

BALANCE BETWEEN CAREER AND FAMILY LIFE AMONG FEMALE DOCTORS IN KING ABDUL-AZIZ MEDICAL CITY, RIYADH, SAUDI ARABIA

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DOI: 10.5455/ijmsph.2013.021220133

Received Date: 02.12.2013

Accepted Date: 20.01.2014

ABSTRACT

Background: The balance between career and family life of women doctors is a topic of research worldwide. This relation has a significant impact on both work and family obligations.

Aims & Objective: To determine the reported effect of career on family life and vice versa among Saudi female physicians.

Material and Methods: A cross sectional study was conducted included all Saudi women doctors who ever married and in current clinical practice at KAMC, Riyadh, between 1 January and 28 February 2013. A self-administrated questionnaire has been used for data collection containing: demographic data, impact of career on family life, common obstacles and suggested solution. Pearson's chi-square was used to analyze the relationship between variables.

Results: The study included 174 Saudi female doctors. More than half of them (56.3%) reported discrimination from colleagues because of their marital status. Seventy-five Saudi female physicians (43.1%) were unsatisfied in balancing their career and family life. More than half of the participants (51.7%) thought their work has a negative impact on their relationship with their spouses/children. Type of job (on call status) was significantly associated with difficulty in transportation to the hospital ($p=0.006$). Providing childcare in medical centers (79.9%) and more days off for maternity leave (75.3%) were most reported solutions suggested.

Conclusion: Poor satisfaction of Saudi female physicians in balancing career and family life is a common problem among those working in KAMC.

Key-Words: Female; Physicians; Career; Satisfaction; Saudi Arabia

Introduction

Finding an acceptable balance between career and family life is a difficult challenge for many physicians.^[1] The medical profession has commonly been characterized by long working hours and obligations to put patient welfare above personal needs and family responsibilities and this is considered a challenge especially for a practicing female doctor.^[2]

It worked out much more easily in the past when the vast majority of physicians were men and their wives were at home to run the household duties and care for the children. As women entered the medical field in increasing numbers, the tensions between career and family life became more prominent. In United States, like most western countries, the number of women pursuing careers in medicine is steadily increasing. In 1997, practicing American women doctors accounted for 22% of the total^[3], in 2002 they became 28%^[4], and it was expected to rise to 30% of practicing doctors by 2010^[5] and up to 50% by the year 2040^[6].

In 1981, Saudi women doctors constituted 4.4% of professionally active Saudi doctors. In 1997, this number reached 20.36 %.^[7] In spite of this increasing proportion of women in medicine during the last few decades, women

doctors face a difficult task in combining family life and medical career and are confronted with the stresses associated with "having it all"; many of them have tackled this by choosing not to marry or have children, or they have limited their career commitment.^[8-10] In 1996, a study concluded that women are more likely to alter their job responsibilities or make a career change to benefit their families and children, with the most common adjustment being a reduction in hours worked.^[11] In 2003, at Norway, 51% of women doctors reported that care of children and possibilities of combining work and responsibilities for children and family had been of great importance in their choice of specialty.^[2] The most prestigious specialties within hospital medicine, like surgery and internal medicine, only recruited 9% of the female doctors compared with 19% of the male doctors.^[12] A 1998 study by Carr et al. ^[12] concluded that decreased academic progress and success is related to childbearing, a finding which substantiates women's concerns about combining academic medicine and parenting. Thus, it may be of great interest to ask: is it possible for female doctors to reach a satisfying balance between career and family life?

As this topic is thought to be a major issue particularly in the medical community of Saudi Arabia and other Islamic countries, and still under-researched, the idea to conduct

this study was conceived, to assess the obstacles and difficulties in balancing family life and career among Saudi women doctors, in addition to find solutions to make this juggling act less difficult for them.

This study aimed to assess reported obstacles and difficulties in balancing career and family life among Saudi women doctors, explore the suggested solutions of each participant in the study in order to reach common possible solutions for the difficulties that face women doctors in balancing between career and family life and assess the relationship between the barriers/factors (demographic factors, family responsibilities, career obligations) with the satisfaction in balancing between career and family life.

Materials and Methods

A cross-sectional Study was carried out in King Abdul-Aziz Medical City (National Guard Hospital), Riyadh, KSA, between 1 January 2013 and 28 February 2013. All Saudi female doctors who ever married and in clinical practice in KAMC. Total population of female Saudi doctors at National Guard is approximately 300. Using a margin of error of $\pm 5\%$, CI of 95% based on 50% of female doctors facing stress/difficulty in balancing their life and work for the Norwegian study (2004)^[2], we estimated a sample size of 170, adjusted up for data losses up to 200.

