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Gender Perspectives on Self-Employment Among Israeli Family Physicians: A Qualitative Study

Irit Chudner [1,*], Avi Shnider [1], Omer Gluzman [2], Hadas Keidar [2] and Motti Haimi [3,4,5,*]

[1] School of Behavioral Sciences, College of Management Academic Studies, Rishon LeZion 7570724, Israel
[2] Maccabi Healthcare Services, Tel Aviv 6801296, Israel
[3] Health Systems Management Department, Yezreel Valley College, Yezreel Valley 1930600, Israel
[4] Rappaport Faculty of Medicine, Technion-Israel Institute of Technology, Haifa 3109601, Israel
[5] Meuhedet Health Services, Tel Aviv 6203854, Israel
* Correspondence: irit@coactive.co.il (I.C.); morx@netvision.net.il (M.H.)

Abstract: Background: While previous studies have shown that occupational choices are influenced by traditional gender perceptions, little is known about gender's role in choosing self-employment among family physicians. Family medicine, with its emphasis on holistic and integrative attitudes that align with independent practice characteristics, presents a unique context for examining gender-related decisions in choosing self-employment. **Objectives:** To examine the role of gender in family physicians' transition to self-employed practice, focusing on gender differences in motivations and considerations for this career choice, and to analyze how traditional gender roles manifest in professional decision-making among highly educated medical professionals. **Methods:** A qualitative study based on in-depth interviews was conducted with 27 self-employed family physicians in Israel who recently chose to start independent practice rather than remaining salaried physicians in Health Maintenance Organizations (HMOs). Interviews were analyzed using thematic content analysis with a gender-sensitive approach. **Results:** Despite their advanced education and professional status, female family physicians tended to maintain traditional gender patterns in their professional choices. Women emphasized work–family flexibility as a primary consideration and expressed less confidence in financial management self-efficacy, often delegating these responsibilities to their spouses. In contrast, male family physicians displayed traditionally "feminine" characteristics in their professional approach, including emphasis on holistic care and family involvement. Male physicians also cited work–life balance and the opportunity for a more comprehensive, biopsychosocial approach to patient care as key factors in choosing family medicine and self-employment. **Conclusions:** The findings demonstrate the complexity of gender roles in family physicians' professional choices, revealing both persistence of traditional gender roles among women and different patterns among men. While male physicians displayed characteristics traditionally identified as feminine, these patterns may reflect both gender role evolution and generational shifts towards work–family integration and collaborative patient care. This study highlights how gender and generational factors shape career decisions in primary care, with implications for medical education and healthcare organization policies.

Keywords: family medicine; gender roles; self-employment; professional identity; medical career choice; primary care; qualitative research; Israel

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1. Introduction

The complex relationship between gender identity and professional career choices has been extensively studied, with research showing that women and men differ in their self-employment decisions (Lombard 2001; Georgellis and Wall 2015). While prior research has examined gender differences in medical specialty choices and career paths in healthcare (McMurray et al. 2002; Buddeberg-Fischer et al. 2006), far less is known about how gender influences physicians' decisions to establish self-employed practices.

Research on gender differences in self-employment patterns reveals several factors. Women often approach self-employment with different motivations than their male counterparts, particularly emphasizing work–life balance and professional autonomy (Thébaud 2016). Men typically shift to self-employment earlier in their careers and are more likely to cite financial gain as a primary motivator (Gupta et al. 2019).

Particularly in the medical field, it has been noted that female doctors frequently take family obligations into account while choosing their careers and often delay major career transitions until their children are older or they have established robust support networks (Adesoye et al. 2017). This timing consideration is less frequently reported by male physicians, who tend to make career transitions based primarily on professional and financial opportunities (Jefferson et al. 2015).

The decision to become self-employed also reflects different risk assessments across genders. Women professionals often report requiring more certainty and preparation before transitioning to self-employment (Malach-Pines and Schwartz 2008). This cautious approach may stem from both practical considerations, such as family responsibilities, and socialized differences in risk tolerance. Furthermore, research indicates that organizational support and mentorship play different roles across genders in self-employment decisions. Women are more likely to seek and value professional networks and mentorship before transitioning to self-employment. Men, conversely, often report greater confidence in making the transition with less formal support structures (Silver et al. 2019).

