical dehumanisation developed by Cetera et al. (2024). Translating its eight dimensions into workplace dynamics enabled a deeper understanding of how organisational structures can overlook or invalidate the day-to-day realities of employees with endometriosis. As Table 5 shows, patterns of objectification, passivity, homogenisation, isolation, loss of meaning, dislocation, loss of personal journey, and reductionist views of health were adapted to illustrate how systemic neglect manifests in professional contexts. The following themes reflect these translated dimensions and demonstrate how endometriosis reveals the human costs of able-bodied organisational expectations. Specifically, they show how chronic pain is rendered invisible by performance norms (objectification), how fluctuating symptoms are met with institutional indifference rather than adaptive support (passivity, dislocation), how employees are compelled into silence and self-management through stigma (isolation, loss of meaning), and how career trajectories are quietly truncated by the cumulative toll of working in bodies that organisations refuse to accommodate (loss of personal journey, reductionist views of health).

As illustrated above, the six themes derived from employee interviews and focus groups map directly onto the Cetera et al. (2024) dimensions above: embodied pain and performing normality (objectification); institutional barriers and rigid policies (passivity, dislocation); silenced voices and disclosure dilemmas (isolation, loss of meaning); exhaustion and career trade-offs (loss of personal journey); emotional labour and mental health (objectification, reductionist views of health); and organisational cultures of silence (homogenisation). Employer surveys surfaced a complementary set of themes from a managerial perspective, centred on training gaps, limited policy awareness, and the structural and sectoral constraints that shape how chronic health conditions are recognised and responded to at work.

4 | Findings

4.1 | Theme 1: Embodied Pain and Performing Normality

Reflecting the objectification dimension of Cetera et al. (2024) (see Table 5), participants described how they felt compelled to suppress pain and perform normality to meet workplace