Because of the total population of our subjects (i.e. 300) and we have estimated our Sample size to be 200 with a response rate of 90% (i.e. 180), Therefore, a simple random sampling technique was adopted to select 200 female Saudi doctors from a list including them at the King Abdul-Aziz Medical City (National Guard Hospital) using a computer.

Data were collected through a newly constructed questionnaire that was developed based on review of the published literatures. The content validation of the questionnaire was done by two methods: It was compared with the objectives of the gold standard questionnaire/study, as provided by the authors who conducted the Norwegian study, 2004^[2] and found to cover them as well it was reviewed by 3 expert reviewers who also agreed that it met the study objectives.

The following information was collected: part 1: demographic data; part 2: Family responsibilities, ; part 3: Career obligations, ; part 4: obstacles and suggested solution. Part 1: Demographic data included mainly age, marital status, speciality, academic level and type of job. Part 2 included questions about impact of family

responsibilities on career: number of children, employment status of the spouse, work gap duration because of family or social responsibilities, effect of specialty choice by family responsibilities, discrimination or negativity from colleagues because of marital status, discrimination or negativity from society because of work as physician. Part 3 studied the Impact of career obligations on family life including : working hours, satisfaction in the balance between career and family life, negative impact of work on relationship with the husband , children and their school performance, percentage of daily household duties and difficulties in transportation to hospital. Finally, part 4 looked for obstacles faced by Saudi women doctors and their suggested solutions.

After we received written permission from King Abdullah Research Center, the questionnaire was distributed to each participant through her departmental secretary and filled up and returned back to the same secretary. All filled questionnaires were sent back by mail to the researcher. A pilot study was conducted on 20 Saudi female doctors, who were excluded from the final analysis. Its aim was to evaluate the validity of the questionnaire and the ability of participants to answer it. Deficiencies in the questionnaire were identified and modified accordingly. Permission was obtained from the King Abdullah International Medical Research Center and the Department of Family Medicine Research Committee, National Guard Health Affairs, Riyadh. An informed verbal consent was obtained from every participant before participation in the study. Participants were assured that collected data will be strictly confidential, and will not be disclosed for any reason, and will be used only for research purposes.

Data entry and analysis were performed by using SPSS software statistical program version 19. Categorical variables were presented in the form of frequencies and percentages. In order to analyze how the perception of the family life barriers will affect the career and vice versa; a Unified Likert scale was used. Pearson's Chi-Square was used to assess the relationship between the barriers/factors (demographic factors, family responsibilities, career obligations) against the satisfaction in balancing between career and family life. P-value less than 0.05 was considered significant.

Results

Out of 200 female Saudi doctors invited to participate in the study, 174 returned filled questionnaires giving a response rate of 87%. The study included 174 Saudi female doctors. Table 1 presents their demographic

characteristics. More than one-third of them (38.5%) were in the age group 25-29 years while 13.8% aged 40 years or above. Majority of them (96%) were currently married. Almost two third of participants (62.6%) originally from central region. Nearly one-quarter (24.3%) were specialized in family medicine, 18.5% in internal medicine, 16.2% in pediatrics and 4.6% in Emergency Medicine. Regarding professional level, they were almost equally distributed between consultants (33.9%), Associate/assistant consultant (31%) and residents (35.1%). Moreover two-thirds of them had on call/inpatient duties and 21.8% had out-patient clinical duties only.

Association between socio-demographic characteristics and satisfaction in balancing between career and family life:

As illustrated in table 2, none of the studied socio-demographic characteristics of Saudi female physicians (age, marital status, specialty, professional level and type of job) was statistically significantly associated with satisfaction in balancing between career and family life.

Association between family responsibilities and satisfaction in balancing between career and family life:

Table 3 demonstrates that more than half (51%) of female physicians who reported discrimination or negativity from colleagues because of marital status compared to only 32.9% of those without such discrimination or negativity were unsatisfied in balancing career and family life. This difference was statistically significant, $p=0.009$. More than half of female physicians (56.2%) who reported discrimination or negativity from the society because of work all of the time compared to 32.6% of those who never reported such discrimination or negativity, However, this difference was not statistically significant, $p=0.083$. The associations between satisfaction in balancing between career and family life and both of work gap duration and affection of choice of specialty by family responsibilities were not statistically significant. In addition the satisfaction in balancing between career and family life was not significantly associated with number of children and employment status of the spouse.