The theoretical framework of Gender Social Identity Theory provides a valuable lens through which to examine these patterns. Building upon the foundational work of Tajfel and Turner (1979), this framework describes how individuals construct and maintain their professional identities in relation to their gender identity (Wood and Eagly 2015). According to this theory, individuals see themselves through societal gender norms and expectations, which influence their professional choices and behaviors through a process of self-categorization and social comparison (Hogg and Terry 2014). Within medical careers, this theoretical perspective reveals the interplay between traditional gender roles and contemporary professional demands, offering insights into how gender identity shapes career trajectories and professional decisions (Schmader and Block 2015). Recent research has demonstrated that despite significant advances in educational and professional opportunities, deeply embedded gender patterns continue to influence specialty choices and practice arrangements in medicine (Burgess et al. 2018).

The Israeli healthcare system is characterized by a unique structure that combines universal national health insurance with four competing health maintenance organizations (HMOs). The system offers family physicians diverse employment pathways, including direct employment as salaried physicians within the HMOs, working as independent contractors in private clinics, or a hybrid model. Unlike other countries such as the UK, where family physicians primarily operate as independent contractors within the NHS, the Israeli structure provides greater flexibility in choosing employment models. The various employment arrangements and contracts significantly impact work–life balance, professional autonomy, and income—factors that influence physicians' career path decisions.

Understanding gender-based patterns is particularly crucial in self-employed family medicine practice, as this demonstrates unique intersections between professional identity and practice model choices. While both male and female physicians increasingly choose to specialize and practice family medicine, their pathways to and timing of independent practice often differ, reflecting complex interactions between gender identity, family responsibilities, and professional aspirations (Jefferson et al. 2015). These differences merit examination as they impact not only individual career trajectories but also healthcare delivery models and workforce planning (Hedden et al. 2021).

Moreover, recent years have witnessed notable shifts in specialty choice patterns among younger physicians globally, with particularly pronounced changes in Israel and other developed healthcare systems. Traditional gender-based preferences in medical specialties are evolving significantly, with more male physicians choosing family medicine than in previous generations, a trend observed across multiple countries (Naimer et al. 2018; Charpin et al. 2024). This shift reflects broader changes occurring internationally, including increased emphasis on work–life integration among younger physicians and enhanced recognition of the specialty's professional and financial opportunities (Goldman and Barnett 2023). The Y and Z generations demonstrate markedly different priorities in their career choices compared to their predecessors, consistently across various healthcare systems. These younger physicians often place greater emphasis on lifestyle factors and professional autonomy regardless of gender, a pattern documented in both North American and European contexts (McKinlay and Marceau 2011; Schrimpf et al. 2024). Research from multiple countries indicates that younger male physicians, in particular, are increasingly prioritizing specialties that allow for meaningful family involvement and personal life balance, challenging traditional gender-based career patterns in medicine (Krilić et al. 2018).

These generational changes, observed globally and combined with evolving gender roles and professional expectations, make it particularly pertinent to examine gender's role in self-employed family medicine practice. Understanding these dynamics is essential for several interconnected reasons: It contributes to the understanding of how changing societal norms influence professional choices in healthcare and also informs policy decisions about practice models and workforce planning. Finally, this knowledge is crucial for addressing barriers and creating more equitable opportunities for both male and female physicians considering self-employment. It can help developing support systems that promote equal access to practice types while acknowledging different needs across gender and life circumstances (Silver et al. 2019). This approach aligns with growing evidence that gender-responsive organizational policies can enhance workforce diversity and improve healthcare delivery (Butkus et al. 2018). As healthcare systems evolve, ensuring equitable pathways to independent practice becomes increasingly important for maintaining a diverse and sustainable primary care workforce.

