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Original Research Article

Addressing the Challenges in Balance Between Career and Family Life Among Women Doctors in Tabuk

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ABSTRACT

Background: Getting an acceptable balance between career and family life is a difficult challenge for many female physicians.

Objectives: To assess the relationship between the barriers/factors (demographic factors, family responsibilities, career obligations) with the satisfaction in balancing between career and family life among female physicians.

Subjects and Methods: A cross sectional study was conducted included a representative sample of female doctors who ever married and in current clinical practice at military and Ministry of health (MOH) hospitals in Tabuk. A self-administrated questionnaire has been used for data collection containing: demographic data, impact of career on family life, common obstacles and suggested solution.

Results: The study included 158 female doctors with a response rate of 88.8%. About half of them (49.4%) reported discrimination from colleagues because of their marital status. Only 12.7% of the participants were satisfied in balancing their career and family life. Almost two-thirds of the participants (67%) thought their work has a negative impact on their relationship with their spouses/children. Type of job (on call status) was significantly associated with satisfaction in balancing between career and family life (p=0.003). Decrease working hours (88%) and providing childcare in medical centers (86.7%) were most reported solutions followed by flexibility at work (31%).

Conclusion: Poor satisfaction of female physicians in balancing career and family life is a common problem among those working in military and Ministry of health (MOH) hospitals in Tabuk.

Keywords: Female Physicians; Career, Family Life, Satisfaction.

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INTRODUCTION

With more women attaining leadership positions in organizations, there has been much debate in recent years about whether executive women can "have it all," meaning a high-powered career and a family.[1]

Getting an acceptable balance between career and family life is a difficult challenge for many physicians.[2] 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 physicians.[3]

This situation was more applicable 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,[4] in 2002 they became 28%,[5] and it was expected to rise to 30% of practicing doctors by 2010[6] and up to 50% by the year 2040.[7]

In 1981, Saudi women doctors constituted 4.4 % of professionally active Saudi doctors. In 1997, this number reached 20.36 %.[8] In spite of this increasing proportion of women in medicine during the last few decades, women doctors face a difficult task in combining medical career and family life as well 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.[9-11]

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.[12] 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.[3] 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.[13] A 1998 study by Carr et al. concluded that decreased academic progress and success is related to childbearing,[13] a finding which substantiates women's concerns about combining academic medicine and parenting.

This study was carried out to determine the reported impact of career on family life and vice versa among practicing women doctors in Saudi Arabia and find possible solutions to make the balance between career and family commitments less difficult for them.

SUBJECTS AND METHODS

The study was carried out in Tabuk city, Kingdom of Saudi Arabia as a cross-sectional one. Tabuk city is located 2200 feet above sea level and has a population of 550000 (2010 census). Tabuk has one military hospital (King Salman Armed Force hospital) and three hospitals belong to Ministry of Health "MOH" (King Khalid, King Fahd and obstetrics & pediatrics hospitals). One of the three MOH was randomly selected. All female doctors who ever married and in clinical practice in military (n=110) and King Khalid hospital, belonging to Ministry of health (MOH) in Tabuk (n=48) from all nationalities were included in the study

Data were collected through a self-administered questionnaire. It has been used previously in Riyadh and proved to be valid and reliable.[14] Approval from the corresponding author to use the questionnaire has been obtained through e-mail communication. The content validation of the questionnaire was done by 2 methods: It was compared with the objectives of the gold standard questionnaire/study, as provided by the authors who conducted the Norwegian study, 2004[3] and found to cover them as well as it was reviewed by 3 expert reviewers who also agreed that it met the study objectives. The questionnaire included demographic data (age, marital status, specialty, academic level and type of job), 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), 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 and finally obstacles faced by women doctors and their suggested solutions.

All ethical considerations and necessary approvals were fulfilled before data collection. Data entry and analysis was performed by using SPSS software statistical program version 20. 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 utilized. Pearson's Chi-square ($\chi 2$) 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.

