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# Impact of Patriarchy on Brain Waste of Female Doctors in Pakistan

[1]Samia Zulfiqar & [2]Anwaar Mohyuddin
[1]Department of Anthropology, Quaid-i-Azam University, Islamabad, Pakistan.
[2]Department of Anthropology, Quaid-i-Azam University, Islamabad, Pakistan.

## ABSTRACT

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The overarching aim of this research is to offer a nuanced and evidence-based exploration of the brain waste of female doctors in the national healthcare system of Pakistan. The study will highlight the societal factors that push doctors out of the profession, with a specific focus on the narratives provided by female doctors. This anthropological study is based on a qualitative phenomenological approach, having constructivist ontology and interpretivist epistemology. Data was collected through case studies and in-depth interviews with 30 female doctors (who are unemployed or left jobs) in the "Twin cities" (Islamabad and Rawalpindi) using snowball sampling. For data analysis, the Stevick-Colaizzi-Keen method was incorporated. The findings are in strong compliance with the idea of the Feminist Political Economy of Health (FPEH) which states that material and cultural discrimination against females influences their social conditions. Although medicine is considered a highly idealized profession for females, lack of sufficient employment opportunities, patriarchal setup, rigid gender role expectations, and lack of adequate support and encouragement from family members make it hard for female doctors to continue with their career pursuits and hence become the target of brain waste. This study is significant as it sheds light on the underexplored issue of brain waste among female doctors in Pakistan, revealing how societal and cultural constraints impede their professional growth.



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## 1.0 Introduction

Brain waste is the term that encapsulates the underutilization of knowledge, skills, and expertise of highly qualified professionals and is usually studied in the context of skilled professionals' immigrants' underutilization or their misallocation (Reitz, 2001; Bratsberg & Ragan, 2002; Mattoo et al., 2008). However, the gender perspective of brain waste has been rarely studied; therefore, interest of the current study. In this article, brain waste will be taken as an existing phenomenon where the skills and educational qualifications of female doctors are being underutilized in Pakistan.

Pakistan requires more than 0.4 million doctors, 0.2 million dentists, and 1.6 million nurses to meet international standards of healthcare (Hussain, 2019). Analysis shows that Pakistan has a 1:1300 doctor-to-patient ratio, which is significantly less than the recommended ratio of 1:1000 by WHO (Qamar et al., 2023). According to the official documents, there are around 232,358 doctors, 23,295 dentists, and only 144,600 nurses who have been registered in Pakistan. Additionally, out of these total doctors, 110,000 are female doctors (Female GP 92,448 and Female Specialist 15,064). With 70% of the medical graduates predominantly female, the Pakistan Medical & Dental Council (PMDC) stated in 2014 that half of graduating female medical students do not pursue their studies in the country (Raza et al., 2023).

In Pakistan, female medical students are two-thirds of the total medical student intake in medical universities. Despite high female enrolment in medical colleges, female doctors' participation in the healthcare workforce remains low in Pakistan (Baig, 2020; Ashraf et al., 2023). The research conducted by (Tahir, Kauser, & Tahir, 2011) also highlighted this issue that the Proportion of working female doctors is 1/4th, showing the professional contradiction of female high enrollment in medical colleges in the country. Furthermore, according to a recent survey, there are 104,974 female doctors in Pakistan, with 14.9% being unemployed and 20.1% are out of the labor force. The survey also indicates that the majority of those not participating in the national healthcare workforce are married. This trend is often referred to as the "doctor bride" phenomenon in Pakistani literature, symbolizing the departure of female doctors from their profession after marriage (Gallup, 2023).