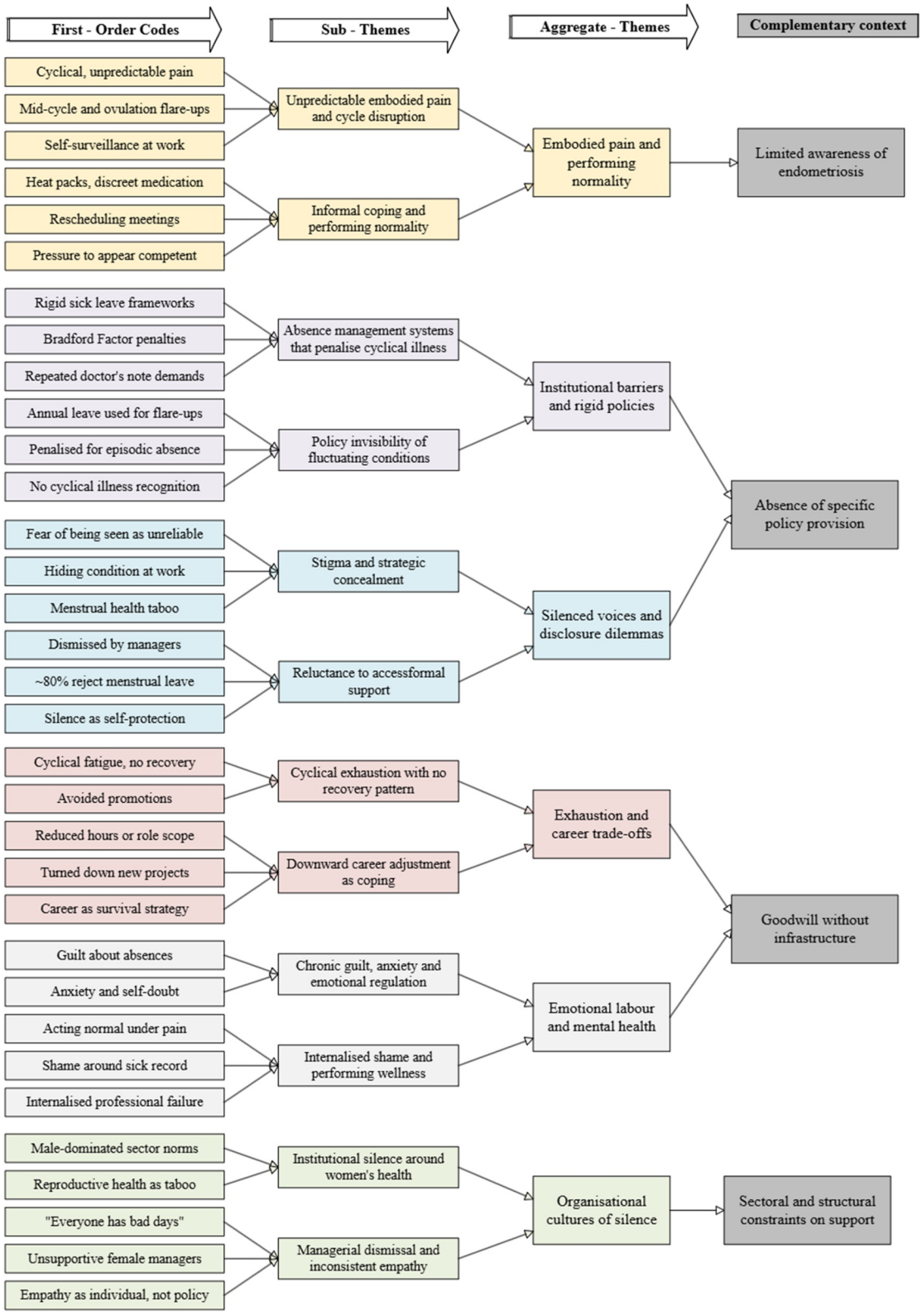

FIGURE 1 | Thematic data structure: From inductive codes to aggregate themes, with complementary employer perspective.

expectations. Many explained that their bodies were treated as functional instruments rather than lived realities, expected to maintain a constant level of performance regardless of pain or fatigue. As one participant put it, "I've learned to smile through cramps and pretend it's fine because no one wants to hear about periods at work" (P15-I, Delivery Manager). This expectation to detach from bodily experience led to self-surveillance and internalised pressure to appear reliable and competent, even when in severe discomfort.

Participants across both interviews and focus groups consistently reported the challenges of managing cyclical, intrusive,

TABLE 5 | Translating clinical dehumanisation to systemic neglect: Addressing workplace gaps in inclusivity and employee wellbeing.

Clinical concept (Cetera et al. 2024)	Adaptation for workplace management
Objectification	**Acknowledging individuality** Managers should recognise each employee's unique circumstances, including health needs, and validate their experience of chronic pain rather than minimising it.
Passivity	**Empowering employees** Employees with health issues should be given greater autonomy to manage their workload, supporting better control over their work-life balance and productivity.
Homogenisation	**Customising support** Rather than assuming all employees have identical needs, managers should offer personalised accommodations, such as flexible working hours or remote work options.
Isolation	**Fostering inclusion** Managers should create an inclusive environment where employees managing chronic conditions feel supported rather than alienated, with open communication as a foundation.
Loss of meaning	**Helping employees find purpose** Endometriosis may disrupt an employee's sense of professional purpose. Managers should support the integration of personal and professional goals and offer opportunities to redefine roles.
Loss of personal journey	**Supporting career continuity** Managers should provide accommodations that allow employees to maintain career progression despite fluctuating health conditions, rather than allowing illness to quietly truncate development.
Dislocation	**Creating a supportive work environment** A supportive environment encompasses both safe physical spaces (e.g., quiet rooms, accessible facilities) and psychological safety in which employees feel able to communicate their needs openly.
Reductionist views of health	**Adopting a holistic view of employee wellbeing** Managers should address not only physical symptoms but also the mental and emotional dimensions of chronic illness, embedding this understanding within workplace policies and everyday management practice.

and unpredictable pain while fulfiling professional responsibilities. Endometriosis-related pain was described as not limited to menstruation but also emerging during ovulation or mid-cycle, often without warning. Participants explained that pain could strike suddenly, disrupting concentration, mobility, and the ability to perform even routine work tasks.

Several participants depicted the pain in vivid, visceral terms. They described sensations that went far beyond typical menstrual cramps: “It feels like my body is being crushed from the inside... three weeks of every month” (P17-I, Programme Manager in Higher Education); “I wake up in pain, go to bed in pain... some days, I can barely walk” (P12-I, Specialist Mental Health Midwife). Others characterised it as “sharp, stabbing, and relentless” (P13-I, Nursery Practitioner) or “like someone is scraping from the inside with their nails” (P3-FG, Wealth Manager). Such extreme descriptions illustrate the embodied and unpredictable nature of endometriosis, where pain is both constant and uncontrollable, leaving individuals to manage their professional lives around its demands.

Because flare-ups could not be anticipated, many participants developed personal coping strategies to balance work and health. These included adjusting meeting times, working remotely when possible, or using heat packs and pain medication discreetly during the day. As one focus group participant explained, “I've learned to cope by taking it one day at a time... I plan my work and social life around my cycle” (P4-FG, Marketing Professional). Others mentioned rearranging tasks to match their fluctuating energy levels, noting that this constant adjustment required mental as well as physical effort. While these self-directed adaptations helped them sustain their work, they also underscored the lack of formal support or understanding within organisational structures. Across interviews and the focus group, participants described formal organisational support as rare and inconsistent; where support was experienced, it was usually informal, discretionary, and dependent on the empathy of individual line managers rather than on clear organisational policy.