Table 1: Association between female physicians' socio-demographic characteristics and satisfaction in balancing between career and family life

Socio-demographic characteristics		Satisfaction in balancing between career and family life			X^2 (p-value)
		Satisfied n=20 N (%)	Neutral n=123 N (%)	Unsatisfied n=15 N (%)	
▪ Age (years)	25-34 (n=61)	8 (13.1)	43 (70.5)	10 (16.4)	
	35-39 (n=54)	6 (11.1)	43 (79.6)	5 (9.3)	**8.13**
	≥40 (n=43)	6 (14.0)	37 (86.0)	0 (0.0)	**(0.087)**
▪ Marital status	Married (n=118)	14 (11.9)	94 (79.7)	10 (8.5)	**0.94**
	Presently single (n=40)	6 (15.0)	29 (72.5)	5 (12.5)	**(0.625)**
▪ Number of children	No (n=22)	6 (27.3)	14 (63.6)	2 (9.1)	
	1-2 (n=78)	5 (6.4)	67 (85.9)	6 (7.7)	**8.61**
	≥3 (n=58)	9 (15.5)	42 (72.4)	7 (12.1)	**(0.072)**
▪ Residence	Tabuk (n=120)	14 (11.7)	91 (75.8)	15 (12.5)	**5.40**
	Outside Tabuk (n=38)	6 (15.8)	32 (84.2)	0 (0.0)	**(0.067)**
▪ Specialty	Internal Medicine (n=27)	3 (11.1)	22 (81.5)	2 (7.4)	
	Obstetrics/Gynaecology (n=25)	2 (8.0)	19 (76.0)	4 (16.0)	
	Family Medicine (n=38)	5 (13.2)	32 (84.2)	1 (2.6)	
	Surgery (n=12)	1 (8.3)	9 (75.0)	2 (16.7)	
	Paediatrics (n=21)	1 (4.8)	17 (81.0)	3 (14.3)	**9.57**
	Others (n=35)	8 (22.9)	24 (68.6)	3 (8.6)	**(0.479)**
▪ Professional level	Consultant (n=19)	5 (26.3)	13 (68.4)	1 (5.3)	
	Assistant/associate consultant (n=42)	3 (7.1)	38 (90.5)	1 (2.4)	**9.21**
	Resident/staff physician (n=97)	12 (12.4)	72 (74.2)	13 (13.4)	**(0.056)**
▪ Type of job	Clinic only (n=43)	6 (14.0)	36 (83.7)	1 (2.3)	
	On call (n=96)	7 (7.3)	76 (79.2)	13 (13.5)	
	Shifts (n=14)	4 (28.6)	9 (64.3)	1 (7.1)	**19.90**
	Laboratory (n=5)	3 (60.0)	2 (40.0)	0 (0.0)	**(0.003)**

RESULTS

The study included 158 female physicians with a response rate of 100%. Almost one-third of them (34.2%) were in the age group 35-39 years whereas 27.2% aged over 40 years. Most of them (74.7%) were currently married. More than half of them (55.1%) were Saudis. Most of them (75.9%) reside in Tabuk. Nearly one-quarter (24.0%) were specialized in family medicine, 17.1% in internal medicine, 15.7% in obstetrics/gynecology and 13.3% in pediatrics. Regarding professional level, 61.4% of the respondents were either residents or staff physician. Moreover almost two-thirds of them (60.8%) had on call/inpatient duties.

Roughly, half of them (49.4%) had one or two children and 33.7% had three children or more. More than half of them (53.8%) married to physicians. Majority of them (91.8%) reported a period of interruption in the career because of either family responsibilities or social commitments. This period of interruption ranged between three and five years among almost two-thirds of them (64.8%) while it was more than five years among 28.3% of them. Almost half of them (49.4%) reported that family responsibilities affected their choice of specialty and they reported discrimination or negativity from colleagues because of their marital status whereas 94.3% of them reported discrimination or negativity from the society because of their work either all the time (8.2%) or sometimes (86.1%).

About two-thirds of the participants (63.3%) were working between 40 to 60 hours per week while only 7.0% were working more than 60 hours per week. Fifteen female physicians (9.5%) were unsatisfied while twenty (12.7%) were satisfied in balancing their career and family life. Almost two-thirds of the participants (67%) thought their work has a negative impact on their relationship with their spouse or children and only 8.6% of them thought their work affects their children's performance negatively at school. Almost two-thirds of them (65.2%) were responsible for 50% of daily household duties. Only 20.9% of the participated female physicians had no difficulties in transportation to the hospital.

Table 1 shows female physicians who had on call were more unsatisfied in balance between career and family life compared to those working in laboratories or clinics (13.5% versus zero and 2.3%, respectively). This difference was statistically significant, p=0.003. Other studied socio-demographic characteristics of female physicians (age, marital status, number of children, residence, specialty and professional level) were not significantly associated with satisfaction in balancing b/w career and family life.