Association between career obligations and satisfaction in balancing between career and family life:

Table 4, shows that more than two-thirds (67.8%) of female physicians who reported negative impact of work on the relationship with spouse or children compared to only 4.9% who did not report such negative impact were unsatisfied in balancing between career and family life, $p<0.001$. Similarly, 72.3% of female physicians who reported negative impact of work on the children

performance at school compared to 19.2% who did not report such negative impact were unsatisfied in balancing between career and family life, $p<0.001$. Almost two-thirds (62.8%) of female physicians who reported difficulties in transportation to the hospital compared to only 24% who did not report such difficulties were unsatisfied in balancing between career and family life, $p<0.001$. Most of female physicians (72.2%) who currently worked more than 60 hours per week compared to 41.1% of those working between 40 and 60 hours per week were unsatisfied in balancing between career and family life. This difference was statistically significant, $p=0.021$. The percentage of daily household duties was not significantly associated with satisfaction in balancing between career and family life.

Factors associated with work gap duration:

Table 5 presents the factors associated with work gap duration. Female physicians aged 35 years or more tended to have 3 to 5 years of work gap duration compared to those in the age group 25-29 years (17.6% versus 3%). No work interruption was reported among 79.1% and 45.1% of female physicians aged ≥ 35 and 25-29 years, respectively. These difference were statistically significant, $p<0.001$. Similarly, female physician who had three children or more tended to have 3-5 years of work gap duration compared to those who had no children (18.6% versus 3.4%). No work interruption was reported by 82.8% and 40.7% of female physicians who had ≥ 3 and those who have no children, respectively. These difference were statistically significant, $p<0.001$. Female physicians who reported effect on choice of specialty by family responsibilities tended to have 3 to 5 years of work gap duration compared to those who had no effect on choice specialty by family responsibilities (8.6% versus 5.4%). No work interruption was reported by 72.8% and 49.4% of female physicians with or without affection of choice specialty by family responsibilities, respectively. These differences were statistically significant, $p=0.006$. Employment status of the spouse was not significantly associated with work gap duration among female Saudi physicians.

Factors associated with type of job (on call status):

As shown in table 6, 80.7% of female physicians who reported discrimination or negativity from colleagues because of marital status compared to 63.4% of those who did not report such discrimination had on call job. This difference was statistically significant, $p=0.012$. Similarly, 80.5% of female physicians who reported negative effect of work on children performance at school compared to 58.3% of those who did not report such negative effect of work had on call job. This difference was statistically significant,

p=0.028. Type of job (on call status) was significantly associated with difficulty in transportation to the hospital, as 80% and 60.9% of those reported sometime difficulty or no difficulty had on call job, respectively. This difference was statistically significant, p=0.006. History of discrimination or negativity from the society because of work, number of currently working hours per a week and negative impact of work on the relationship with spouse or children were not significantly associated with type of job (on call status).

Table-1: Demographic data of the participants in the study (n=174)

Demographic Variables		N	%
Age in Years	25-29	67	38.5
	30-34	56	32.2
	35-39	27	15.5
	≥40	24	13.8
Marital Status	Married	167	96.0
	Separated/divorces/widowed	7	4.0
Area of Origin	Central	109	62.6
	Western	30	17.2
	Eastern	23	13.2
	South	9	5.2
	North	3	1.7
Specialty (n=173)	Internal Medicine	32	18.5
	ER	8	4.6
	Obstetrics/Gynaecology	23	13.3
	Psychiatry	8	4.6
	Family Medicine	42	24.3
	Surgery	18	10.4
	Paediatrics	28	16.2
Professional Level	Others	14	8.1
	Consultant	59	33.9
	Associate/assistant consultant	54	31.0
	Resident	61	35.1
Type of Job	Out Patient Clinic only	38	21.8
	On call/inpatient services	116	66.7
	Shifts	9	5.2
	Others	11	6.3

Table-2: Association between female physicians' socio-demographic characteristics and satisfaction in balancing between career & family life

