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Balancing Profession, Family and Cultural Norms by Women Dentists in Pakistan

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Abstract

"Feminization of dentistry" in Pakistan is clearly visible in the gender distribution of an average dental class that boasts of 70% - 80% female students. Yet after graduation, many of these women choose not to pursue their careers, resulting in a void of practicing dentists in the country, despite an exponential increase in private sector dental colleges. This phenomenological designed qualitative study aimed to investigate the reasons behind this dynamic. Fourteen in-depth interviews' and two focus groups' discussion from a rich and diverse sample of 20 purposively selected working and non-working, younger and older women dentists from the cities of Islamabad, Rawalpindi, Lahore, Peshawar and Abbottabad obtained data to achieve saturation. All interviews were audio recorded with consent, transcribed verbatim, transcripts analyzed and coded into themes and sub-themes. Respondent validation and investigator triangulation ensured validity and credibility of findings. The core finding is that a support system is an essential pre-requisite facilitating a woman dentist to pursue her career; the primary driver for this support is "economic need". This core factor circuitously interlinks three peripheral themes, which are 1) traditional gender roles dominate, restricting women dentists from pursuance of career, especially if they have a strong economic base; 2) becoming a dentist enhances social capital and lucrative marriage prospects, lending to the concept of "doctor brides" which becomes a prime reason for choosing this education. Practicing the profession becomes secondary, especially when the marital union is with a well-to-do family; 3) life stage priorities with respect to motherhood is a barrier to full time career pursuance and if economic needs are met, most prioritize motherhood over profession. In conclusion, the average graduating dentist is female, from an expensive private sector dental college, affordable by the socio-economically privileged class; she often marries into an equivalent or higher SES class based on her "doctor" title. Since "economic need" is a dominant determinant of pursuance of career, a majority of women dentists opt for the luxury of choosing not to work.

Recommendations include revision of policies for admission into dental colleges and retentive protocols on renewal of license to practice.

Keywords

Women Dentists, Pakistan, Family-Work Balance, Doctor Brides, Economic Need

1. Introduction

Pakistan is the third fastest growing population in the world but ranks 122nd among 190 countries in terms of health care [1]. Human resource is a critical factor in health related gaps. The country has responded by allowing establishment of private sector medical and dental colleges to increase the production of doctors and dentists to meet the demands of the burgeoning population [2].

The entry of women in the field of dentistry in Pakistan has dramatically increased from a dismal ratio of 1:3 female to male dentists in the early 1990s to an astounding reversal to 2:1 in 2017 [2]. Attributable to the abolishing of the quota system and introduction of the open merit system, this reversal, referred to as the "feminization of dentistry" globally [3], brings about its own unique challenges in the changing landscape. Influx of women into traditionally male-dominated health occupations has led to many arguments on its positive and/or negative consequences [4].

In Pakistan, the arguments have mainly revolved around reasons behind the high dropout rate of female dental graduates from the career path that has resulted in an alarming void of practicing dentists despite the exponential production of dentists by the rapidly increasing number of private dental colleges [2] [5]. There are 49 dental teaching institutes in Pakistan, out of which 35 are private sector colleges and 14 are in the public sector [2]. As of January 2018, there is an approximately one dentist for every 8955 persons in Pakistan (23,225 dentists [2] to 208 million population [6]), a statistic competitive with developing nations. However, in reality this is a misleading figure because not only do the vast majority of female graduates, who constitute 70% - 80% of a graduating class [2], opt out of their careers but also a substantial number of both male and female dentists choose to leave the country contributing to the brain drain phenomenon. This has naturally resulted in continuation of male domination of the dental field in terms of both post-graduate qualifications as well as occupying most leadership roles. There are twice as many male post-graduate dentists as compared to female post-graduates [2]. Despite these disheartening statistics, many female dentists show remarkable, distinguished career paths that touch the glass ceiling in Pakistan [7].