Table 2 demonstrates that 17.9% of female physicians who reported discrimination or negativity from colleagues because of marital status compared to only 1.3% of those without such discrimination or negativity were unsatisfied in balancing career and family life. This difference was statistically significant, p=0.002. Almost half of female physicians (46.2%) who reported discrimination or negativity from the society because of work all of the time compared to none of those who never reported such discrimination or negativity. This difference was statistically significant, p<0.001. The associations between satisfaction in balancing between career and family life and both of work gap duration, spouse employment status and affection of choice of specialty by family responsibilities were not statistically significant.

Table 3, shows that 18.2% of female physicians who currently work more than 60 hours per week compared to none of those working less than 40 hours per week were unsatisfied in balancing between career and family life. This difference was statistically significant, p=0.031. Fourteen (13.2%) of female physicians who reported negative impact of work on the relationship with spouse or children compared to none of those who did not report such negative impact were unsatisfied in balancing between career and family life, p=0.002. Similarly, 36.4% of female physicians who reported negative impact of work on the children performance at school compared to 3.1% who did not report such negative impact were unsatisfied in balancing between career and family life, p=0.006. Half of female physicians who reported having less than 50% of household duties compared to 12.5% of those reported having 100% of household duties were unsatisfied in balancing between career and family life, p<0.001. The difficulty in transportation to the hospital was not significantly associated with satisfaction in balancing between career and family life.

Table 2: Association between family responsibilities and satisfaction in balancing between career and family life

Family responsibilities variables		Satisfaction in balancing between career and family life			X^2 (p-value)
		Satisfied n=20 N (%)	Neutral n=123 N (%)	Unsatisfied n=15 N (%)	
▪ Employment status of the spouse	Physician (n=85)	7 (8.2)	69 (81.2)	9 (10.6)	3.34
	Non-physician (n=73)	13 (17.8)	54 (74.0)	6 (8.2)	(0.189)
▪ Work gap duration	No interruption (n=13)	3 (23.1)	8 (61.5)	2 (15.4)	3.62
	1-2 years (n=10)	1 (10.0)	8 (80.0)	1 (10.0)	(0.727)
	3-5 years (n=94)	10 (10.6)	74 (78.7)	10 (10.6)	
	>5 years (n=41)	6 (14.6)	33 (80.5	2 (4.9)	
▪ Effect on choice of specialty by family responsibilities	No (n=78)	11 (14.1)	61 (78.2)	6 (7.7)	0.78
	Yes (n=80)	9 (11.3)	62 (77.5)	9 (11.3)	(0.676)
▪ Discrimination or negativity from colleagues because of marital status	Yes (n=78)	9 (11.5)	55 (70.5)	14 (17.9)	12.82
	No (n=80)	11 (13.8)	68 (85.0)	1 (1.3)	(0.002)
▪ Discrimination or negativity from the society because of work	All the time (n=13)	1 (7.7)	6 (46.2)	6 (46.2)	23.19
	Sometimes (n=136)	17 (12.5)	110 (80.9)	9 (6.6)	(<0.001)
	Never (n=9)	2 (22.2)	7 (77.8)	0 (0.0	

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

Career obligation Variables		Satisfaction in balancing between career and family life			X^2 (p-value)
		Satisfied n=20 N (%)	Neutral n=123 N (%)	Unsatisfied n=15 N (%)	
▪ Number of currently working hours per a week	<40 (n=47)	10 (21.3)	37 (78.7)	0 (0.0)	**10.60**
	40-60 (n=100)	9 (9.0)	78 (78.0)	13 (13.0)	**(0.031)**
	>60 (n=11)	1 (9.1)	8 (72.7)	2 (18.2)	
▪ Negative impact on the relationship with spouse or children	Yes (n=106)	9 (8.5)	83 (78.3)	14 (13.2)	**17.27**
	No (n=14)	6 (42.9)	8 (57.1)	0 (0.0)	**(0.002)**
	Neutral (n=38)	5 (13.2)	32 (84.2)	1 (2.6)	
▪ Negative impact on the performance of children at school (n=128)	Yes (n=11)	0 (0)	7 (63.6)	4 (36.4)	**14.46**
	No (n=64)	10 (15.6)	52 (81.3)	2 (3.1)	**(0.006)**
	Neutral (n=53)	4 (7.5)	42 (79.2)	7 (13.2)	
▪ The percentage of daily household duties	100% (n=16)	2 (12.5)	12 (75.0)	2 (12.5)	**26.57**
	75% (n=29)	4 (13.8)	23 (79.3)	2 (6.9)	**(<0.001)**
	50% (n=103)	11 (10.7)	86 (83.5)	6 (5.8)	
	<50% (n=10)	3 (30.0)	2 (20.0)	5 (50.0)	
▪ Difficulties in transportation to the hospital	No (n=74)	6 (8.1)	62 (83.8)	6 (8.1)	**6.93**
	Yes (n=33)	6 (18.2)	26 (78.8)	1 (3.0)	**(0.139)**
	Sometimes (n=51)	8 (15.7)	35 (68.6)	8 (15.7)	

Table 4: Factors associated with work gap duration among female physicians.