4.2 | Theme 2: Institutional Barriers and Rigid Policies

Reflecting the passivity and dislocation dimensions identified by Cetera et al. (2024), participants described how institutional policies rendered them passive subjects within rigid systems

that failed to recognise cyclical health needs. Participants described workplace policies that poorly adapted to the fluctuating nature of endometriosis. Standard sick leave frameworks were often designed around short-term illnesses, leaving employees uncertain about how to request time off for symptoms that appeared intermittently and without warning.

P3-I, a Clinical Engagement Project Officer, noted the absence of formal procedures that accounted for chronic or cyclical health issues, explaining that she often felt "guilty" for needing time off when flare-ups occurred unexpectedly. "There are no guidelines for this kind of condition. It's not like a one-off illness... it comes back again and again, and they don't know what to do with it," she explained.

Similarly, P7-I, a Risk Manager, described how strict documentation requirements discouraged her from taking necessary leave: "They want a doctor's note every time, but you can't go to your GP every week. It's impossible and embarrassing". The repeated need to justify absences led several participants to avoid taking time off altogether, even when symptoms were severe, fearing it might affect performance evaluations or job security. As a result, some chose to use their annual leave instead of sick leave to manage flare-ups discreetly, further reducing their rest time and reinforcing the hidden nature of their condition.

P10-I, a Disability Advisor, emphasised that existing policies failed to accommodate unpredictable conditions: "When I have a flare-up, I often lose days at a time, but policy only allows for continuous sick leave. I end up being penalised financially because my absences are seen as separate incidents." This is likely a reference to the Bradford Factor, a widely used absence management tool that calculates a score by multiplying the number of separate absence episodes by the total days lost. Because it treats frequent short absences as more disruptive than single long ones, it systematically disadvantages employees with cyclical or episodic conditions, who by definition cannot consolidate their absences into a single continuous period (Brewis & Beck, 2023).

Several participants pointed out that endometriosis, unlike many other chronic health conditions, is difficult to document or validate because of its invisibility and diagnostic uncertainty. The lack of clear recognition within human resource systems reinforced a sense of being "unseen" or "not taken seriously." This structural gap between the experience of a fluctuating condition and the inflexible logic of workplace attendance rules illustrates how existing policies often reproduce inequity rather than mitigate it.

4.3 | Theme 3: Silenced Voices and Disclosure Dilemmas (Personal Stigma)

Stigma surrounding reproductive and menstrual health created forms of isolation and loss of meaning similar to those described in Cetera et al. 's (2024) framework. Many described an ongoing dilemma between honesty and self-protection, weighing whether to reveal their condition or conceal it to avoid judgement.

P6-I, a Product Technician in the medical device industry, recalled facing dismissive attitudes from her supervisor, who interpreted her requests for flexibility as excuses rather than legitimate needs. "When I said I was in pain, he rolled his eyes and said everyone has bad days. I stopped asking after that." Similarly, P4-I, a Teacher of Chemistry, described how guilt and shame prevented her from sharing her condition openly: "I didn't want people to think I was using it as an excuse not to do my job, so I just said I was fine."

Several participants highlighted how broader social taboos around menstruation reinforced their silence. As one explained, "People think it's just a period... they have no idea how much pain I'm in" (P11-I, Pharmacist). Another added that mentioning endometriosis in professional settings often created discomfort: "If you say it's gynaecological, people look away or change the subject. You feel like you've said something inappropriate" (P3-FG, Wealth Manager).

This personal stigma also affected how women imagined using potential workplace protections. When asked whether they would use menstrual leave if a law similar to Spain's existed in the UK, nearly 80% said they would not. Participants explained that they feared being judged or perceived as less committed. One participant said, "Even if it was allowed, I wouldn't take it. People would think I'm weak or taking advantage" (P9-I, Deputy Head of News). These responses show that stigma not only influences disclosure but also discourages women from accessing support, even when institutional mechanisms are hypothetically available.

For many participants, silence became a coping mechanism to protect professional identity and credibility. Yet this concealment also carried an emotional cost, creating feelings of loneliness and frustration. As one participant reflected, "You end up hiding such a big part of your life. It's easier than explaining, but it makes you feel invisible" (P5-FG, Veterinarian).

4.4 | Theme 4: Exhaustion and Career Trade-Offs

Aligned with the loss of personal journey dimension from Cetera et al. (2024), participants revealed how endometriosis disrupted their career trajectories, forcing them to make trade-offs between health and ambition. Participants frequently discussed how extreme tiredness and fluctuating energy levels limited their ability to take on new responsibilities or pursue promotions, leading to difficult trade-offs between ambition and wellbeing.

P18-I, a Senior E-commerce Manager, emphasised that her exhaustion was cyclical and beyond her control: "It's not normal tiredness. It's like my body just shuts down, and I have to keep going anyway." Another participant described how the lack of recovery time between flare-ups made it impossible to regain focus or momentum at work, saying, "You're constantly catching up. Even when you feel better, you're already behind" (P21-I, Environmental Specialist).