2. Methods

2.1. Research Design and Sampling

This study employed a qualitative research methodology to explore gender role in personal decision-making processes in choosing self-employed family medicine practice (Creswell et al. 2007). Semi-structured interviews were conducted with twenty-seven Israeli family physicians who had transitioned to self-employed practice within the previous seven years. Initial participant recruitment utilized snowball sampling, followed by purposive sampling to ensure demographic diversity in terms of age, geographical location, and Health Maintenance Organization (HMO) affiliation. Sample size determination followed the data saturation principle, where data collection continued until no new themes emerged from additional interviews (Guest et al. 2020).

The reporting in this article is displayed in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al. 2007).

2.2. Interview Protocol Development

A semi-structured interview guide was developed through a collaborative effort of an interdisciplinary team comprising a senior self-employed family physician-researcher, a junior family physician, a senior medical director in one of the Israeli's HMOs, and two social science researchers. The guide incorporated the think-aloud technique, a validated method where participants verbalize their thought processes during decision-making (Ericsson and Simon 1980). This approach was selected for its effectiveness in capturing nuanced decision-making processes without increasing participant cognitive load.

The interview guide included specific questions exploring gender dimensions in family medicine career choices. Participants were asked to reflect on how gender identity influenced their and their colleagues' choice to become self-employed family physicians. The interviews explored work–life balance considerations affecting practice management decisions, challenges or opportunities encountered in self-employed practice, and patient-physician relationships in self-employed versus HMO settings. The semi-structured interview guide also included questions exploring push and pull factors influencing physicians' decisions to become self-employed, which has been previously published (Chudner et al. 2024).

2.3. Data Collection Procedure

Following initial agreement to participate, thirty-two physicians received formal study information letters. Of the initial 32 eligible participants who expressed interest, five were unable to participate due to workload constraints, resulting in a final sample of 27 participants. Interviews were conducted via Zoom by the research team and a professional group facilitator. Sessions lasted between 40 and 110 min and were audio-recorded with participant consent. All demographic characteristics, including gender, were self-identified by participants through a demographic questionnaire administered during the initial recruitment phase of the study. Following institutional ethics guidelines, video recordings were deleted after interviews, with audio files retained for transcription and analysis purposes.

2.4. Data Analysis

The research team employed inductive content analysis (Creswell 2013) to process the interview data. The analysis began with independent reviews of recordings and transcripts by all researchers, followed by initial documentation of impressions and emerging themes. Researchers then proceeded with coding key phrases and potential themes, which were subsequently classified into themes. The team conducted comparative analysis of individual researchers' findings, engaging in thorough discussions to resolve coding differences. Through this iterative process, the team developed consensus on final themes and their categorization, paying particular attention to gender-related patterns and insights that emerged from the data.

2.5. Ethical Considerations

The study received approval from the Ethics Committee of The College of Management Academic Studies (approval number 0134-2024). All participants provided informed consent prior to interviews, and all research procedures adhered to established ethical standards for qualitative research.

3. Results

3.1. Sample Characteristics

The study sample consisted of twenty-seven family physicians who had transitioned to self-employed practice, with a predominant representation of female physicians (67%, n = 18). The participants had a mean age of 42.6 years, with the majority being married (88%, n = 24) and having an average of 2.4 children. Most participants (87%, n = 24) were specialized in family medicine, with an average of six years since completing their specialization. The geographical distribution of the participants' practices showed a concentration in the central region of Israel (59%, n = 16), followed by Jerusalem (19%, n = 5), the northern region (15%, n = 4), and the southern region (7%, n = 2). Regarding their professional affiliations, the majority completed their family medicine specialization through different HMOs in Israel: Maccabi Healthcare Services (55% n = 14), followed by Meuhedet (22%, n = 6), Clalit (14%, n = 4), Leumit (1%, n = 1), and other organizations (1%, n = 2). The participants demonstrated linguistic diversity, with all being Hebrew speakers (100%), while 30% were also Arabic speakers, and 20% were Russian speakers. In terms of their current working arrangements with Health Maintenance Organizations (HMOs), the majority were in contract with Maccabi (70%, n = 19), followed by Meuhedet (19%, n = 5), and Clalit (7%, n = 2). Notably, 18% (n = 5) of the participants worked with multiple HMOs simultaneously, indicating a diversified practice model. This distribution accurately represents the population of self-employed family physicians in Israel. While Clalit Healthcare Services is Israel's largest HMO, serving approximately 52% of the population (Chernichovsky 2019; Ben Naim and Hershko 2022), the majority of self-employed family physicians work with Maccabi and Meuhedet Healthcare Services.