Variables		Work gap duration				X^2 (p-value)
		No n=13 N (%)	1-2 years n=10 N (%)	3-5 years n=94 N (%)	>5 years n=41 N (%)	
Age (years)	25-34 (n=61)	12 (19.7)	8 (13.1)	39 (63.9)	2 (3.3)	**94.7**
	35-39 (n=54)	0 (0.0)	1 (1.9)	46 (85.2)	7 (13.0)	**(<0.001)**
	≥40 (n=43)	1 (2.3)	1 (2.3)	9 (20.9)	32 (74.5)	
Number of children	No (n=22)	7 (31.8)	3 (13.6)	12 (54.5)	0 (0.0)	**52.01**
	1-2 (n=78)	3 (3.8)	5 (6.4)	59 (75.6)	11 (14.1)	**(<0.001**
	≥3 (n=58)	3 (5.2)	2 (3.4)	23 (39.7)	30 (51.7)	
Employment status of the spouse	Physician (n=85)	8 (9.4)	7 (8.2)	46 (54.1)	24 (28.2)	**2.63**
	Non-physician (n=73)	5 (6.8)	3 (4.1)	48 (65.8)	17 (23.3)	**(0.452)**
Effect on choice of specialty by family responsibilities	Yes (n=78)	7 (9.0)	4 (5.1)	46 (59.0)	21 (26.9)	**0.52**
	No (n=80)	6 (7.5)	6 (7.5)	48 (60.0)	20 (25.0)	**(0.915)**

Table 4 demonstrates that female physicians aged 40 years or more tended to have more than five years of work gap duration compared to those in the age group 25-34 years (74.5% versus none). The difference was statistically significant, p<0.001. Similarly, female physician who had three children or more tended to have more than five years of work gap duration compared to those who had no children (51.7% versus none. This difference was statistically significant, p<0.001. Employment status of the spouse and effect on choice of specialty by family responsibilities were not significantly associated with work gap duration among female physicians. As shown in table 5, 71.7% of female physicians who reported discrimination or negativity from colleagues because of marital status compared to 50.0% of those who did not report such discrimination had on call duty. This difference was statistically significant, p=0.005. All of female physicians who work more than 60 hours per week compared to only 10.6% of those who work less than 40 hours per week had on call duty. This difference was statistically significant, p<0.001.

History of discrimination or negativity from the society because of work, negative impact of work on the relationship with spouse or children, negative impact on the performance of children at school and difficulty in transportation to the hospital were not significantly associated with type of job (on call status).

Figure 1 illustrates the difficulties that female physicians are facing in balancing their career and family life. Household duties represent 86.1% of these difficulties. Most of female physicians reported children (79.1%) whereas 67.7% reported transportation as obstacles they faced for balancing between their career and family life.

Figure 2 displays the solutions suggested by female physicians in Tabuk that can make the balance between their career and family life better. Decrease working hours (88%) and providing childcare in medical centers (86.7%) were most reported solutions followed by flexibility at work (31%). Other reported solutions (29.8%): more days off for married women (13.3%), more days off for maternity (12.7%) and strong mentoring program (3.8%).