Demographic Variables	Satisfaction			X ² (p-value)	
	Satisfied n=34 N (%)	Neutral n=65 N (%)	Unsatisfied n=75 N (%)		
Age in Years	25-29	14 (20.9)	22 (32.8)	31 (46.3)	2.81 (0.590)
	30-34	13 (23.2)	20 (35.7)	23 (41.1)	
	≥ 35	7 (13.7)	23 (45.1)	21 (41.2)	
Marital Status	Married	34 (20.4)	61 (36.5)	72 (43.1)	2.19 (0.335)
	Separated/divorces/widowed	0 (0)	4 (57.1)	3 (42.9)	
Specialty	Internal Medicine	9 (28.1)	9 (28.1)	14 (43.8)	16.90 (0.262)
	ER	0 (0)	1 (12.5)	7 (87.5)	
	Obstetrics/Gynaecology	1 (4.3)	9 (39.1)	13 (56.5)	
	Psychiatry	1 (12.5)	2 (25.0)	5 (62.5)	
	Family Medicine	10 (23.8)	17 (40.5)	15 (35.7)	
	Surgery	3 (16.7)	8 (44.4)	7 (38.9)	
	Paediatrics	7 (25.0)	11 (39.3)	10 (35.7)	
Professional Level	Others*	3 (21.4)	7 (50.0)	4 (28.6)	0.14 (0.998)
	Consultant	11 (18.6)	23 (39.0)	25 (42.4)	
	Associate/assistant consultant	11 (20.4)	20 (37.0)	23 (42.6)	
Type of Job	Resident	12 (19.7)	22 (36.1)	27 (44.3)	2.29 (0.319)
	On call	20 (17.2)	46 (39.7)	50 (43.1)	
	No On call	12 (27.9)	14 (32.6)	17 (39.5)	

* Others included Pathology, Radiology and others

Table-3: Association between family responsibilities and satisfaction in balancing between career and family life

Variables	Satisfaction			X ² (p-value)
	Satisfied n=34 N (%)	Neutral n=65 N (%)	Unsatisfied n=75 N (%)	
Number of Children				
No (n=29)	9 (31.0)	12 (41.4)	8 (27.6)	5.63 (0.229)
1-2 (n=90)	13 (14.4)	34 (37.8)	43 (47.8)	
≥3 (n=55)	12 (21.8)	19 (34.5)	24 (43.6)	
Employment of the Spouse				
Physician (n=75)	14 (18.7)	28 (37.3)	33 (44.0)	0.08 (0.963)
Non-physician (n=99)	20 (20.2)	37 (37.4)	42 (42.4)	
Discrimination or Negativity from the Society Because of Work				
All the time (n=16)	1 (6.2)	6 (37.5)	9 (56.2)	8.24 (0.083)
Sometimes (n=112)	18 (16.1)	43 (38.4)	51 (45.5)	
Never (n=46)	15 (32.6)	16 (34.8)	15 (32.6)	
Work Gap Duration				
1-2 years (n=54)	14 (25.9)	17 (31.5)	23 (42.6)	5.17 (0.271)
3-5 years (n=12)	0 (0)	5 (41.7)	7 (58.3)	
No interruption (n=107)	19 (17.8)	43 (40.2)	45 (42.1)	
Discrimination or Negativity from the Colleagues Because of Marital Status				
No (n=76)	22 (28.9)	29 (38.2)	25 (32.9)	9.40 (0.009)
Yes (n=98)	12 (12.2)	36 (36.7)	50 (51.0)	
Effect on Choice of Specialty by Family Responsibilities				
No (n=92)	18 (19.6)	29 (31.5)	45 (48.9)	3.31 (0.191)
Yes (n=82)	16 (19.5)	36 (43.9)	30 (36.6)	

Table-4: Association between career obligations and satisfaction in balancing between career and family life

Variables	Satisfaction			X ² (p-value)
	Satisfied n=34 N (%)	Neutral n=65 N (%)	Unsatisfied n=75 N (%)	
Negative Impact on the Relationship with Spouse or Children				
Yes (n=90)	1 (1.1)	28 (31.1)	61 (67.8)	79.65 (<0.001)
No (n=41)	24 (58.5)	15 (36.6)	2 (4.9)	
Neutral (n=43)	9 (20.9)	22 (51.2)	12 (27.9)	
Negative Impact on the Performance of Children at School				
Yes (n=47)	0 (0)	13 (27.7)	34 (72.3)	33.68 (<0.001)
No (n=52)	17 (32.7)	25 (48.1)	10 (19.2)	
Neutral (n=53)	9 (17.0)	18 (34.0)	26 (49.1)	
Percentage of Daily Household Duties				
>75% (n=20)	3 (15.0)	7 (35.0)	10 (50.0)	4.42 (0.620)
50% (n=58)	9 (15.5)	25 (43.1)	24 (41.4)	
25% (n=58)	16 (27.6)	18 (31.0)	24 (41.4)	
<25% (n=38)	6 (15.8)	15 (39.5)	17 (44.7)	
Difficulties in Transportation to the Hospital				
No (n=25)	8 (32.0)	11 (44.0)	6 (24.0)	14.23 (0.007)
Yes (n=43)	2 (4.7)	14 (32.6)	27 (62.8)	
Sometimes (n=106)	24 (22.6)	40 (37.7)	42 (39.6)	
Number of Currently Working Hours Per a Week				
40-60 (n=151)	32 (21.2)	57 (37.7)	62 (41.1)	7.77 (0.021)
>60 (n=18)	0 (0)	5 (27.8)	13 (72.2)	