3.2. Key Themes

The analysis revealed several key themes regarding gender differences in family physicians' self-employment choice of practice model. These themes were categorized into (1) female-specific themes, (2) male-specific themes, and (3) themes common to both genders. Female physicians emphasized considerations around work–life balance, family responsibilities, and the timing of transition to independent practice based on children's ages and available support systems. Both genders shared common motivations around professional autonomy, quality of care, and the desire for control over their practice environment. The themes emphasize the ways in which gender affects not only the decision to become self-employed, but also the timing and approach to this career transition.

3.2.1. Female-Specific Themes

A. Practice Financial Management

Female physicians often expressed less confidence in managing the financial aspects of independent practice. They frequently described seeking external support for financial management and viewing this as a significant challenge in transitioning to independence. This theme emerged consistently across interviews, with many women noting it as an initial barrier to considering independence. In five interviews, women indicated that their husbands were the ones handling their financial matters, including issuing invoices, managing taxes, handling staff payroll, and playing a central role in shaping work contracts with Health Maintenance Organizations and determining overhead costs paid to clinics. A recurring narrative emerged across several interviews where female family physicians expressed sentiments like *"I'm good at treating people, not at managing money."* (Interview 5). This division, where clinical work remained in the female physician's domain while financial management was delegated to spouses, appeared to be a common arrangement that helped these women overcome initial hesitation about independent practice.

"I admit I'm not very talented in this [managing the financial aspects], but these are disadvantages I'm willing to accept—I often get paid help to manage to meet all my money related tasks." (Interview 19)

"Women have less self-confidence in financial success and managing finances or confidence in their abilities. . .the leap to independence, which basically means 'I think I will succeed, and it will work out'. . .women have less of this confidence compared to men." (Interview 11)

"My husband handles my financial matters and issues my invoices." (Interview 26)

B. Staff Management and Payroll

In retrospect, staff management and payroll responsibilities were a major concern among female physicians when they initially considered their transition to independent practice. One-third of female physicians recalled how they had described these administrative duties as especially daunting before making the transition, anticipating they would add complexity to their already-demanding clinical roles. Looking back, they remembered their concern about dealing with staff conflicts, shift scheduling, and recruiting staff. While some female physicians now acknowledge that these management tasks proved simpler than they had initially feared, others continue to cite staff management duties as a burden in their daily practice.

"There are a lot of bureaucratic tasks and salaries to pay. . . it takes a lot of time and management that takes away from medical practice." (Interview 18)

"On one hand, I always wanted to have my own dedicated secretary who would be loyal only to me, but on the other hand, managing employees is not something I want to do at all. . . it's very convenient when the HMO (Health Maintenance Organization) handles all the surrounding aspects for you." (Interview 6)

C. Support System Requirements

The presence or absence of support systems played a role in female physicians' decision-making regarding independent practice. Support networks, whether family or professional, influenced timing and confidence in transitioning to self-employment. Female physicians without support stated they delayed their transition until their children were older or their personal circumstances provided more stability. The professional aspect of support was equally crucial—having colleagues for consultation and coverage was frequently cited as essential. In cases where both domestic and professional support systems were strong, female physicians reported feeling more confident in making the transition earlier. However, those with limited support networks often opted to remain in salaried positions until they could establish more robust backup systems.