Table 5: Factors associated with type of job of female physicians

Variables		Type of job		X^2
		Not on call n=62 N (%)	On call n=96 N (%)	(p-value)
▪ Discrimination or negativity from colleagues because of marital status	Yes (n=78)	22 (28.2)	56 (71.8)	7.87
	No (n=80)	40 (50.0)	40 (50.0)	(0.005)
▪ Discrimination or negativity from the society because of work	All the time (n=13)	3 (23.1)	10 (76.9)	4.27
	Sometimes (n=136)	53 (39.0)	83 (61.0)	(0.118)
	Never (n=9)	6 (66.7)	3 (33.3)	
▪ Number of currently working hours per a week	<40 (n=47)	42 (89.4)	2 (10.6)	
	40-60 (n=100)	20 (20.0)	80 (80.0)	72.15
	>60 (n=11)	0 (0.0)	11 (100)	(<0.001)
▪ Negative impact on the performance of children at school (n=128)	Yes (n=11)	5 (45.5)	6 (54.5)	2.99
	No (n=64)	29 (45.3)	35 (54.7)	(0.224)
	Neutral (n=53)	16 (30.2)	37 (69.8)	
▪ Difficulty in transportation to the hospital	No (n=11)	5 (45.5)	6 (54.5)	2.99
	Yes (n=64)	29 (45.3)	35 (54.7)	(0.224)
	Sometimes (n=53)	16 (30.2)	37 (69.8)	
▪ Negative impact on the relationship with spouse or children	No (n=74)	33 (44.6)	41 (55.4)	2.08
	Yes (n=33)	10 (30.3)	23 (69.7)	(0.354)
	Neutral (n=51)	19 (37.3)	32 (62.7)	

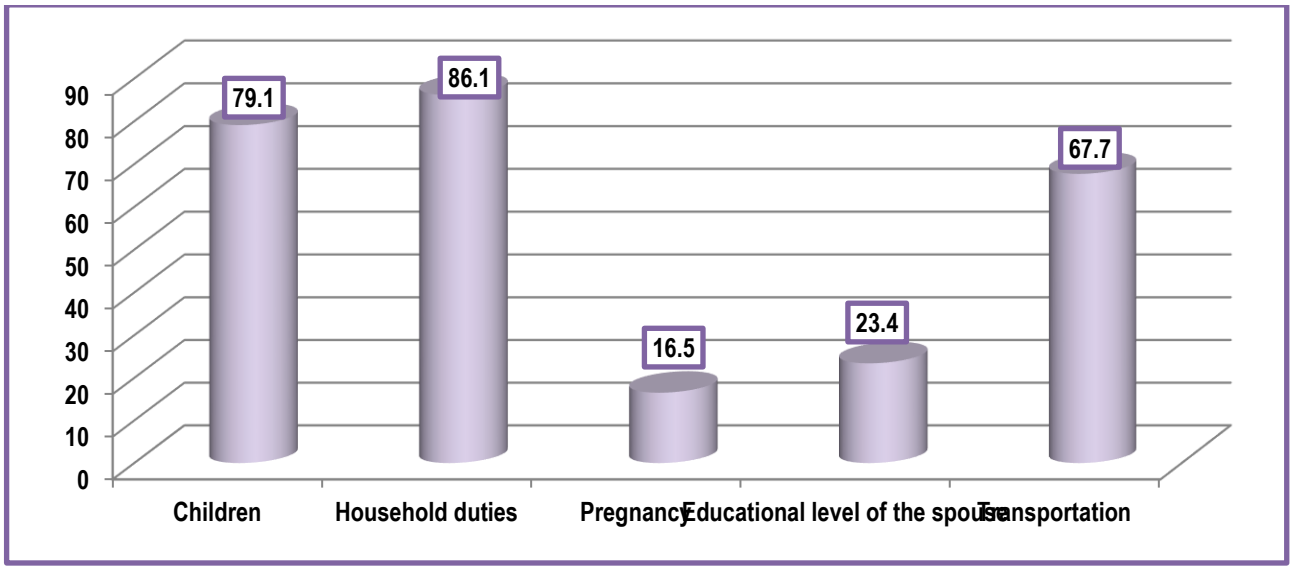

Fig 1: Difficulties faced by female physicians in Tabuk in balancing their career and family life.