The pertinent query is that, on one hand, what factors contribute to the high dropout of female Pakistani dentists from the profession, while on the other hand, what factors allow a woman dentist to not only pursue her career but also

reach top key positions in an otherwise male-dominated field? Research on this topic in Pakistan is limited to two studies conducted by one team of investigators. Tahir S., *et al.* identified presence or absence of a support system consisting of family/husband/supervisor/peer support as the key factor that allows women dentists to pursue their careers or drop out respectively [8] [9]. Other factors included individual motivation, accessible professional opportunities and unfriendly organizational policies. Based this evidence, arise several new questions e.g. what factors create a conducive support system or lack thereof? What factors drive motivation and passion for the practice of dentistry taking some to touch the glass ceiling while others, having spent five years in dental school, find that this field does not excite her? What is the perceived lack of professional opportunities? Does life course stage play a role? Social scientists use the historical construct of "life stages" to refer to the division of individual lives into a series of sequential stages, shaped by the interaction of cultural, demographic, economic, and institutional factors. The "life course" perspective in each life stage focuses on major life cycle transitions, such as marriage, parenthood, schooling, and entry into and exit from the labor force [10].

This study was conducted to investigate these questions from both the perspective of women dentists who were pursuing their careers and those who had chosen not to do so.

2. Methodology

A qualitative research methodology based on the phenomenological inquiry approach was used. By looking at multiple perspectives of the same situation, this methodology aimed to understand the "insider's" perspective. Approval was obtained from the Institutional Review Board Committee of Islamabad Medical and Dental College.

For the purpose of this study, work status was defined as the primary career role inclusive of teaching in a dental college, clinical practice or a combination of both. The terms "working" and "non-working" were coined for the study to refer to subjects who are pursuing or no longer pursuing their dental careers respectively. The latter were also occasionally referred to as having "dropped out" of their careers.

For maximum variation and richness of data, a diverse sample of twenty-four female dentists, purposively selected from the cities of Islamabad, Rawalpindi, Abbottabad, Peshawar and Lahore were approached by a snowballing technique to participate in the study. Two declined to participate and data saturation was achieved with a sample of twenty subjects. Age, being an important factor for life course stage was our primary selection criteria. Additional inclusion criteria were working status. Hence, the study participants consisted of two groups of eleven younger (aged 26 - 35 years) and nine older (>40 years) female dentists. Within each age group, both working and non-working women were present.

Data collection, that took place over 3 1/2 months, was via fourteen in-depth

key interviews and two focus-group discussions (FGD). Six telephonic and eight face-to-face conversations that were conducted at a venue/time convenient for the subjects obtained the former. Sample size for a qualitative research is driven by data saturation and about twelve participants for a homogenous group is considered sufficient to reach saturation point [11]. The in-depth interviews were conducted as a first stage where sampling occurred concurrently with data collection and analysis. Each interview was initiated based on five semi-structured open-ended questions that were developed based on previous evidence [8] [9] but participants were encouraged to talk freely about their experiences. Medium of communication was mainly colloquial English language interspersed with the occasional Urdu words and/or dialogues. Each interview lasted between 60 - 90 minutes. With consent of subjects, all interviews were audio recorded.

Based on the key themes that emerged from the interview transcripts, one FGD was conducted with younger dentists (three working and four non-working) while the other was with older dentists (four working and two non-working). An ideal number of participants for an effective FGD is between 5 - 8 [12]. The venue of FGDs was private residences of two participants who showed willingness to host. Some subjects' participation overlapped in both interviews and the FGDs. Conversations of the FGDs were audio recorded with permission of all participants.

Audio recordings were transcribed verbatim. Sentences in Urdu, transcribed verbatim, had the English translations in parenthesis, as some members of the team of investigators were not fluent in reading Urdu. Quality assurance for accuracy of transcriptions was done on a weekly basis by randomly selecting audio recordings and comparing with their written transcripts. Open coding was the initial step of analysis where a comprehensive text analysis of each transcript highlighted key indigenous words/phrases. Using the key-in-word-context (KWIC) approach, categories were determined. This process was accompanied alongside by axial coding interconnecting the categories as more interviews' transcripts added more data, until themes began to emerge. Emerging themes developed the framework for FGDs that allowed the investigators to develop conversation prompts to gather data on social-cultural contradictions and informal methods of social control by which the women dentists acquire and maintain achieved and ascribed status. Additional new data obtained underwent the same analysis routine repetitively until no new themes or sub-themes emerged.

Because the instrument of measurement is human, and easily criticized as unreliable, internal validity and dependability was established by respondent validation and investigator triangulation respectively. The former was carried out by returning our interpretations to the interviewees to validate that they are a true representation of their communicated lived experience. They were encouraged to dispute any errors in interpretation and provide any further thoughts or details that may have emerged since the interviews. All participants approached for respondent validation replied with affirmative feedback. A qualitative expert re-

searcher, an anthropologist by profession who was unrelated to the team or the institution to avoid conflict of interest or interpretative bias, carried out the latter and came up with congruent themes, thus lending credibility to the study findings.