"I was able to do this because I had my mother's support. Even when the children were sick, I didn't need to take sick days." (Interview 14)

"If you're a young mother with small children and don't have backup support for when the child is sick or when you need to stay home—stay salaried." (Interview 7)

"I actually always had support, so I felt I can open my clinic [become self-employed] so usually for me there's no such thing as taking sick days, I manage with my hours, I work my hours." (Interview 19)

"We have a community of independent family physicians on WhatsApp, if they're not sitting with us in the clinic . . .. who you can call anytime, any moment, and they'll answer you." (Interview 2)

3.2.2. Male-Specific Themes

A. Business Development Focus

Male physicians tend to demonstrate other patterns in their approach to independent practice, particularly in their financial planning and motivations. Their approach emphasized financial clinic building and expansion opportunities alongside clinical excellence, with many making the transition to self-employment sooner after completing their specialization. Notably, male physicians tended to discuss financial motivations more directly and unapologetically, focusing on maximizing earnings rather than just seeking financial security. They often expressed greater initial focus on entrepreneurial aspects of the clinic and show more willingness to take financial risks earlier in their careers. Male physicians more frequently framed their practice in terms of business success and growth potential from the outset.

> "I knew doctors as self-employed do better, I knew it's the place where you can earn more." (Interview 23)

> "For the self-employed [FPs], the thinking is very different from the salaried ones. I can think about how to expand the clinic, maybe rent out rooms." (Interview 3)

> "As a self-employed physician you make more money." (Interview 8)

B. Earlier Transition to Independence

Male physicians generally demonstrated a pattern of transitioning to independent practice earlier in their careers, often viewing it as a natural next step after specialization. They showed greater willingness to take on practice management responsibilities alongside clinical duties soon after completing their specialization, expressing less hesitation about the administrative burdens. This earlier transition often aligned with their career development goals and was frequently planned well in advance, even during their training period. They tended to view practice management as an integral part of their professional development rather than a burden to be avoided.

> "I see my colleges who finished, men, and the day after they went independent, and they work twice as much as I do today. They reach very high incomes." (Interview 20)

> "When I finished my residency, within two months I closed [the deal with HMO] and within six months I was already independent because it just seemed like the most natural and right thing." (Interview 1)

3.2.3. Common Themes Across Genders

A. Work–Life Balance and Family Considerations

Female and male physicians consistently described the need to balance professional aspirations with family responsibilities. The ability to manage childcare responsibilities while maintaining professional duties emerged as a primary consideration in both female and male decision-making processes. Physicians of both genders tended to view independent family medicine practice as compatible with family life, finding ways to integrate both and seeing self-employment as a framework that allows needed flexibility—not only to be with children but to "have a life," including time for personal activities and being home during daytime hours.

> "Being a self-employed family physician is a life with a very flexible schedule that's convenient for managing family life. . .it's not shameful to say that my priority is family first." (Interview 10)

"I can decide to close my clinic when I want to be with my family. . .and if I want to work Saturday evening I work, if I want to answer electronic requests [from patients] at 23:00 I do it for myself." (Interview 24)

"I didn't work in August this year, never worked afternoons, didn't work Fridays and this suited my family constraints." (Interview 9)

"One of the considerations for becoming self-employed was to be more at home with my wife and children and not to be like my father doing hospital shifts." (Interview 17)

B. Professional Autonomy and control over practice

Both male and female physicians emphasized the importance of professional independence in their decision-making, with autonomy consistently cited as a primary motivator for transitioning to self-employment. Both genders strongly valued the ability to control clinical decisions, shape their practice environment, and develop their professional path according to their vision. The desire for autonomy was seen as essential for delivering optimal patient care and achieving professional satisfaction. Both valued the potential for growth and development that independent practice offered. However, there were some gender differences in how this autonomy was conceptualized: male physicians more frequently emphasized managerial and business-related autonomy alongside professional independence, while female physicians focused primarily on professional and personal autonomy in their narratives.