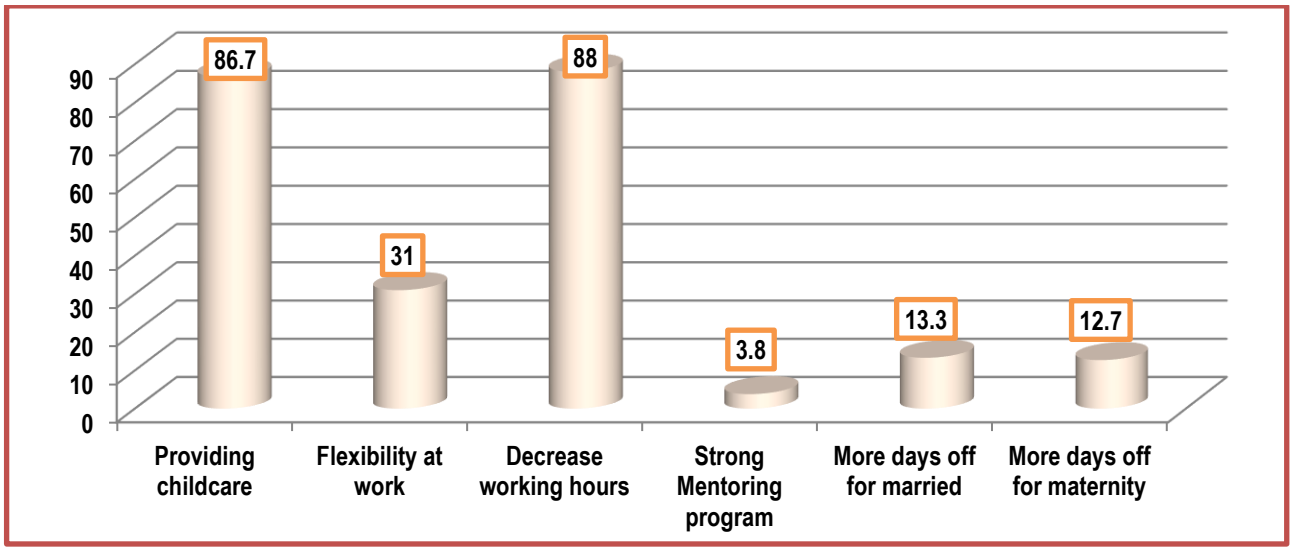

Fig 2: Suggested solutions for making the balance between career and family life less difficult: Physicians` perspectives.

DISCUSSION

Female doctors in Saudi Arabia, like in most countries do not choose between a career and children, they have it both ways. However, there are persisting differences between women and men in how family responsibilities affect their medical career.[3] Career patterns differ not only between women and men, but also between women in different types of specialities. Although most women doctors in this study combined parenthood and career, there were substantial differences in the way they did this.

The last decades' profound changes in the patterns of women's employment and family life may explain why most women doctors choose to combine work and family obligations.[3]

Women, differently from men, consider the balancing between family, parental, and job roles when making career decisions.[15] When specialty choices are examined, women are proportionately overrepresented in the primary care fields. They are underrepresented in most surgical fields,[16] with the exception of obstetrics and gynecology, where women now comprise the majority of practicing physicians.[5] This particular 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.[17] In accordance with that, the present study revealed that almost half of female physician (49.4%) reported that their family responsibilities affected their choice of specialty.

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 study, 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. 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.[18] 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 present study, reduction of working hours and flexibility at work, were among the most suggested solutions to decrease work demands.

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 previous researches that have found negative relationships between satisfaction in balancing between career and family life and work/family conflict.[18,19] 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.[20]

One of the most critical decisions that facing women in medical jobs is the appropriate time to have children and start a family. 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.[21] 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.[21] The present study supported these concerns, as childcare and pregnancy were mentioned by a considerable percentage of the female physicians as an important obstacle for balancing career and family life.

Policies on maternity leave are important factors in selecting a position as a practicing physician. In the present study, almost half of female physicians reported effect on choice of specialty by family responsibilities. However, this did not significantly associate with work gap duration. Although the American Medical Association in 1984 enacted its first maternity leave guidelines,[22] policies continue to differ widely among hospitals and health care institutions.[15,23]

Many institutions and residency programs do not have specific written policies, but prefer to handle maternity leave on an individual basis.[24] Both the American Medical Association and the American Academy of Pediatrics recommend clearly delineated written leave policies[24,25] 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.[2]

The American College of Physicians recommends maternity leave beginning at least 2 weeks prior to an expectant mothers due date and advises that one parent should be the infant's primary caregiver for at least 4 months.[26] Many physicians, nevertheless, work until the baby's birth.[21] Canadian physicians receive 20 weeks of paid maternity leave [27]; in most of the industrialized world, employers provide the mother with a minimum of 12 weeks of paid leave.[4] 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. Providing more days off for maternity leave as a possible solution in improving the balance between career and family life was mentioned by minority of physicians in the current study.

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 physician practices, and can be minimized by notifying colleagues well in advance of the impending birth and the mother's plans for maternity leave.[3] The current study 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.

The most notable strength is that the study population constituted a representative sample of ever-married female physicians working in military and Ministry of health (MOH) hospitals in Tabuk with 100% response rate. 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.

In conclusion, only minority of ever-married female physicians working in military and Ministry of Health hospitals in Tabuk were satisfied in balancing career and family life. Decision-makers and workplace supervisors can use relevant data to help female physicians in balancing career and family life.

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