3. Results

3.1. Description of Participants

The participants consisted of 11 and 9 younger and older women dentists respectively. In the younger group, the working status was five working and six non-working while marital status was eight married and three unmarried. Of the married women, only one did not have children while all the rest had 1 - 3 children aged ranging between toddler to pre-teen. Of the single younger women, one dentist was a divorced mother of three children while the others had never married and hence were childless. In the older group, the working status was six working and three non-working while marital status was five were married with children and three were single mothers of teenage and adult children with the exception of one who never married. All the young dentists and one older dentist were graduates of private dental colleges. The remaining eight older dentists were public sector dental college graduates.

To ensure anonymity of participants, subjects were allocated alphabetical/numerical codes of YW (young working), YNW (young non-working), OW (older working) and ONW (older non-working). Details of participants' demographics are tabulated as Table 1.

3.2. Thematic Findings

Four themes, one core and three peripheral, were identified. Findings are augmented with verbatim statements of participants, presented in quotes. Bracketed words within the quotes are added by the investigators, in lieu of either translation of a word of Urdu/Arabic, the context of the situation or verbatim response of participant that investigators thought pertinent to include here.

3.3. Core Theme-Support System

A woman dentist in Pakistan can work and pursue her career based solely on a support system. This support differs according to marital status. The support system facilitating a married female dentist was a social network composed of the marital family (husband/in-laws) or natal family or a combination of both. Single women dentists' support systems were either social, composed of the natal family, or based more on technical aspects such as transport system, availability of domestic help and child-care services. Our core theme is divided into two sub-categories

1) ***Economic need***: The primary driving force behind the infrastructure of any type of support system was economic need, a factor determined mainly by socio-economic status (SES). Given the inflated cost of living in Pakistan, even a

Table 1. Description of study participants.

Code	Age	Marital Status	Children/Ages	Qualifications & Graduating College	Work Status	
YW 1	29	Married	Two children 4 & 2 yr old	BDS Private sector college	Working	Lecturer No clinical practice
YW 2	34	Single; Never Married	None	BDS, FCPS Private sector college	Working	Assistant Professor; Practicing in an evening group practice
YW 3	35	Single; Divorced	Three children 3, 5 & 6 yr old	BDS, MPH Private sector College	Working	Assistant Professor; practicing in an afternoon group practice
YW 4	33	Married	None	BDS, PG Resident Private sector College	Working	Lecturer + PG resident in teaching hospital; Practicing in evening clinical practice
YW 5	35	Married	Three children 10, 8, 6 yr old	BDS, MSc Private sector College	Working	Assistant Professor and private practice
YNW 1	28	Married	Pregnant with first child	BDS Private sector College	Non-working	Home maker
YNW 2	29	Married	One child 11 months old	BDS Private sector College	Non-working	Home maker
YNW 3	34	Married	Three children 1, 4 & 6 yr olds	BDS, MPH Private sector College	Non-working	Home maker
YNW 4	29	Married	One child, 2 yr old	BDS Private sector College	Non-working	Home maker
YNW 5	30	Married	Two child, 3 & 5 yr. old	BDS Private sector College	Non-working	Home maker
YNW 6	27	Single; never married	None	BDS Private sector College	Non-working	Lives with parents
OW 1	44	Married	Two children 13 & 14 yr old	BDS, MSc, MPhil Public sector college	Working	Associate Professor; runs self-owned private practice
OW 2	46	Single Divorced	Three children 10, 11 & 14 yr olds'	BDS, FCPS Public sector college	working	Associate Professor; runs self-owned private practice in evenings
OW 3	56	Single Divorced	Two children, 16 & 25 yr old	BDS, FCPS Public sector college	Working	Professor, practicing in evening group practice
OW 4	52	Single Widow	One child 24 yr old	BDS, MPhil Public sector college	Working	Professor; runs self-owned private practice in evenings
OW 5	49	Married	Three children 16.18 & 21 yr	BDS, Msc Public sector college	Working	Full time self-owned private practice
OW 6	60	Single Never Married	None	BDS, PHD Public sector college	working	Professor; runs self-owned private practice
ONW 1	41	Married	Three children 14, 15 & 19 yrs	BDS Private sector College	Non-working	Home maker
ONW 2	51	Married	Two children 20 & 22 yr olds	BDS Public sector college	Non-working	Home maker
ONW 3	49	Married	Two children 19 yr old twins	BDS Public sector college	Non-working	Home maker

middle class SES means that a single income source is often insufficient to provide for a good quality life [13]. Women dentists, who came from a modest middle level SES, be it a natal family status or a marital family status continued to pursue their career as a natural sequence to graduation because their income was a welcome addition. This finding was true for both age groups. Husbands, in-law families and in some cases the natal family, all played key roles in providing support in form of babysitting, administration of domestic help and pick/drop of children's various academic and extra-curricular activities, enabling the mother to balance both home and work front.