Association between effect on choice of specialty by family responsibilities and number of children: As demonstrated in table 7, there was no significant association between number of children and effect on choice of specialty by family responsibilities.

Association between academic level and discrimination or negativity from colleagues because of marital status: Almost two-thirds (64.8%) of associate/assistant consultants reported discrimination or negativity from colleagues because of marital status compared to

49.2% of consultants. However, this difference was not statistically significant, p=0.057. [Table 8]

Table-5: Factors associated with work gap duration among Saudi female physicians

Variables	Work Gap Duration (Years)			X ² (p-value)	
	1-2 n=54 N (%)	3-5 n=12 N (%)	No Interruption n=107 N (%)		
Physician's Age (years)	25-29 (n=67)	12(17.9)	2 (3.0)	53 (79.1)	24.20 (<0.001)
	30-34 (n=55)	23 (41.8)	1 (1.8)	31 (56.4)	
	≥35 (n=51)	19 (37.3)	9 (17.6)	23 (45.1)	
Number of Children	No (n=29)	4 (13.8)	1 (3.4)	24 (82.8)	26.20 (<0.001)
	1-2 (n=90)	28 (31.1)	1 (1.1)	61 (67.8)	
	≥3 (n=55)	22 (40.7)	10 (18.6)	22 (40.7)	
Employment of the Spouse	Physician (n=75)	21 (28.0)	5 (6.7)	49 (65.3)	0.71 (0.707)
	Non-physician (n=99)	33 (33.7)	7 (7.1)	58 (59.2)	
Effect on Choice of Specialty by Family Responsibilities*	No (n=92)	20 (21.8)	5 (5.4)	67 (72.8)	10.12 (0.006)
	Yes (n=81)	34 (42.0)	7 (8.6)	40 (49.4)	

* missing system 1

Table-6: Factors associated with type of job of Saudi female physicians

Variables	Type of job		X ² (p-value)
	On call n=116 N (%)	No on call n=43 N (%)	
Discrimination or negativity from colleagues because of marital status			
No (n=71)	45 (63.4)	26 (36.6)	5.96 (0.012)
Yes (88)	71 (80.7)	17 (19.3)	
Discrimination or negativity from the society because of work			
All the time (n=13)	12 (92.3)	1 (7.7)	5.51 (0.064)
Sometimes (n=104)	70 (67.3)	34 (32.7)	
Never (42)	34 (81.0)	8 (19.0)	
Number of currently working hours per a week (n=154)			
40-60 (n=136)	97(71.3)	39 (28.7)	2.51 (0.069)
>60 (n=18)	16 (88.9)	2 (11.1)	
Negative effect on children performance at school (n=140)			
No (n=48)	28 (58.3)	20 (41.7)	5.42 (0.028)
Yes (n=41)	33 (80.5)	8 (19.5)	
Neutral (n=51)	37 (72.5)	14 (27.5)	
Difficulty in transportation to the hospital			
No (n=23)	14 (60.9)	9 (39.1)	6.78 (0.006)
Yes (n=36)	22 (61.1)	14 (38.9)	
Sometimes (n=100)	80 (80.0)	20 (20.0)	
Negative impact on the relationship with spouse or children			
No (n=38)	25 (65.8)	13 (34.2)	1.30 (0.068)
Yes (n=81)	61 (75.3)	20 (24.7)	
Neutral (n=40)	30 (75.0)	10 (25.0)	

Table-7: Association between effect on choice of specialty by family responsibilities and number of children

Number of Children	Effect on Choice	
	No [n=92; N (%)]	Yes [n=82; N (%)]
No (n=29)	20 (69.0)	9 (31.0)
1-2 (n=90)	44 (48.9)	46 (51.1)
≥3 (n=55)	28 (50.9)	27(49.1)

X²=3.67, p=0.159

Table-8: Association between academic level and discrimination or negativity from colleagues because of marital status