These experiences often led to difficult career decisions. Some participants chose less demanding roles or part-time work to manage their symptoms, while others avoided applying for promotions altogether. A participant working in the public sector explained, "I stay in the same position because I can't risk

more pressure. I know it looks like a lack of ambition, but it's survival" (P2-FG). P8-I, a Team Leader in a telecommunications company, explained that her energy levels fluctuated so dramatically that she often had to turn down new projects: "By the end of the day, I'm wiped out. I have nothing left to give. I used to take on more, but now I just can't keep up." Similarly, P25-I, a University Lecturer, described how she declined additional managerial responsibilities because of her condition: "I said no to a Programme Leadership role. I knew the meetings and deadlines would be too much for me, and I didn't want to fail at it."

For some, this exhaustion forced significant professional compromises. P7-FG, a Social Worker, shared that she eventually left her "dream profession" because the physical and emotional toll of endometriosis made the demands of her previous job unsustainable. Others, like P26-I, a Psychological Practitioner, spoke about having to adapt their workload and pace, often feeling that their professional capabilities were judged through the lens of their condition rather than their competence.

Unlike stress-related fatigue or burnout, exhaustion linked to endometriosis had no clear pattern or recovery phase, making it harder to explain or plan around. Participants described living in a constant negotiation between conserving energy and maintaining performance, often feeling that success came at the cost of their health.

4.5 | Theme 5: Emotional Labour and Mental Health

Managing endometriosis in a professional environment required participants to engage in continuous emotional labour. This emotional management often came at a psychological cost, creating feelings of guilt, anxiety, and self-doubt that compounded the physical challenges of their condition. Drawing on Cetera et al. 's (2024) ideas of objectification and reductionist views of health, these findings illustrate how employees were treated primarily through the lens of performance, rather than as whole individuals with interconnected physical and psychological needs.

P5-I, an Engagement Advisor, shared the strain of repeatedly explaining her condition to supervisors and colleagues: "It's exhausting having to keep saying why you're off or what's wrong with you. After a while, you just feel like a burden." P13-I, a Nursery Practitioner, described how her sickness record led to feelings of shame and isolation within her department: "Every time my absence comes up, I feel exposed. I know people see me as unreliable, and that really hurts."

Participants explained that the performance of professionalism required constant emotional regulation. As P2-I, Consultant Researcher put it, "I feel like I'm constantly failing. I can't plan anything, and that makes me feel anxious all the time." Another added, "Mentally, it's exhausting. You're trying to appear fine while your body is in pain." (P16-I, Head of Sociology in Secondary Education). This pressure to remain productive and composed led many to internalise their struggles, describing an ongoing sense of tension between how they felt and how they were expected to appear.

Guilt was one of the most pervasive emotions discussed. Many participants felt responsible for any disruption their symptoms caused to colleagues or team dynamics. One explained, "I feel guilty every time I miss work. I don't want to let my team down, but sometimes I just can't do it." (P1-I, Senior Research Midwife). Others felt guilty for not meeting their own professional standards, expressing frustration that their ambition was constrained by their health. Over time, this guilt evolved into chronic emotional fatigue that mirrored their physical exhaustion.

For many participants, the effort to "act normal" in unsupportive environments became as draining as the condition itself, showing how the emotional and physical dimensions of endometriosis are deeply intertwined in the workplace experience.

4.6 | Theme 6: Organisational Cultures of Silence

Participants described how organisational cultures, particularly in male-dominated or traditionally hierarchical sectors, sustained a structural silence around women's health. Discussions about menstrual or reproductive issues were often viewed as inappropriate or unprofessional, leading employees to conceal their symptoms to maintain credibility. As one participant stated, "In a male-dominated industry, it's hard to raise awareness about women's health issues" (P6-FG, Veterinary Nurse). Others explained that the expectation to appear strong and resilient discouraged them from seeking help or adjusting workloads. "You just keep quiet and keep going," said P20-I, Deputy Service Delivery Manager, "because that's the culture here." This institutional silence operates as a form of homogenisation (Cetera et al. 2024): rather than recognising the distinct health realities of employees with endometriosis, workplace cultures impose a uniform standard of professionalism that renders those realities invisible and unspeakable.

Several women emphasised that the problem was not limited to men's lack of understanding but also to a wider organisational discomfort with the subject. A participant working in an engineering team (P19-I) noted, "It's not that people are cruel; it's just that they don't know what to say, so they say nothing." Another shared that a male manager told her (P23-I, Account Manager) to "push through it" because "everyone has bad days," which made her feel her pain was trivialised. Such responses reflect what Cetera et al. (2024) term objectification: the employee is seen through the lens of productivity and performance rather than as a person whose embodied experience carries its own validity. The consequence is a form of dislocation (Cetera et al. 2024), in which the employee's physical and emotional reality is structurally absent from the spaces and conversations where it most needs to be present.