**Table 1: Status of female medical graduates in Pakistan (numbers and percentages)**

| Status in Labour Force | Rural | Urban | Total |
|---|---|---|---|
| Employed | 15,075<br>(52.0)<br>[22.1] | 53,134<br>(69.9)<br>[77.9] | **68,209**<br>**(65.0)**<br>**[100]** |
| Unemployed | 8,950<br>(30.9)<br>[57.3] | 6,669<br>(8.8)<br>[42.7] | **15,619**<br>**(14.9)**<br>**[100]** |
| Out of Labour Force | 4,945<br>(17.1)<br>[23.4] | 16,201<br>(21.3)<br>[76.6] | **21,146**<br>**(20.1)**<br>**[100]** |
| Total | **28,970**<br>**(100)**<br>**[27.6]** | **76,004**<br>**(100)**<br>**[72.4]** | **104,974**<br>**(100)**<br>**[100]** |

* The figures in parenthesis are column percentages, and those in braces are column percentages.

At present, there is a paucity of research specifically delving into the brain waste of female doctors in Pakistan. The lack of research focusing on this critical issue has hindered our understanding of specific contextual barriers, including cultural, social and professional factors, which contribute to the underutilization of female doctors. This not only impacts the healthcare sector in Pakistan but also results in the underutilization of the valuable skills of this highly skilled group. Expanding on the conceptual framework of brain waste, which typically examines the underutilization of skilled immigrants, this study will focus on the underutilization of female doctors in the national health sector of Pakistan. Specifically, we are interested in exploring how gender roles and traditional societal norms in Pakistan discouraged half of the female medical graduates from pursuing their careers. This study will contribute to the existing body of anthropological knowledge by elucidating the lived experiences of female doctors, helping navigate the convoluted landscape of brain waste among FD and suggesting interventions to develop a more gender-inclusive environment to counter brain waste).

## 2.0 Literature Review

Brain waste of Pakistani female graduates has been explored and reported in various quantitative, qualitative and mixed-method studies. For instance, (Baig, 2020) in her study dispelled myths and presented facts about the feminization of medical education by highlighting the related challenges and opportunities for the healthcare sector and society at large. She employed a comprehensive literature review approach by synthesizing data from different studies, articles and reports based on both quantitative and qualitative data. The findings showed a difference between enrollment statistics and continuation of practice, i.e., a huge percentage of female graduates do not continue to practice medicine in Pakistan. Multiple factors, including traditional gender roles, work-life imbalance, workplace discrimination, are considered barriers to practice and hence leading to a shortage of practicing doctors and negatively impacting the healthcare delivery system. To lessen underutilization among female doctors, the author suggested that the admission process be changed to include consideration of a variety of factors, including family support, passion, motivation behind pursuing a medical career, resilience under pressure, communication skills, and aptitude. Although the author's argument is compelling, it did not involve first-hand field research and proposed intervention and suggestion based on secondary data do not represent the direct point of view of the study population.

However, few other studies such as one qualitative research conducted in Karachi to explore the issue related to female medical graduates not entering the medical profession. The research identifies cultural and societal factors contributing to the issue and provides a deep understanding based on in-depth interviews and focus group discussions among the final year students (both male and female) from 4 different colleges in Karachi. The role strain theory was employed to analyze the conflict between professional aspirations and societal expectations. The findings emphasized several themes, which state that in Pakistan, parents encouraged their daughters to seek medical degrees for social status, honor, and prestige, as well as to provide a safety net for their daughters if their marriages didn't work out. Patrilocal cultural norms, early and arranged marriages and conflict between traditional gender roles and professional roles are

highlighted as major influences on women's career prospects. Furthermore, it is also stated that unfriendly postgraduate systems deter women from continuing in the field. The comprehensive analysis of multiple factors, including parental influence, role conflict and other organizational factors, highlighted the reasons for the shortage of physicians (male and female) in Pakistan. This study is context specific as it provides a nuanced understanding of the taken issue. However, the selected sample failed to capture the evolving nature of career decisions as it mainly relied on final-year medical students. By incorporating female doctors who are already out of the workforce and experience the phenomena directly, the research could have provided additional and direct insights into long-term factors affecting female career trajectories (Moazam & Shekhani, 2018).