"The control over my schedule, my environment, not getting micromanagement every time a new regional manager arrives." (Interview 16)

"What's important is that patients feel very welcome and accepted in the clinic, feel comfortable and that they're being treated with dedication. We can build this environment when we have control over our practice." (Interview 23)

"I want my medicine to be as I learn and advance it, I don't want to practice medicine from 20 years ago." (Interview 15)

C. Holistic Integrative care

Both genders expressed commitment to maintaining high standards of patient care. The ability to practice medicine according to their professional values was a key consideration. Independent practice was often seen to provide more personalized and comprehensive care. In an independent clinic, physicians mentioned they can dedicate more time to understanding the patient's family background, lifestyle, and environmental factors affecting their health. Physicians raised an independent clinic as a setting where they can schedule longer appointments, provide closer follow-up, and integrate complementary treatment methods when needed. All these factors contributed to creating a more meaningful connection with the patient and a deeper understanding of their unique needs, leading to better therapeutic outcomes.

"I need time to listen—to listen to what the patient needs to say, and in my own clinic [as an self-employed physician], I can structure my practice to allow for this." (Interview 19)

"The spirit in our clinic is good. . . there's a lot of effort to reduce bureaucratic tasks from us doctors, and that makes a huge difference in how we can practice." (Interview 6)

"As an independent physician, I'm even more dedicated to my patients. . . when you're on your own, someone comes to you and you're the one who needs to

> solve their problems. . . when you're alone, you need to embrace them more." (Interview 12)
>
> "The clinic feels like part of the community and neighborhood. . . as a community family physician in the neighborhood, it feels much more like I'm truly their doctor." (Interview 9)

This analysis reveals the interplay of gender-specific and common factors influencing physicians' decisions to transition to self-employment. The findings highlight how gender continues to shape career decisions in family medicine, while also identifying universal professional values and aspirations.

4. Discussion

This study reveals both persistent gender-based patterns and emerging shifts in how family physicians approach the decision to become self-employed. Viewed through the lens of Gender Social Identity Theory (Tajfel and Turner 1979), our findings demonstrate how physicians' professional decisions are shaped by internalized gender roles and societal expectations. This theoretical framework helps explain how self-categorization and social comparison processes influence physicians' perceptions of their capabilities and career choices.

Our findings show that female physicians continue to face unique challenges in transitioning to independent practice, particularly regarding work–life integration and family responsibilities. These patterns align with Gender Social Identity Theory's assertion that individuals construct their professional identities in relation to societal gender norms, affecting how they perceive and approach career opportunities (Hogg and Terry 2014). This aligns with previous research by Jefferson et al. (2015) showing that women physicians often delay career advancement decisions to accommodate family responsibilities. The careful timing of starting self-employment based on children's ages and available support systems remains a predominantly female consideration, supporting the findings of Adesoye et al. (2017) regarding the persistent influence of gender roles on medical career choices.

A striking theme that emerged from our research is the gender disparity in confidence regarding financial and business management aspects of independent practice. Female physicians consistently expressed lower levels of self-efficacy in managing the financial aspects of their practices, often seeking external support or delegating these responsibilities to spouses. This finding resonates with broader research on gender differences in financial self-efficacy in professional settings (Sasser 2005). The pattern where clinical expertise is separated from business management in women's practices—exemplified by quotes like "I'm good at treating people, not at managing money"—suggests a persistent gender-based divide in professional self-concept that may be limiting women's pursuit of independent practice.

In contrast, male physicians in our study demonstrated notably higher levels of confidence in their ability to manage both clinical and business aspects of independent practice. This was evidenced by their tendency to transition to independence immediately after completing their specialization, often expressing certainty about their ability to build successful practices. This gender disparity in business confidence appears to influence not only the timing of transition to independent practice but also the way practices are structured and managed.

Particularly noteworthy is how these differences manifest in practice management approaches. While male physicians often described taking on comprehensive management roles, female physicians frequently developed collaborative arrangements, either with spouses or external professionals, to handle financial and administrative responsibilities. This finding suggests that women physicians may be creating innovative solu-

tions to overcome perceived barriers to independence, rather than avoiding independent practice altogether.

The study also revealed an interesting pattern regarding staff management concerns. While both genders acknowledged administrative challenges, women physicians initially perceived these responsibilities as more daunting, though many later reported that these aspects proved more manageable than anticipated. This gap between anticipated and actual challenges suggests that preconceptions about management capabilities might be unnecessarily deterring some women from pursuing independent practice.