Surprisingly, a few participants described more positive experiences with male managers, who were often perceived as more empathetic and less likely to minimise symptoms. P6-I reflected, "My previous male manager was the only one who really asked what he could do to help. He listened and didn't make it awkward." This example suggests that what participants found helpful was not necessarily formal provision alone, but practical flexibility, emotional intelligence, and a willingness to treat the condition as legitimate.

These examples suggested that empathy depended less on gender and more on awareness and emotional intelligence. In contrast, two participants recounted unsupportive interactions with female managers who dismissed their experiences by comparing them to their own menstrual discomfort. One recalled, "She said, 'I get periods too, maybe you're overreacting.' Hearing that from another woman was really disheartening." (P24-I, Primary Education teacher). Such comments illustrate how gendered expectations can operate in complex ways, where shared biological experiences do not always translate into solidarity or understanding. This is an expression of loss of meaning (Cetera et al. 2024): the feeling that one's lived reality has no legitimate place in organisational life. When even those who share a biological experience dismiss it, the employee's sense that her condition is professionally illegible is profoundly reinforced.

5 | Discussion

This study makes three conceptually distinct contributions to FDT scholarship and HRM research. First, it extends FDT's critique of compulsory able-bodiedness into the domain of HRM policy by identifying, through the adapted Cetera et al. (2024) framework, the specific institutional mechanisms through which systemic neglect is enacted. Where existing FDT scholarship has largely theorised the structural production of disadvantage at a general level, this study uses the eight dimensions adapted from Cetera et al. (2024) to show how such disadvantage is enacted through HRM practice. These dimensions are empirically reflected across the six themes identified in our analysis.

Second, the study develops physiodiversity as a concept that translates FDT's structural critique into a policy-level vocabulary accessible to HRM practitioners. By building on the precedent of neurodiversity (Singer 1999) and extending it to encompass chronic, cyclical, and fluctuating physiological conditions, the concept provides a bridge between theoretical critique and organisational redesign. Third, building on Williams et al. 's (2025) theorisation of endo time, this study demonstrates how absence management tools such as the Bradford Factor constitute a form of temporal marginalisation that is structurally embedded rather than individually produced, showing that the disincentive to formalise endometriosis-related absence is not merely a cultural artefact but one structured through policy design. In combination, these allow us to move beyond documenting the effects of endometriosis at work to explaining how and why organisational systems reproduce disadvantage for employees with cyclical and chronic conditions.

Unlike other chronic or gynaecological conditions, endometriosis is uniquely marked by invisibility, diagnostic uncertainty, and its association with reproductive function, which together make its workplace implications deeply gendered. Viewed through the lens of FDT, the study highlights how the disadvantages associated with chronic reproductive conditions stem from social and organisational structures rather than biological inevitability. Participants' experiences demonstrate how able-bodied workplace norms define fluctuating bodies as unreliable or less capable, reinforcing systemic inequalities. This supports Wendell's (1989) argument that disability and disadvantage emerge from the interaction between the body and its social environment.

The findings suggest that the professional challenges faced by women with endometriosis are not rooted in individual limitations but in structural expectations of constant productivity and emotional control. Fear of judgement and stigma often discourage openness, leading to self-censorship and overcompensation. This reflects what Krsmanovic and Dean (2022) and Grogan et al. (2018) describe as gendered self-protection in performance-driven environments that reward resilience while penalising vulnerability.

Read through FDT, each of our six themes illuminates a specific mechanism through which this structural production of disadvantage operates in HRM practice. Theme 1, embodied pain and performing normality, illustrates what Shildrick (1997) terms the compulsion to manage and conceal the leaky body, revealing how the expectation of visible, uninterrupted productivity renders cyclical embodiment professionally illegible. Theme 2, institutional barriers and rigid policies, demonstrates how absence management frameworks, including the Bradford Factor, constitute what Williams et al. (2025) theorise as temporal marginalisation, encoding able-bodied assumptions directly into policy design. Theme 3, silenced voices and disclosure dilemmas, extends Shildrick's (2019) account of neoliberal embodied precarity by showing how stigma around reproductive health operates not only as a cultural attitude but as a rational, structurally produced response to real occupational risk. Theme 4, exhaustion and career trade-offs, gives empirical substance to FDT's claim that the interaction between the body and organisational arrangements, not the body itself, forecloses opportunity; the truncated careers documented here are structural outcomes, not individual failures. Theme 5, emotional labour and mental health, extends Price's (2015) body-mind concept by demonstrating that the psychological labour of performing wellness is an organisationally imposed demand, not an incidental consequence of illness. Theme 6, organisational cultures of silence, illustrates how homogenisation, in Cetera et al. 's (2024) terms, operates as the institutional enforcement of a professional norm that renders certain bodies, and their knowledge of their own conditions, inadmissible. Overall, these six themes do not merely confirm FDT's theoretical architecture; they extend it by mapping the specific points at which that architecture intersects with the everyday mechanisms of HRM practice.