"*I got married to a businessman. Soon after the marriage, his business went bankrupt and although he is trying very hard in a new business, we still have not recovered from the loss. So, we decided I should work. My salary helps out until his business stabilizes.*" [*YW*1]

"*My husband and his family all help me out so I can work. My mother-in-law keeps an eye on the nanny. My younger brother-in-law picks and drops the kids, sometimes my mother also helps.*" [*YW*5]

Contributing to the family financial resources became an empowering factor giving women an equal standing in the family and decision-making. By virtue of this empowerment, most of these women continued to work beyond the stage where economic needs eventually met and SES elevated because now their careers held an equal importance to the spouse's career within the family value system. So many of our married older women dentists rose in their careers, specializing along the process and today were occupying leadership roles in both academia as well as leading practitioners within their respective cities.

"*My husband and I are like equal partners. He realized the importance of my career especially during the time he lost his job. He insisted on his mother taking care of the house and kids while I worked. Now he has a good job that pays well but he is still supportive of my career.*" [*OW*5]

"*My husband is a banker and brings a salary which is enough to run the house. My income has always been our savings which we invested in real estate and are now in the stage of building our own house.*" [*OW*1]

Not surprisingly, economic need was also the main incentive behind the career growth of single women dentists of both age groups as all continued to work despite enormous difficulties. Economic need superseded all hurdles, barriers, cultural expectations and norms.

"*My family* (*natal*) *did not approve of my decision to file for divorce because they are very traditional. So now, they do not support my children and me even though they can. So I have to survive on my own. My children are very young and its very, very difficult but* '*Alhamdollilah*' (*Praise be to Allah*)*, my dental career gives me a good income in a respectable manner.*" [*YW*3]

"*I'm not married and my family lives in the village in Kashmir. So of course I have to work and inshallah, always will. After all, a girl's go to pay her bills.*" [*YW*2]

"*My husband passed away when my son was* 3 *years old and my family wanted me to remarry. I didn't want that, so I chose to be independent, support myself and give my child the best possible life. It was a very rough time and my son was often alone while I worked late hours. But I am very grateful that I am a dentist, it gave me the financial security that facilitated my independence.*" [*OW*4]

"*I'm a chronic bachelor girl …* (*laughs*) *… so of course, my career is my life-line, my identity and my source of livelihood that gives me the ability to live my life the way I want.*" [*OW*6]

On the other side of the coin, women dentists from higher socio-economic backgrounds were equally adamant in claiming that their economic strength allowed them the luxury of not having to work for a living. Non-working dentists of both age groups made most of such claims.

"*I'm married into a family where there is no need for me to work. In fact, I think the pocket money he* (*husband*) *gives me is more than I can ever hope to earn …* (*laughs*) *… so why should I work*?" [*ONW*1]

"*My husband says he is a good provider, he can buy anything we need but he can't buy a mother for our child. And I agree with him …* (*pause*) *… all my needs are met, so why work*?" [*YNW*4]

"*My father says a woman 'bechari'* (*translated as 'poor'/'pitable'*) *only works when there is a 'majburi'* (*compulsion*)*; there is no need for me to work for money as that is not an issue for us. Otherwise, I can work for experience if I want.*" [*YNW*6]

This theme of "economic need" resurfaces at several points during the peripheral thematic findings interlinking the different findings in a circuitous manner.

2) ***Occupation of spouse***: The second factor that contributes to an easy creation and sustenance of a social support system is the occupation /educational qualification of the spouse. A husband who is a health care professional, either dental or medical, gave their dentist wives an extra edge. Belonging to the same profession promoted a greater understanding of the importance of pursuing the career as it represented something more than just a job. Such husbands were more willing to assist their wives in balancing the work-home fronts. Non-health professional husbands were less understanding and supportive of the wife's dental career.