(Ashraf et al., 2023) aimed to assess gender bias, bullying, and discrimination in medical schools and to explore the phenomenon of "doctor brides" in Pakistan. A multicentric survey at 14 medical institutions (public and private) across Pakistan was conducted to record the responses of both male and female students. The findings show that both males and females are subject to discrimination and bullying, and after marriage or childbirth, females are forced by in-laws or husbands to quit medicine or change their careers from clinical practice to teaching. Although the study addresses pressing issues in medical education and female participation in the workforce, it relies solely on self-reported data that can be subject to bias and inaccuracies. Further, the lack of depth in the provided data limits the understanding of the "doctor brides" phenomenon.

(Raza et al., 2023) in their study accentuated the obstacles encountered by female doctors in the Pakistani healthcare sector that prevent them from practicing medicine using the "social role" and "spillover" theory. It employed a qualitative exploratory inquiry. The study participants were categorized into two groups: female doctors who never practised after graduation and other group involve female doctors who had previously been employed and left after 1-2 years of practice. Across Pakistan, 59 semi-structured interviews with nonworking female doctors were conducted in numerous cities by the researchers. The data was analyzed through thematic analysis. The key finding identified three major themes, including workplace challenges, socio-cultural obstruction, and familial restrictions that are forcing female doctors out of the healthcare workforce. The study's inclusion of 59 interviews from across the country provides a broad and in-depth perspective on the issue. However, the study does not track changes over time because of a lack of longitudinal data limiting the understanding of how different factors evolve throughout a female doctor's career. Also, the article failed to relate the narratives of the doctors to compare them with the existing policies to check the validity of the taken stance. For example, authors claim that there is no written policy to safeguard women from harassment in the workplace, but in reality, "The Protection Against Harassment of Women at the Workplace Act" was developed in 2010 by the government to protect women. This shows the biased approach of the authors and lack of regard to cross-validate the data.

Another qualitative study aims to explore and understand the multifaceted reasons why many female graduates do not enter the medical profession or remain in the medical workforce. 31 female doctors were selected for in-depth interviews to provide a comprehensive understanding of the individual, organizational and sociocultural factors related to the phenomenon. The

relational framework sheds light on the complexities involved in the dropout rate of female doctors in Pakistan. The study also provided inclusive policy interventions and emphasized developing mentorship programs, family support and awareness programs to foster an environment that can help engage females in the healthcare workforce. The study is context-specific, as it addresses the unique cultural and societal dynamics in Pakistan. It is found that the authors failed to give complete information regarding the sampling technique to select the participants; hence, it limits the ability to assess the potential biases in the sample, and findings cannot be generalized to a broader population (Mohsin & Syed, 2020).

In sum, the existing research on the brain waste of Pakistani female doctors highlighted multiple issues and utilized various theoretical frameworks to explain their findings. However, to the best of my knowledge, no research has explored this phenomenon from the perspective of a "Feminist political economy of health." This approach could provide a comprehensive understanding of the underlying factors that place women in a relative position in a patriarchal society. Therefore, the current study will contribute to evidence-based research by contextualizing the FPEH framework to analyze female doctors' narratives.

**2.1 Theoretical Framework**

"Feminist political economy of health" has been incorporated in the present research, which is used in multiple disciplinary investigations such as public health, political science, sociology, gender studies, and public health. FPEH states that material and cultural discrimination against females influences their social conditions and health (Armstrong & Armstrong, 1994; Doyal, 1995). Feminism provides the foundation for the feminist political economy of health that strongly adheres to the idea that gender inequalities arise from patriarchy (Raphael, Bryant, & Rioux, 2019).

According to feminists' society is designed in such a way that both male and female genders have different experiences, and most women end up in subjugated positions. It is believed that the social, political, and economic issues for women are deeply rooted in historical narrations that only represent the male standpoint and ignore the female take. Feminist literature extends the idea of materialism by interlinking domestic roles and market relations that highlights the factor of women's subjugation as she is mostly involved in unpaid domestic work (Armstrong & Braedley, 2013). This unpaid role not only modulates the extent of their participation in the paid economy but also affects their social, political, and material conditions (Armstrong, Armstrong, & Coburn, 2001).