These patterns reveal a wider policy gap. According to our findings, even where supportive frameworks exist, such as menstrual leave policies, underlying gender norms can undermine their use. The persistence of stigma around pain and reproductive health means that formal rights alone do not guarantee inclusion. Many women still resort to using annual leave to manage symptoms, showing how invisibility and silence continue to shape workplace behaviour. As Theme 3 demonstrates, this reluctance is not only a product of stigma but also a rational calculation: in workplaces where absence management tools penalise frequent short absences, taking designated menstrual leave could paradoxically worsen an employee's absence record rather than protect it (Brewis & Beck, 2023). Additionally, the persistence of such tools in UK organisations further

compounds this dynamic: by scoring frequent short absences more harshly than single prolonged ones, these mechanisms structurally disadvantage employees with longer-term health issues (CIPD, 2026). As Williams et al. (2025) demonstrate, workplace policies concentrated on accommodating stable, enduring disabilities consistently fail employees whose conditions are characterised by regular irregularity, penalising the very unpredictability that defines endo time.

The complementary organisational context provided by the employer survey suggests limited awareness and inconsistent practices further compound the issue. While there is often goodwill, organisational structures rarely accommodate cyclical conditions effectively. This mirrors broader evidence, including the Endometriosis Workplace Support Report (House of Commons Library 2019), indicating a persistent lack of understanding at institutional levels. Addressing this gap requires cultural as well as procedural change, recognising that chronic health conditions challenge traditional notions of efficiency and capability. At the same time, the few positive accounts in the data suggest that participants valued support that was practical, non-stigmatising, and discretionary in the right direction, particularly flexible scheduling, remote working where feasible, and managers who listened without minimising symptoms. The problem was not the total absence of support in every case, but its inconsistency and dependence on individual goodwill rather than organisational design.

Price's (2015) concept of the body-mind reinforces this view by showing that physical and emotional wellbeing are inseparable. Supporting employees with chronic conditions therefore requires integrated approaches that combine flexibility, psychological safety, and inclusive design. For employees with endometriosis, pain is not a peripheral physical event that leaves professional functioning intact. It infiltrates concentration, emotional regulation, and the capacity to perform identity at work, as Themes 4 and 5 document in detail. Organisations that address only the physical dimension of chronic illness, through absence policies or medical documentation requirements, therefore miss the integrated nature of the burden employees carry. A genuinely inclusive response must engage with the body-mind as a whole.

Overall, these findings point to the need for a conceptual shift in how HRM frameworks understand the workforce. We propose the concept of physiodiversity to name this shift: the recognition that physiological variation, including chronic, cyclical, and fluctuating conditions, is a natural dimension of human diversity rather than an individual deviation from an able-bodied norm. Building on the logic of neurodiversity (Singer 1999), physiodiversity extends FDT's critique of compulsory able-bodiedness into the domain of HRM policy, arguing that organisations which fail to accommodate physiological variation are not simply inflexible but are actively reproducing structural inequality. Where neurodiversity foregrounds cognitive and neurological variation, physiodiversity foregrounds embodied, hormonal, cyclical, and fluctuating forms of physiological difference that are often rendered invisible by HRM systems designed around stable availability and continuous productivity. The concept does not reduce to individual accommodation; rather, it calls for the redesign of the organisational assumptions, including attendance norms, performance metrics, and disclosure cultures, that currently make endometriosis invisible, and its effects individually borne. Thus, physiodiversity advances HRM scholarship by providing a conceptual bridge between FDT's structural critique and the practical language of diversity and inclusion that organisations already use. The practical implications that follow are grounded in this conceptual reorientation.

5.1 | Practical and Policy Implications

5.1.1 | *Embedding Physiodiversity Into Inclusive HR Practices*

The findings show that workplaces often assume consistent, able-bodied performance. Because endometriosis is cyclical and unpredictable, participants described constantly adjusting to these expectations. Working through pain, hiding absences, and avoiding disclosure were coping strategies shaped by systems that overlook embodied differences. Themes 1 and 2 are particularly instructive here: the compulsion to perform normality (objectification) and the institutional rigidity that renders employees passive within their own health management (passivity, dislocation) together reveal how the assumption of able-bodied productivity is not merely an oversight but a structural feature of organisational life (Cetera et al. 2024).

The following recommendations operationalise physiodiversity as developed above, translating its conceptual claims into concrete HRM actions. Like neurodivergent employees (Erbil et al. 2024), people managing chronic cyclical conditions often face limited accommodations, especially where supportive policies and legal frameworks are absent; the implications below address this gap directly.

Embedding physiodiversity into HR strategies is not about compliance but about organisational learning and fairness. Employers can integrate these principles into existing systems such as flexible scheduling, wellbeing policies, and return-to-work programmes rather than designing entirely new structures. For larger organisations, this may mean revising formal inclusion and absence policies. For smaller ones, it can involve informal yet compassionate management practices and open dialog. Recognising cyclical health needs through flexible working, intermittent sick leave options, and self-managed scheduling can improve both wellbeing and engagement (Li et al. 2024). These inclusive adjustments reflect a shift from individual resilience towards collective responsibility for workplace equity.