"*We were class fellows and we started a small clinic immediately after graduation. Today we have expanded the clinic and we both are teaching. So yes, I think his being a dentist was very vital in my career because we operate as a team.*" [*YW*5]

"*I married my cousin who runs a family business. He never understood why I wanted to work and after the twins, I just gave up trying to convince him.*" [*ONW*3]

"*My husband and I are both doing our post-graduate residencies. Me in oper-*

ative and him in surgery. So he is very cooperative with me, helps out in the house and although his mother is putting pressure (*to give her a grandchild*)*, he understands we can't start a family at this stage.*" [*YW*4]

The three peripheral themes, in no particular order of ranking, are:

3.4. Peripheral Theme I: Enhancement of Social Capital

"Why did you become a dentist" was a prompt question that initiated each interview as well as the FGDs. The three most common responses were a combination of personal ambition, family pressure/desire and the social prestige that comes with adding the title of "Dr" to one's name. The social capital that automatically comes with this prestige was beneficial to both the girl and her family thus explaining the family pressure/desire factor. Having the qualification of a dentist enhanced a girl's social image, making her a desirable candidate as a wife and daughter-in-law. In many cases, the status symbol of being a "Dr" was the endpoint of attaining this qualification and actually practicing dentistry was not on the charts.

"*I am the first female doctor in my family because we are a very conservative family where girls do* '*purdah*' (*veil*) *and cannot attend co-education schools but my father allowed me to study …* (*pause*) *…which was good for us because see …*? *... I married into a well-to-do family.*" [*YNW*1]

"*My in-laws are a very prominent family you know, and my mother-in-law always wanted to have a doctor* '*bahu*' (*daughter-in-law*)." [*YNW*2]

"*My husband is happy to have a wife who is called a doctor but says being a dentist doesn't mean that I HAVE to work.*" [*YNW*3]

"*In our time in the* 1980*s*-90*s, female dentists and doctors were few and rare, so I received very many good proposals* (*of marriage*)*. So today I am,* '*Mashallah*' (*Allah has willed*) … (*laughs*) … *happily married and secure. So why do I need to work*?" [*ONW*2]

3.5. Peripheral Theme II: Cultural Norms: This Theme Has Two Sub-Categories

1) ***Role of provider***: The financial lucrative nature of dentistry, commonly cited as an important reason for becoming a dentist [14] [15] [16], was not alluded to in this study, although it was definitely mentioned as a very beneficial outcome by working, older dentists under the core theme of economic need. This finding is attributed to the fact that the cultural norm in Pakistan, as is for any eastern, Muslim country, dictates a man's key role as a provider and a woman's as homemaker. If a man can provide comfortably, a woman would happily prioritizes her family first. A woman seldom views herself playing the role of provider in the future, unless driven by unfortunate circumstances.

"*In the beginning, I did not work because my children and home were my first priority. But when my marriage started to sour, I wanted to be financially independent of him* (*husband*)*, so I started working. So, after the divorce, I was*

standing on my own two feet (*financially*)." [*OW*2]

When asked of non-working dentists as to why she has chosen not to pursue a career, often the blame was transferred to external factors such as restrictions by husbands/marital families and unavailability of job opportunities. The former, on prodding deeper, proved to be a superficial transference as most of the non-working dentists, of both age groups, in principle agreed with the so-called restrictions and were satisfied with their status quo.

"*My husband says he is a good provider, he can buy anything we need but he can't buy a mother for our child. And I agree with him … (pause) … all my needs are met, so why work*?" [*YNW*4]

"*I got married immediately after my house-job and then I had my first born within the first year of marriage, so I never really worked. Now I'm not sure I want to go back … I'm quite satisfied with the way my life is …*" [YNW3]

"*I think the most important thing for a woman should be her family and children. Her Islamic duty is towards them first and foremost. So, if she can afford to, then there is no need for her to work.*" [*ONW*2]

In fact, one young unmarried dentist claimed that she would not like to start any new venture, in terms of her career, because marriage is round the corner for her and every decision she makes should be after that. Although she has no idea who she will marry, she had already transferred the responsibility of the pursuance of her career or lack thereof to the unsuspecting spouse-to-be. Her personal inclination was intrinsically irrelevant.