Academic Level	Discrimination or Negativity	
	No [n=76; N (%)]	Yes [n=98; N (%)]
Consultant (n=59)	30 (50.8)	29 (49.2)
Associate/ assistant consultant (n=54)	19 (35.2)	35 (64.8)
Resident (n=61)	27 (44.3)	34 (55.7)

X²=2.83, p=0.057

Table-9: Association between employment status of the spouse and negative impact on the relationship with him or children

Employment Status of the Spouse	Negative Impact on the Relationship		
	No [n=41] N (%)	Yes [n=90] N (%)	Neutral [n=43] N (%)
Physician (n=75)	19(25.3)	37 (49.3)	19(25.3)
Non-physician (n=99)	22 (22.2)	53 (53.5)	24 (24.3)

X²=0.34, p=0.863

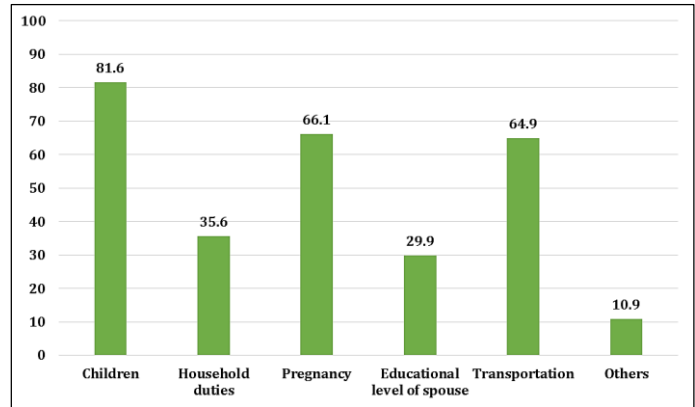


Figure-1: Difficulties faced by Saudi female physicians in balancing their career and family life

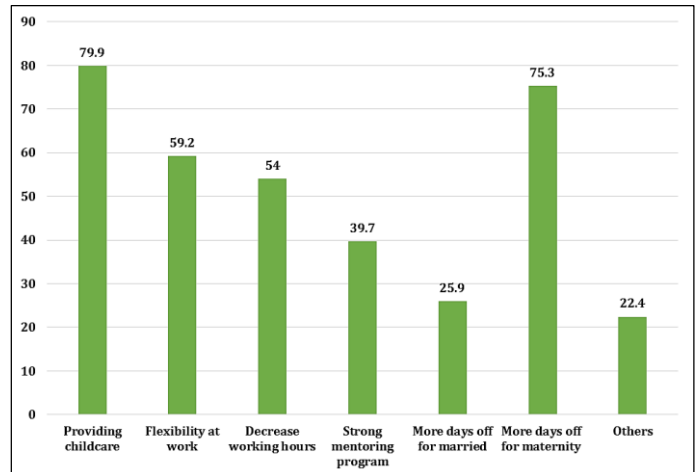


Figure-2: Solutions mentioned by female Saudi physicians that can make the balance between career and family life less difficult

Association between type of job and discrimination or negativity from colleagues because of marital status:

As shown in table 9, there was no statistically significant association between employment status of the spouse and negative impact on the relationship with him or children among female physicians.

Obstacles and solutions: Figure 1 illustrates the difficulties that female Saudi physicians are facing in balancing their career and family life. Children represent 81.6% of these difficulties. Almost two-thirds of female physicians reported pregnancy (66.1%) and transportation (64.9%) as an obstacles. Household duties and educational level of spouse were mentioned by 35.6% and 29.9% of respondents, respectively. Other reported obstacles (10.9%) were Long working hours, Extra working duties (committees, teaching), living outside the

primary region, pregnancy and risk of exposure to infectious diseases, shortage of time to spend with husband, family and social obligations. Figure 2 displays the solutions suggested by female Saudi physicians that can make the balance between their career and family life better. Providing childcare in medical centers (79.9%) and more days off for maternity leave (75.3%) were most reported solutions followed by flexibility at work (59.2%) and decrease working hours (54%). Other reported solutions (22.4%) were activate part time jobs in the government section with fair salary, governmental support for driving allowance, providing transportation, supportive community groups for working women and their children, governmental support to get housemaid.

Discussion

This study was designed to explore female Saudi physicians' work/family balance. This research sought to extend the prior literature in several ways. First, it included multiple negative (work/family conflict) aspects of balancing multiple roles. Second, specific predictors of conflict and enrichment (work/family conflict self-efficacy and support) were included (such as number of children, negative impact on the relationship with spouse or children, negative effect on children performance at school, discrimination from colleagues because of marital status, and effect on choice of specialty by family responsibilities....). Finally, it included specific outcome variable (satisfaction in balancing between career and family life).