Drawing on the feminist critique, it is important to note that power is a complex and multilayered phenomenon. If we want to understand this concept in the context of healthcare human resources, then it is necessary to scrutinize micro-level interactions. In micro-level interactions, power works in a non-coercive way. As Foucault observed, power is not simply hindering; it promotes ways of living. Power is a productive force that shapes and governs the capacities, abilities, and wills of subjects (Foucault, 1990; Barry et al., 1996). It is also important to note that the behavior of subjects is conditioned in unequal life conditions. Power relations are themselves involved in the production of an uneven environment in which one group is placed in

a subjugated position in comparison to the other groups. But now the point arises: Can we put all the blame on the privileged groups that are responsible for the exploitation? Definitely, power circulates unevenly because involved actors possess unequal capacities and different degrees of control over interaction, so we cannot place blame on the privileged groups. Rather, all involved actors play their role in defining social interactions and individual behaviors (Young, 2011).

Many researchers shed light on the relationship between unequal power distribution and health vulnerabilities of the female gender, but how the power of patriarchy influences the behavior of female doctors in healthcare services has been rarely discussed, hence the subject of the present research. We are interested in knowing how different social forces are shaping the behavior of female human resources in Pakistan's national healthcare sector and its corresponding relation with brain waste.

**3.0 Methodology**

This article is based on my PhD research data. A qualitative phenomenological approach, having constructivist ontology and interpretivist epistemology has been used. This approach helps in the comprehensive exploration of the social factors of brain waste. Phenomenological investigation helps in analyzing the embedded meanings in human experiences to apprehend the fundamental nature of the phenomena being investigated (Lopez & Willis., 2004). Data was collected through case studies and in-depth interviews with female doctors in the “Twin cities” (Islamabad and Rawalpindi). We have incorporated snowball sampling to reach 30 out of the workforce female doctors. The Inclusion criteria are unemployed female doctors (who are willing to do the job but failed to get it due to any reason) and female doctors who left their jobs due to any reason (willingly or unwillingly) living in Twin cities and are willing to participate in the present research.

For data analysis, Stevick-Colaizzi-Keen method was incorporated (Moustakas, 1994). The analysis begins with a full description of the brain waste phenomenon. Then, we find statements from the respondents which depict their experience of brain waste. We enlisted significant statements to develop a list of nonrepetitive, nonoverlapping statements and grouped them into “meaning units”. The list of the units was formed that provides a textual description, i.e., an explanation of the experience and what happened through the help of verbatims. We tried to capture all possible meanings and divergent perspectives of brain waste. Lastly, we construct an overall description of the meaning and the essence of the experience.

**4.0 Findings and Results**

The respondent's demographic details show that the female doctor’s range in age group 21 to 35 years. Out of 30, 17 are married and 13 FD are unmarried. The highest degrees of the respondents are MBBS and BDS. 18 FD left their jobs and 12 are searching for jobs as they are unemployed. The most common reason for their unemployment is referred to the lack of job opportunities in the healthcare sector of Pakistan. 19 female respondents highlighted family pressure as the major reason for joining the medicine field whereas 11 claimed that they joined medicine in accordance with their own choice.

When respondents were asked whether they were willing to rejoin healthcare services, only 4 FDs who left their jobs showed a willingness to rejoin at some later stage of their life, while

other out of workforce respondents totally refused to rejoin because of their family responsibilities and other factors.

Table 2 Demographic details of Respondents

| DEMOGRAPHIC OF RESPONDENTS | | | |
|---|---|---|---|
| **Age group** | **Frequency** | **Marital status** | **Frequency** |
| 21-25 | 4 | Married | 17 |
| 26-30 | 17 | Unmarried | 13 |
| 31-35 | 9 | Total | 30 |
| Total | 30 | | |
| **Highest degree** | **Frequency** | **Job-status** | **Frequency** |
| BDS | 5 | Left | 18 |
| MBBS | 25 | Unemployed | 12 |
| Total | 30 | Total | 30 |
| **Willing to rejoin HRH** | **Frequency** | **Reason for joining medicine** | **Frequency** |
| Yes | 16 | Family Pressure | 19 |
| No | 14 | Decided by themselves | 11 |
| Total | 30 | Total | 30 |