However, our study also reveals significant evolution in how gender influences career decisions. Younger male family physicians increasingly emphasize work–life balance and express desire for active involvement in family life, consistent with findings by Goldman and Barnett (2023) showing changing patterns in physician work hours and family involvement across genders. This represents a departure from traditional career-centric male physician patterns documented in earlier studies. Nevertheless, when comparing participants' personal experiences with their general perceptions of gender differences, we found that while some perceived gender-based barriers were validated by actual experiences, others appeared to reflect internalized societal assumptions rather than lived realities (especially the female-specific themes, as seen in the Results section).

Both male and female physicians in our study emphasized the importance of comprehensive, patient-centered care incorporating biopsychosocial elements. This finding challenges the historical assumptions about gender-based differences in practice style. For example, a study by Roter and Hall (2004) demonstrates that compared to their male counterparts, female primary care physicians and their patients had longer visits and more patient-centered communication. In our study, male family physicians demonstrated a strong connection to verbal communication and holistic care approaches, supporting research by Cruess et al. (2019) showing evolving professional identity formation in medicine that transcends traditional gender roles.

The importance of supportive organizational culture emerged as crucial for both genders, though its impact manifested differently. Female physicians particularly valued organizations that accommodated family responsibilities, while both genders emphasized the need for professional autonomy. This aligns with research by Chudner et al. (2020) on power dynamics in primary care settings and their influence on practice decisions.

4.1. Generational Changes

Our findings indicate significant generational shifts in how physicians approach work–life integration and career decisions. Younger physicians of both genders demonstrate greater emphasis on lifestyle considerations and professional autonomy, supporting Naimer et al.'s (2018) observations about changing perceptions of family medicine careers among medical students.

4.2. Limitations and Future Research

Several limitations should be considered when interpreting this study's findings. First, while our qualitative approach provided rich insights into physicians' decision-making processes, the Israeli healthcare context may limit generalizability to other healthcare systems. The unique structure of the Israeli HMOs and their employment models might not fully represent the challenges and opportunities faced by family physicians in other countries (Chernichovsky 2019). Additionally, by focusing solely on currently self-employed physicians, our study may not capture the full spectrum of barriers faced by those who have chosen not to pursue such roles, suggesting an important direction for future research. Second, our sample primarily included physicians from urban and central regions of Israel,

potentially underrepresenting the experiences of physicians in peripheral areas. This geographic limitation is particularly relevant as practice location can significantly influence employment model choices and opportunities (Tabenkin and Gross 2000). Third, while we attempted to include physicians across different career stages, our sample included more established physicians, potentially underrepresenting the perspectives of early-career physicians. This timing bias might affect our understanding of current decision-making patterns among newer graduates).

4.3. Policy Implications and Future Directions

Our findings have implications for policy development in medical education and professional development. The gender differences in approaching self-employment suggest the need for targeted interventions. Specifically, incorporating successful self-employed physicians as role models and mentors in medical education programs could help address gender-based barriers and enhance self-efficacy among female physicians considering independent practice. Additionally, professional development programs should focus on building business and financial management skills, particularly addressing the confidence gap identified in our study. These programs should be designed to support both genders while being sensitive to the unique challenges faced by female physicians. Medical schools and healthcare organizations should consider implementing structured mentorship programs that connect experienced self-employed physicians with those considering this career path, ensuring representation of both male and female role models to promote gender equity in independent practice.

5. Conclusions

The evolution of gender roles in family medicine self-employment choices reflects broader societal changes while retaining some traditional patterns. Understanding these dynamics is crucial for healthcare organizations in developing supportive structures that accommodate diverse physician needs and preferences.

These evolving patterns in physician employment preferences have important implications for healthcare organization and delivery. As noted by Hedden et al. (2021), developing healthcare systems that can successfully support and retain physicians while preserving high-quality patient care requires an understanding of these shifts.

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