"*I don't want to start a job or a post-graduation because I will have to leave it once I get married. It really all depends on where I marry and who I marry.*" [*YNW*6]

2) ***Unavailability of professional opportunities***: Interestingly, although this is a reason that is technical in essence, our research determined that "unavailability of professional opportunity" was subjective in nature, driven by cultural priorities. The dental job market in cities, as viewed by our study participants, is composed of either teaching in a dental college or working in a private clinical practice. None of our subjects, with the exception of two older participants, viewed working in a public sector hospital under the umbrella of government service as a practical option. This was because government service employees are subject to postings/transfers to different government hospitals, rural or urban, within the province/state. Decision of transfers are often beyond their control making such a job unpopular especially with women. [17] As urbanite residents, our study participants' reluctance to work anywhere other than within their own city was resolute.

"'*I didn't bother applying for a government job. They can post you anywhere they want and it is not possible for a girl to just get up and go where they decide … the families would never allow and it is not even safe.*" [*YNW*2]

"*I sat for the public service exam, passed it but my first posting was to Layyah* (*a remote rural town*) *… can you imagine*? *I tried all my connections to change*

this but nothing worked. So I never joined." [*OW*1]

Having narrowed their job market to the private sector, the non-working young dentists were looking for flexible part-time work preferably within the neighborhood to accommodate domestic demands. Such part-time opportunities were few and apart. The alternate of establishing a self-owned private practice, where one could choose timings of convenience, was not considered a viable option as a brand new practice requires full-time attention and long hours of dedication to be profitable, thus negating their primary premise of flexible part-time work. Based on these narrow, somewhat stringent parameters, the blame for not working was transferred to the perception of "unavailability of good professional opportunities" in the dental market.

"*There are no good jobs nowadays. I'd like to work in a clinic that is nearby so I don't have to travel too much and for* 2-3 *days a week so that my family is not disturbed.*" [*YNW*1]

"*I would like to work but only on part time basis where my family's needs are not compromised.*" [*YNW*4]

On the other hand, the opinion of working dentists, of both age groups, was that job opportunities are available as long as one is willing to put in hard work, dedication and at least at the start of the career, a full time involvement. Flexible hours and part-time basis was a luxury that becomes available only if one has reached the zenith of their career. Most of the working dentists were disdainful of the perceived lack of opportunities cited by non-working dentists, claiming that the degree of elasticity of self-created parameters when looking for a job depends on economic need; thus bringing us back to our core theme.

"*There is always a job available … your* '*nakhra*' (*finicky attitude*) *only depends on how much you need the money.*" [*YW*3]

"*These youngster graduates want everything without wanting to put in any effort. I have slogged for two decades and I still don't have the flexibility I'd like.*" [*OW*2]

"*You can't have your piece of cake and eat it too.*" [*OW*6]

3.6. Peripheral Theme III: Life Stages Priorities

The maternal role is the key defining factor that determines whether a woman dentist pursues her career or drops out of it, temporarily or permanently. This finding was true for all the mothers of our study irrespective of age, working and marital status. For a mother, especially of babies and young children, the career took a back seat. Whether this was on a temporary basis or a more permanent move depended mostly on their economic safety net taking us back to our core theme, although personal motivation was also another factor. Young non-working dentists who were in the newly acquired stages of motherhood identified the children as their primary priority and were happy to be stay-at-home moms. On the other hand, working young mothers, if given a choice, too would prefer to take a break from their careers to raise their children.

"*Yes, if my husband's salary was good, I would never work because I like to look after the kids myself and not depend on domestic servants.*" [*YW*1]

Older dentists also recall that they chose to be stay-at-home moms when the children were young.

"*I took two years off from working when my daughter was born. Once she was ready for pre-school, I started working again but only in the mornings while she was at school. Years later, I repeated the same thing when my son was born.*" [*OW*3]

"*I was doing my house-job when my son was born. I wanted to breastfeed, so I dropped out for* 2 *years. After that I rejoined and completed my house-job and have been working since then without break.*" [*OW*4]

Whether they return to their careers after a hiatus or not becomes a personal choice. What drives the decision is mostly individual circumstances, personal motivations and the duration of the hiatus. If the break from career spans several years, then the self-confidence of the dentist becomes shaky and becomes a limiting factor.

"*Would I like to rejoin my career as a dentist? I don't know … maybe I would go back to working when the kids are grown up but I can't say for sure. I'm quite satisfied with my life at the moment.*" [*YNW*5]

"*No, I would not like to work now. I think its too late now and honestly, I don't see why I should struggle.*" [*ONW*3]

"*I want to have more kids and when my family is complete and kids are grown, then I would like to go back to my career …* (*long pause*) *… but I don't think I'll remember a single thing about dentistry by then …* (*laughs nervously*)." [*YNW*4]

However, motivation and intrinsic passion also plays an important role when making life stage priorities. In some cases, professional ambition and an inner drive to excel was a factor that determined the decisions made in the arena of parenting instead of vice versa. One dentist was married but had chosen to delay starting a family despite her age and family pressure because her first priority was to establish her career, which will allow her flexibility in decision making when she becomes a mother without compromising on either facet of her life.