**Medicine: Ideal profession for females**

The present research shows that in Pakistan, the medical profession is considered a highly idealized profession for females. From the moment a girl is born, parents start dreaming that their girl child will become a doctor and earn a name and fame for the family, and in future prospects, they will have security. But what happens after becoming married shows the ironic picture of the patriarchal society in which women have to sacrifice their jobs to fulfill the conventional domestic role. Instead of becoming "on-duty doctors," they become "doctor brides," and if they try to deviate from these expected roles, society labels them as irresponsible and, in severe cases, immoral. The labels associated with career-oriented women put a mental toll on female doctors. The societal pressure to prioritize family duties over career advancement can be immense, leading many female doctors to put their ambitions on hold and leave their patients unattended.

Respondents commonly believed that parents in Pakistan often encourage their female children to get admission to medicine to improve the family's social status and find a good marital match after becoming doctors. Parents are ready to spend millions of rupees in case their daughters are unable to get admission to government medical colleges for the sake of prestige. A respondent sstate that:

*"Look, in Pakistan. Being a doctor increases the chance of finding a better spouse... especially for women when everybody these days seems to demand a doctor bahu(daughter-in-law), which, by the way, is very prevalent. Huge investments are made by parents to secure their daughter's future…."*

Another female respondent is of the view that:

*"Most girls who get an MBBS degree don't end up practising medicine because, first of all, there is so much pressure to become a doctor. There are so many other fields, but since it is a respectable profession, parents force their daughters to get into the field…even if they are not interested. So these forced doctors never hesitate to leave their career whenever they get a chance…. Secondly, in our society, medicine is considered a prerequisite for a marriage proposal. Everyone is looking for a doctor daughter-in-law. Its ironic… later they don't cooperate with their doctor daughter-in-law and force her to leave the career."*

**4.1 Lack of job opportunities and unemployment among Female Doctors**

Due to a lack of job opportunities, a prominent loss of talent has been observed, as doctors are unable to find opportunities to utilize their full potential and contribute to improving the public healthcare system. In Pakistan, an MBBS degree is either gained through private medical colleges, which are dreadfully expensive, or through public colleges at subsidized rates. Still, in both cases, young doctors experience uncertainty while paving the path to economic stability.

After MBBS, a medical student starts working as a House officer to do a house job and get a license to be a medical practitioner. From house officers to medical officers, these young medical professionals face a number of hurdles. First and foremost is the lack of availability of house job positions in public hospitals, and if they do succeed in getting a house job, the stipend is quite minimal in nature, and in some cases, it is a volunteer position. The struggle of a young doctor never ends here. After completing house jobs, another desolation is waiting for these young doctors who are trying to get employment as medical officers. Unfortunately, many of them failed to secure their job position. Hence, they are forced to seek employment in the private sector or overseas, and in the case of our respondents, they remain unemployed. One of the respondents is of the view that:

*"In Pakistan, one of the main reasons for brain waste among doctors is the lack of jobs due to a surplus of medical professionals. Further, insufficient resources are another reason for brain waste in the public healthcare system. The worse situation of the medical sector forced many doctors to work in the private sector or seek employment abroad so that they could earn more and work in better-equipped healthcare facilities."*

Another respondent reported that:

*"In Pakistan, medicine has become a deeply saturated field. Without contacts or money, it's extremely difficult to find jobs. Young doctors have to face constant disappointment after spending years of struggle and investment due to the lack of availability of jobs."*

However, the overall situation in the healthcare sector is a paradox: there is an obvious shortage

of doctors in Pakistan, regardless of the high production of medical graduates. It shows that Pakistan produces enough medical graduates to fulfill the growing needs of its population. Still, issues lie with the allocation as there are limited job opportunities, so it is hard to utilize the talent of young graduates, hence having a negative impact on healthcare services.