Women, far more than men, consider the balancing of family, parental, and occupational roles when making career decisions.^[18,19] When specialty choices are examined, women are proportionately overrepresented in the primary care fields and psychiatry. They are underrepresented in most surgical fields^[20], with the exception of obstetrics and gynecology, where women now comprise the majority of practicing physicians.^[21] This skewed specialty choice may be related in part to the female physicians' awareness of the competing demands that will be made on her time by career, marriage, and children. Factors other than a balanced lifestyle clearly are at play, however, as evidenced by the high percentage of women in obstetrics and gynecology, despite the intensive and unpredictable character of that field.^[22] In accordance with that, the present study revealed that almost half of female Saudi physician reported that their family responsibilities affected their choice of specialty. In our study Family Medicine is synonymous with Primary Health care, as the nature of job is similar for Family Medicine Specialists and non-specialized general practitioners.

The relationship between negative impact of career obligations on the relationship with spouse or children and satisfaction in their balancing with family life was explored in the current study. It was hypothesized that impact of the career obligations on the relationship with spouse or children would be negatively related to satisfaction in work/family conflict. Results in the current study are consistent with past research that has found negative relationships between satisfaction in balancing between career and family life and work/family conflict.^[23,24] Thus, this finding confirmed what has been reported by Hennessy and Lent as women who have higher self-efficacy beliefs as measured by self-efficacy scale, in managing conflict that arises when work and family responsibilities interfere with one another are likely to experience less work/family conflict and consequently they will be more satisfied in balancing career and family life.

The timing for starting a family is a critical decision for women in medicine. The most opportune time biologically for a woman to have children coincides with the phase of life when career demands are most intense, making the balancing of career and family particularly difficult for women during their 20s and 30s.^[25] This period in a woman's life coincides with medical school, residency, and fellowship training, when work demands are high and finances are strained, with little money available to hire support personnel. Many important issues must be weighed in the balance when deciding to have a child. When is a good time to get pregnant and begin a family? If postponed until a woman's mid-30s or later, the risks of infertility and congenital anomalies increase. The present study supported these concerns, as pregnancy was mentioned by most of the Saudi female physicians as an important obstacle for balancing career and family life.

A problem sometimes encountered by physician-mothers is the resentment of their colleagues. Other residents or practicing physicians may object to any increased work that they must shoulder when female doctors reduce their work hours or take time off due to pregnancy or the birth of a child.^[26-28] They also may resent what may be perceived as "special treatment" afforded to pregnant physicians or physician-mothers. Some colleagues may view a female doctor's pregnancy and family commitments as evidence of a diminished dedication to medicine and career. The impact of pregnancy and childbirth is somewhat lessened in large residency programs or physician practices, and can be minimized by notifying colleagues well in advance of the impending birth and the mother's plans for maternity leave.^[22] The present

research confirmed that the discrimination or negativity from colleagues because of marital status of female physicians had a negative impact on their satisfaction in balancing career and family life.

Among solutions mentioned by most of female physicians in improving the balance between career and family life is providing more days off for maternity leave. The American College of Physicians recommends maternity leave beginning at least 2 weeks prior to an expectant mother's due date and advises that one parent should be the infant's primary caregiver for at least 4 months.^[29] Many physicians, nevertheless, work until the baby's birth. ^[25] Canadian physicians (including residents) receive 20 weeks of paid maternity leave^[30]; in most of the industrialized world, employers provide the mother with a minimum of 12 weeks of paid leave.^[31] Interestingly, many American physicians do not take the entire 6 weeks of maternity leave to which they are entitled.^[20] This may be partly attributable to concern about colleagues' attitudes toward their staying home with their infant, as well as their own feelings of guilt about being away from their patients and work. In KSA, paid maternity leave days shall end no later than 40 days after date of delivery as per rules and regulations of the government.