This distinction also guards against the risk of gender washing, which Burke and Imas (2026) discuss as both an organisational practice and an analytical feminist construct for examining the dissonance between gender equity rhetoric and women's lived experiences. In the context of menstrual and reproductive health, gender washing may occur when organisations adopt supportive language, awareness campaigns, or isolated wellbeing initiatives without changing the absence systems, disclosure norms, and managerial discretion through which employees continue to experience disadvantage. Physiodiversity therefore requires more than symbolic recognition; it calls for the redesign of HRM practices that determine whether cyclical

and chronic conditions are treated as legitimate features of working life.

To be fully inclusive, workplaces must also balance gender awareness with biological accuracy. Endometriosis primarily affects those with uterine anatomy, but it is not limited to cisgender women. Trans men, non-binary, and gender-diverse individuals are also affected (Adler et al. 2024; Ellis et al. 2024; Eder and Roomaney 2024; Jeffrey et al. 2024). Policies should therefore use language that acknowledges biological specificity while ensuring that all affected employees feel recognised and supported.

5.1.2 | Strengthening Awareness Through Scalable Education and Dialog

While awareness and education are essential to reducing stigma, mandatory company-wide training on female reproductive conditions may not be feasible for all organisations, especially smaller firms or those with limited female representation. Instead, a scalable and context-sensitive approach is more realistic. Large organisations could embed menstrual and reproductive health education into broader wellbeing, diversity, or line-manager training. Smaller companies might offer optional online modules, distribute informational materials, or collaborate with external experts and charities to deliver short awareness sessions. This recommendation is grounded directly in Theme 3 (silenced voices and disclosure dilemmas) and Theme six (organisational cultures of silence), both of which reveal how stigma operates not only at the individual level but as a feature of organisational culture that reproduces the homogenisation and isolation dimensions of systemic neglect (Cetera et al. 2024). Awareness training is therefore not an optional add-on but a necessary condition for interrupting these structural patterns.

Training should aim not only to convey medical information but to cultivate empathy, communication, and managerial confidence when responding to health disclosures. Research shows that stigma surrounding endometriosis and women's health fosters silence and fear of judgement (Nielsen et al. 2023). Managers who receive even brief education on these topics demonstrate more inclusive attitudes and greater sensitivity towards fluctuating health conditions (Sang et al. 2016). Anonymous health disclosure mechanisms or internal wellbeing champions can further normalise discussion and support employees who might otherwise conceal their symptoms.

Such scalable awareness initiatives reduce inequality without creating unrealistic obligations for smaller employers. They also reflect a pragmatic understanding that inclusivity in health is not about scale but about responsiveness, embedding understanding into the everyday culture of work.

5.1.3 | Building Supportive Cultures and Partnerships

Creating endometriosis-friendly workplaces extends beyond individual accommodation to systemic cultural change. Organisations can partner with advocacy and health charities to develop low-cost awareness materials, policy templates, and peer-support resources. Incorporating such external partnerships can help smaller organisations overcome capacity constraints while signalling commitment to employee wellbeing. This sub-section draws directly on Themes 4 and 5, which together document how the cumulative toll of exhaustion, career compromise, and emotional labour, corresponding to the loss of personal journey and reductionist views of health dimensions in the Cetera et al. (2024) framework, requires responses that go beyond policy adjustment to address the relational and cultural fabric of organisational life. Participants emphasized the need for workplace schemes that support menstrual health, menopause, and endometriosis management. For example, Endometriosis UK, a leading charity in the UK, offers an "Endometriosis Friendly Employer Scheme" with guidelines on how organizations can better support employees with chronic health conditions. Organisations seeking practical entry points can draw on free employer resources developed by the Menstruation Friendly Accreditation (Menstruation Friendly UK, n.d.), which offers evidence-informed toolkits, policy templates, and guidance for creating menstruation-supportive workplaces at no cost.

Practical measures include ensuring access to restrooms equipped for menstrual health needs, offering quiet or rest spaces during flare-ups, and providing access to counselling programmes. Making ergonomic chairs, heating pads, and other comfort aids available can also help alleviate lower abdominal pain, as many participants reported relief from warmth. Allowing employees to wear comfortable clothing can also make a significant difference. Peer support and group learning are particularly beneficial, as shown by Gstoettner et al. (2023), who found that women with endometriosis gain confidence and relief through shared understanding. Facilitating such networks within workplaces can reduce isolation and enhance trust.