"*I will start a family only when my career and my clinic is at a stable point. That way I can decide if I work part-time or take a short break or whatever is feasible at that time regarding my child's needs.*" [*YW*4]

All the working young mothers in our study cited that the stress of balancing motherhood and work is exaggerated by the lack of adequate maternity leave and workplace child-care support. Having a quality, well equipment daycare center within the hospital premises would be a very gratifying development to ease the guilt conscience typical of a working mother separated from her child for long hours and to accommodate breast-feeding schedules. The duration of an average maternity leave was also cited as too short. Many felt that it should be longer and if that was not possible, then the options of flexible hours for at least

six months after the maternity leave would be welcome.

"*I wish the hospital had a day care center, life would so much easier and I wouldn't have to depend on my in-laws so much … I am always under obligation to my mother-in-law who never lets me forget.*" [*YW*5]

4. Discussion

The dynamics determining whether a female dentist pursues her career or not in Pakistan are a complex, multi-faceted web interlinking traditional cultural norms and its evolving pattern to incorporate modern life, socio-economic influences, emerging organizational policies and individual motivation.

A support system as an essential prerequisite enabling a female dentist to practice is a primary finding that is the same as Tahira *et al.* research [8] [9]. Our study went a step further and identified that the key driver of a support system is "economic need". This factor is prime as it eclipses all supposed barriers and hurdles such as socio-cultural norms, life stage priorities and personal motivations. Although congruent with researches that identify financial gains as one of the reasons that motivate the choice of a dental career [14] [15] [16]; in our study we see that it plays out in a more nuanced gender-specific and cultural context explicit manner. At a primary level, working is associated with income while passion, drive, motivations for the work are abstract notions that occupy a secondary but equally vital plane. So when a female dentist in Pakistan chooses to work or not, the primary reason is whether she needs the income or not. When her income is a welcome addition to the family resources, then everyone involved contributes to creating a support system that will facilitate her. Typical gender roles and cultural norms take a back seat. Decisions revolving around maternity needs and child-care are made such that they reinforce and sustain the support system. When she does not need the income, then a support system often fails to develop impeding an already fledgling passion to work. Given that the number of non-working women dentists greatly surpass the number of those working, indicates that higher socio-economic influences dominate. We find that this core factor of "economic need" connects and circuitously interlinks all other themes of our study.

A secondary factor behind a conducive support system was having a spouse who is a healthcare professional. This added advantage enabled women dentists to develop a support system with greater ease, a finding similar to a US study on the challenges and strengths of dual-physician marriages [18]. According to Tahira *et al.*, a peer/supervisor driven support system was also important, a finding that our study did not reveal. Many of our older working participants were postgraduate supervisors who were of the opinion that it was unprofessional to accommodate demands of students who were mothers, without compromising quality of training, patient care and equality amongst students. However, the overall opinion that organizational support in terms of child-care centers within the working premises and longer maternity leaves or flexible working hours

post-maternity would greatly support young mothers to work is congruent with similar findings from other studies [8] [9] [19] [20].

Social prestige that comes hand-in-hand with the occupation as a doctor is a universal, timeless phenomenon common to different countries across the globe and Pakistan is no exception [21]. However, with the feminization of a previously male-dominated field of medicine and dentistry, the social prestige concept has developed new facets in Pakistan. An evolving aspect of the Pakistani social culture where arranged marriages are still the norm, demands for an ideal wife have risen beyond the typical attributes of beauty and added "doctors/dentist" because this title befits the image of a trophy wife [22]. Colloquially referred to, as "doctor brides" [5], there are many candidates eager to fulfill this demand which our study has evidenced. Whether they choose to work or not after tying the knot, the majority exhibit the latter. Blaming husbands and in-law families, the commonly cited reasons are socio-cultural restrictions and gender role requirements. This approach assumes that, theoretically speaking, if given the freedom of choice, these female dentists would enthusiastically pursue their careers. Such an assumption is naïve and simplistic because women are from the same culture and they too possess the same intrinsic value system that accepts traditional gender roles of men as providers and women as homemakers. Therefore, if there is an economically sound base, which is more often than not, given the "doctor bride" opts for the highest contender, traditional cultural values become dominant. However, if life circumstances change for the worse and economic need is the call of the hour, the same women quickly shed cultural norms and rise to the occasion and start working. Fortunately, such situations are not commonplace and thus, unfortunately, these women dentists never work and fulfill the Hippocratic Oath they undertook on graduation.