For women who plan to have children, policies on maternity and parental leave are important factors in selecting a residency program or a position as a practicing physician. In the present study, slightly less than half of Saudi female physicians reported effect on choice of specialty by family responsibilities. In addition, this also was significantly associated with work gap duration. Although the American Medical Association in 1984 enacted its first maternity leave guidelines^[19], policies continue to differ widely among hospitals and health care institutions.^[18,32] Many institutions and residency programs do not have specific written policies, but prefer to handle maternity leave on an individual basis.^[33] Both the American Medical Association and the American Academy of Pediatrics recommend clearly delineated written leave policies^[33,34] which can decrease the expectant mothers anxiety about her pregnancy, reduce any resentment during her absence, and preclude inconsistencies in leave time. Besides the length of maternity leave provided by a program, other important issues include whether maternity leave is paid or unpaid, the amount and duration of insurance benefits available for the mother and child, the impact of leave time on completion of training or consideration for tenure, schedule flexibility, the availability of leave for adoption of a child, and provisions for paternity leave.^[22]

As maternity or family leave draws to an end, the physician-mother must confront new challenges in balancing her career and family. One of the most crucial jobs in preparing for the mother's return to work is the search for consistent and competent childcare. It is essential for the physician-parent to have a high degree of confidence in the quality of the childcare, so anxiety regarding the child's safety and wellbeing does not distract the physician from focusing on patients and other work-related activities while away from home. A high degree of confidence and trust in the child's caregivers can dramatically reduce the stress of balancing parenthood and career. In the current research, satisfaction in the balancing between career and family life was significantly associated with negative impact of career obligations on both of the performance of children at school and the relation with children. Options for childcare are varied In USA and include^[22]: (1) a live-in nanny, which is expensive and reduces family privacy but provides a high degree of flexibility and eliminates transportation time; (2) a paid childcare provider who comes to the home, which also is expensive and requires a backup plan in the event of the provider's absence; (3) paid or unpaid childcare provided by extended family; (4) informal childcare in a provider's home which again requires a backup plan in the event of unavailability of the provider but costs less and gives the parent more control over timeliness; (5) a formal, licensed day-care which is the most highly regulated and least expensive alternative but lacks flexibility in hours, often makes no provision for ill children, and can result in an increased incidence of childhood illnesses. Few hospitals or medical schools provide onsite day-care, but that option is ideal for the physician parent, particularly when the day-care program offers round-the-clock care and provides setting for mildly ill children. A USA study concluded that women are more likely to alter their job responsibilities or make a career change to benefit their families and children, with the most common adjustment being a reduction in hours worked.^[34] The same retrospective study found that 85% of female physicians made career changes for the benefit of their children and family, while only 35% of male physicians made similar changes. Alternative work options are available in some healthcare and academic medical settings, including part-time work, shared positions, alternating work and family time (such as alternating one year of work with a year spent home raising children), taking family leave, having summers off, or reducing travel. In the current study, activate part time jobs in the government section with fair salary, reduction of working hours and flexibility at work, were among the most suggested solutions to decrease work demands.

The most notable strength is that the study population constituted all ever-married female physicians working in King Abdulaziz Medical City (National Guard Hospital), Riyadh. A simple random sampling technique was adopted to select the participant. In addition, the participation rate (87%) of the present study is quite high, given that typical response rate in surveys among physicians are around 50%^[35,36] or even lower^[37]. This suggests that selection bias in the study is limited, and that we may generalize our conclusions. In contrast, an important limitation is the cross-sectional design of the study, which precludes evaluation of the temporality and causality of the observed relationships.

Conclusion

In conclusion, only 19.5% of Saudi female physicians working in National Guard, Riyadh were satisfied in balancing career and family life. Poor satisfaction of Saudi female physicians in balancing career and family life is significantly associated with discrimination or negativity from colleagues because of their family status, negative impact of career obligations on the relationship with spouse or child, negative impact of career obligations on performance of children at schools, difficulty in transportation to the hospital and number of working hours.

Recommendations: (1) Providing childcare in medical centers. (2) Providing more days off for paid maternity leave. (3) Flexibility at work as there is a need of a fundamental change in the hospital culture, enabling doctors to be more involved in their family life without it being detrimental to their career. (4) Decrease working hours for married female physicians. (5) Further study including Saudi female physicians from other healthcare sectors and other cities to generalize the results. (6) A more equal division of domestic and caring responsibilities, and better opportunities in hospitals to adjust work to family responsibilities when having children, would probably reduce the gender differences in how family responsibilities affect the medical careers of men and women, and allow more women to complete specialization. (7) Counsellors and workplace supervisors can use relevant data to help female physicians in balancing career and family life.

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Cite this article as: AlGhamdi T. Balance between career and family life among female doctors in King Abdul-Aziz Medical City, Riyadh, Saudi Arabia. *Int J Med Sci Public Health* 2014;3:203-211.
Source of Support: Nil
Conflict of interest: None declared