At a strategic level, integrating menstrual and reproductive health into existing wellbeing policies and equality frameworks aligns with evidence-based HR practices. High-performance work systems that jointly prioritise wellbeing and productivity are more sustainable than those centred solely on output (Jo et al. 2020; Shantz et al. 2016). Adamson et al. (2021) criticise organisational diversity practices that focus only on increasing the number of minority group members without valuing their unique perspectives. This tokenistic approach prioritises appearances over meaningful inclusion, missing the benefits of diverse viewpoints and potentially isolating minority employees. HR systems that reinforce fairness, justice, and trust (Alfes et al. 2012) can transform chronic health challenges from private struggles into shared organisational learning.

The implications of this study are not limited to organisations alone. Our findings also point to a role for government and public policy in addressing the wider cultural and institutional conditions that sustain silence around endometriosis and other gendered health conditions. Because stigma, disbelief, and the normalisation of menstrual pain are socially embedded rather than workplace-specific, organisational practices may be necessary but not sufficient on their own. This argument aligns with the wider policy direction in England, where the Women's Health Strategy and its renewed priorities emphasise the need to listen to women's voices, improve menstrual health education, and strengthen access to care for conditions such as endometriosis (Department of Health and Social Care 2022, 2026).

It also resonates with parliamentary attention to endometriosis in the workplace, where flexible working, statutory sick pay, and reasonable adjustments have been identified as key areas for employer and policy consideration (House of Commons Library 2022). Wider policy interventions, such as clearer guidance on cyclical and chronic conditions in employment, support for public awareness campaigns, and stronger integration of menstrual and reproductive health into equality, wellbeing, and occupational health frameworks, may help create an environment in which workplace change is more likely to take hold.

5.2 | Limitations and Future Research Directions

This study offers important insights into employees' experiences of managing endometriosis at work, but several limitations should nevertheless be noted. First, the focus on full-time employees means that the experiences of those who have reduced their hours, changed jobs, or left the workforce because of severe symptoms are not represented. As such, the findings should be understood in terms of transferability, rather than generalisation, and may reflect the experiences of those able to remain in stable employment.

Second, the sample was primarily white, well-educated, and employed in white-collar roles, which limits the diversity of perspectives included. Future research should engage participants from blue-collar sectors, different ethnic and cultural backgrounds, and varied socioeconomic positions. It is also important to explore the experiences of trans men, gender-diverse, and non-binary individuals, as endometriosis affects these groups as well (Ellis et al. 2024; Eder and Roomaney 2024; Jeffrey et al. 2024). Including these voices would help build a more inclusive understanding of how endometriosis shapes working lives.

Third, although interviews generated rich and detailed accounts, managerial data were collected through open-ended survey responses rather than interviews. This approach offered breadth but limited the depth of organisational perspectives. Future studies could incorporate interviews, case studies, or observational work to examine policy implementation and organisational culture in more detail.

Finally, while this study centres on endometriosis as a gendered and cyclical condition, some of the concepts developed, particularly physiodiversity, may be relevant to other chronic or fluctuating conditions. Further research could explore how physiodiversity operates across different health conditions and workplace settings, helping to refine its conceptual boundaries and organisational implications.

6 | Conclusion

Our study demonstrates that endometriosis is not simply a medical condition that employees manage in spite of their working lives; it is a condition that workplace structures actively shape, sustain, and in many cases worsen. The six themes documented here reveal a consistent and interlocking pattern of systemic neglect, one in which organisational assumptions about productivity, presence, and the able body render the experiences of women with endometriosis simultaneously invisible and consequential. FDT provides the theoretical architecture for understanding why this neglect is not incidental but structural; it reflects whose bodies organisations are designed for, and whose are not. The concept of physiodiversity developed here offers both a diagnostic and a generative contribution to HRM scholarship: it names what is missing from current diversity frameworks and points towards the redesign that is needed. For practice, it means that organisations have both the tools and the responsibility to act. The cost of inaction, measured in lost careers, suppressed potential, and the quiet toll of working through pain that organisations refuse to see, is not borne by the organisation. It is borne entirely by the people least able to afford it.[1]

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Ethics Statement

This study was approved by the Brunel University of London Research Ethics Committee. Informed consent was obtained from all participants prior to their involvement. Participants were fully briefed on the study's nature and purpose, their rights, and the voluntary nature of their participation.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Confidentiality and anonymity were strictly maintained throughout the study. All data were securely stored by the authors, with identifying information removed during analysis and reporting. The data supporting the findings are available upon request from the corresponding author but are not publicly accessible due to confidentiality agreements, as they include sensitive information that could compromise participant and company privacy.

Endnotes

[1] In this study, we use the term "women" to refer specifically to cisgender women, defined as individuals assigned female at birth who identify as women. Our participant group was limited to this population. We acknowledge that endometriosis can affect people of diverse gender identities, including transgender men, non-binary individuals, and others assigned female at birth (Ellis et al. 2024; Eder and Roomaney 2024; Jeffrey et al. 2024). However, due to the scope of our study, we focus here on cisgender women's experiences.

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