The biological timing of the maternal role, a crucial life course milestone, often coincides with the start of a dental career. Our finding that most mothers found it difficult to balance young children and work is comparable to studies from different countries and cultures [23] [24] [25]. The timing of this universal life stage plays a decisive role for women dentists. Ideally those who can afford to, prefer to be mothers first and dentists later, blithely putting their careers on the back seat or on hold. Young mothers who continue working; do so for reasons less to do with motivation and more to do with "economic need". This was also found to be true by Tahira *et al.* [10] [11]. Older female dentist leaders also prioritized child rearing when needed and then rejoined their careers to grow to heights competitive with their male counterparts who had smooth uninterrupted career growth paths. To go the next step, whether the hiatus from career is temporary or permanent break is determined by several factors such as motivation/determination, economic need, and duration of hiatus and in some cases, adverse change in life circumstances. Often a long duration of a hiatus itself becomes a deterrent from rejoining the career as the self-confidence of the woman dentist becomes shaky. Therefore, the take home message from this finding is

that professional peer and employer expectations need to change. To compare a woman dentist's career path to a male dentist is akin to comparing oranges with apples. A woman dentist will always become a mother and that role should not become a point of conflict with her profession. It must become a norm that young female graduates will have a rocky path at the beginning of a career and these delays should not be held as evidence against her, blocking and impeding her growth.

Motivation and determination are concepts that we encountered in our study, which is congruent with Tahira *et al.* and Al-Lawati & Hunsaker [26]. Motivation is an abstract notion, intrinsic in origin and ambiguous in definition. Why do some women have this passionate inner drive to excel and grow professionally while others, from the same background, academic exposure, facing the same cultural norms, expectations and barriers, lack it? This question remained unanswered in our study and needs further research.

5. Conclusion

In conclusion, with "economic need" identified as a vital indicator, the high drop-out rate of female dentists from the profession in Pakistan can be attributed to the fact that a vast majority of the graduating dentists come from rich, well-to-do families. The number of private sector dental colleges is two and half times more than the public sector colleges [2]. The key difference between the two is the fee structure. The annual fees of an average private sector college is an unbelievable 15 - 16 times more than that of a public sector college, attributable to the latter being partly supported by government funds. In Pakistan, admission into a medical/dental college is based on a central admission policy for each province where all applicants appear for one central entrance exam and their resulting merit determines the college of their choice. This means that public sector colleges, because of their cost effective fees structure, have a higher merit for admission and their student body is often composed of the crème de la crème of the brightest students. Meanwhile, the main bulk of students are in private dental colleges, whose admission merit level is mediocre but fee structure is high, affordable only by the well-to-do. With abolishing of the previous admission policy which was based on a quota seat system (*i.e.* specific number of seats according to different criteria such as gender, backward rural areas, parents' profession, international student etc.) and replaced with an open merit-only admission system, the number of female students inducted rose exponentially. Today the average class is composed of 70% - 80% female dental students [2], a fact that demonstrates that girls obtain higher marks than their male counterparts. Given that "economic need" as a dominant determinant for pursuance of career and that the average student is a female from a well-to-do family, then it is to be expected that a vast majority of female dentists in Pakistan, who otherwise were bright, intelligent students, opt for the luxury of not pursuing their careers.

6. Recommendations

There are several recommendations that can begin to address this complex situation. The open-merit admission policy needs revisiting for discussion to perhaps reintroduce an equitable gender-based quota system. The Pakistan Medical and Dental Council (PMDC), the authority that issues licenses to private sector dental colleges, should play a decisive role in controlling fees structures to increase affordability by the average middle to low SES student. PMDC also issues license to practice to dentists; it is recommended that a minimum time duration of working experience be made mandatory for every renewal of the dental license, with penalties for non-compliance. Penalties should not be financial in nature but technical clauses such as suspension of license and renewal based on sitting for relicensing exams. Dental organizations should be encouraged to introduce mother-friendly policies in terms of maternity leave, flexible working hours and child day care to accommodate the rocky path that women navigate between motherhood and their dental profession.

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