The respondents perceived numerous interconnected social factors responsible for brain waste among female doctors in Pakistan as follows:

**Table 3: Responses that reflect various factors of brain waste among female doctors**

| Major social factors of brain waste among female doctors |
|---|
| Unsupportive family |
| Lack of employment opportunities |
| Workload pressure and difficulty in work-life balance |
| Fixed gender roles |
| Difficult working environment, Gender discrimination |
| Family pressure/ Pressure from in-laws |
| Family responsibilities |
| Sacrifice for kids |
| Left because of marriage |
| Lack of daycare facility |
| Lack of professional opportunities |
| Left because husband's good salary |

In the present research all the raised social factors are closely linked to patriarchy and can be analyzed in the light of the feminist political economy of health. Socially constructed gender roles maintain a patriarchal power structure that limits women's participation in the workforce and increases the chance of economic dependency among female doctors. An unsupportive family is a clear reflection of societal norms that prioritized female domestic roles over professional ambitions. The families who once wanted “doctor brides” put pressure on female doctors to discontinue their jobs and perform family responsibilities after marriage.

In Pakistani society, women are considered responsible for performing domestic duties (Mohyuddin & Shehzad, 2014). Performing roles outside of the domestic domain increases the workload on females. Research also highlighted that most of the time female doctors leave their jobs due to workload. Difficulty in maintaining work-life balance and workload pressure as a factor of brain drain shows that the dual burden on females creates immense pressure on them, leading to burnout and exit from the workforce. This disproportionate burden on the female gender to perform family responsibilities is a critical issue as it perpetuates gender inequality in society and influences the social standing of women negatively. The respondents also highlighted hostile work experiences as a factor that pushes female doctors out of the workforce. According to political economy, gender discrimination and hostile work environments reflect the broader social gender inequalities (Iversen, Rosenbluth, & Rosenbluth, 2010).

Some respondents highlighted that as soon as female doctors get married, they build

economic dependence on the husband's income and confine themselves to unpaid domestic chores only. The societal expectation of motherhood also contributes to brain waste as many female doctors leave their jobs to focus on their children's upbringing and education. Lastly, the lack of professional opportunities and sound facilities in the workplace, such as daycares and security, also shows the lack of sensitivity towards the female gender, failing these doctors to get an equitable chance to prosper in their professional careers.

### 4.2 A clash between marriage and career prospects

The respondents reported that the idea of getting married at an appropriate age act as a hindrance to the career progress of female medical professionals. In Pakistani society, the clash between career aspirations for women and marriage at an appropriate age stem from deeply ingrained societal norms that prioritize marriage at a young age and family for women, even at the expense of their professional ambitions. Women are often pressured to marry at a young age because, in Pakistani culture, marriage is not just a personal choice but a cultural expectation. And women are not allowed to violate these cultural expectations. One of the respondents is of the view that:

*"I was really happy with my job regardless of difficulties…. as I reached the age of 27, my parents forced me to get married because, after a year or so, I would not be treated as an acceptable option in the marriage market."*

Another respondent who is currently jobless and preparing for specialization states:

*"I am 28, and all of my family members are putting pressure on me to get married because, soon I would be out of the league to get any suitable partner for marriage. Right now, I want to do my specialization, and my priority is my career, but everyone is busy telling me that I am a woman, and I don't have any moral obligation to earn. My future husband can do this for me, so I shouldn't waste my energy on specialization".*

Another intriguing aspect of research highlighted that; stigma related to unmarried women also creates additional barriers for female doctors. Those women who delay their marriages in pursuit of their careers face judgment and social ostracization as one of the respondents narrates her unmarried senior doctor's situation in the following words:

*"My direct senior was very competent, but she was unmarried. Just check out my selection of words about her. I am saying she was competent and am also attaching her marital status with it… just to prove that although she was successful in her career, as a woman, she was actually far behind…. It is because our society has attached certain social expectations to a woman; that is, if you are a woman, you should get married early, become a wife and a mother, and perform your due roles, and if you are not ready to accept these roles and choose another path for yourself then you must get ready for the stigma and judgments. My senior also experienced stigma, and no one was ready to accept her reality as a career-oriented woman. Everyone was biased against her as she failed to achieve the ultimate level of womanhood and therefore*

*encouraged me to get married early even at the cost of my career."*

**4.3 Fixed gender roles and brain waste among female doctors**

The findings illustrate that Pakistan is a society that strongly holds the idea of fixed gender roles. The general standards of behavior that are expected to be followed by the societal members are provided by culture. Women in Pakistan are largely expected to perform the roles of caregivers and homemakers due to the patriarchal sociocultural setting. Although a significant change has been observed in the last few decades but still gender role division exists in its all glory.

Pakistan is a nation with a larger percentage of female graduates in the medical and dentistry disciplines, similar to India and Bangladesh. The statistics show that in Pakistan, more than 70% of medical students are females in cities, especially in Punjab and Sindh. This increased ratio of females in the field of medicine is known as the 'feminisation of medicine' (Baig, 2020; Weizblit, et al, 2009; Hossain, et al., 2019). Unfortunately, despite high female enrolment in medical colleges, female doctor's participation in the healthcare workforce remains low in Pakistan. One of the respondents is of the view that:

*"I left my job because of my family. Balancing the demands of my family, especially with children, made it challenging to continue working in such a demanding profession. Managing household tasks and caring for my children required significant time and energy, and the lack of support systems both at the workplace and at home made it difficult to maintain my career."*

Another respondent said:

*"Women mostly leave their careers due to cultural expectations, childcare duties and Spousal influence. Men in our society are not ready to share domestic responsibilities with females. As we have a stereotypical approach towards those men who work at home and share the burden of their wives. As a society, we are not ready to accept a man working in the kitchen and if he does, he is "Zanmureed" (submissive/slave husband). So how can you expect that women can survive in a job market with their domestic duties as well."*

Social expectations of gender roles influence the lives of Pakistanis in every aspect, and the healthcare system is no exception. Consequently, female doctors feel compelled to conform to social expectations and often prioritize their family responsibilities over their professional aspirations. Globally, several factors with female medical students and doctors have been brought up in recent literature. Studies found that female doctors have a harder time juggling their home and professional lives since they have more domestic duties, specifically following marriage and having offspring (Hossain, et al, 2019; Starmer et al, 2019; Mohsin & Syed, 2020; Moazam & Shekhani, 2018).

**4.4 Lack of family support and discontinuation of career**

It is important to note that the journey of female doctors to pursue their careers is not an easy one. In fact, the first hurdle faced by these professionals is often starting at home. The lack of adequate support and encouragement from family members makes it hard for female doctors to continue with their career pursuits. The attribution of traditional gender roles shapes the ideology of the families, and most of the time, families reject the idea that females can participate in work

after getting married. One of the respondents stated that:

*"Families do not live-in isolation; they follow the strong patriarchal norms of the society that always discourage women from progress regardless of the fact that they are 51% of the total population, and if they start participating, it can boost the overall development of the country. Female doctors are expected to shun their careers to fulfil their familial roles. And this whole scenario has a negative impact on the healthcare system as patients become deprived of doctor services".*

The majority of the respondents state that family not only influence the career selection of females but also has a greater role in continuing with their career prospects. A female doctor who has work experience of 3 years stated:

*"If female doctors are deprived of their support, it means that they are at the edge of collapse. Sooner or later, they are going to admit their defeat. The professional success of women is largely dependent on family. After getting married, I realized that my in-laws were not ready to accept my working hours. There was a constant tussle between me and my family. I was not able to work properly. I felt so much pressure during that time. So in order to maintain the peace of my family, I decided to quit my job."*

This shows that there is a close relationship between female career success and family support. The respondents who have little, or no family support are prone to burnout and brain waste. These Female doctors face the greatest obstacles in the form of families as they are expected to put their families before their careers after marriage. One of the respondents' states:

*"After getting into the medical field, career development for women is one of the hardest tasks. In traditional societies, societal limitations and restrictions block the career progress of female doctors at every step. Most of the women failed to cope with the societal pressure and wasted their skills and expertise by leaving the profession altogether."*

These narrations are in compliance with the findings of (Weitsma, 2014; Starmer, et al., 2019; Jefferson et al., 2015) which say that female doctors have to shoulder a greater share of household duties than male doctors, thus confirming fixed gender roles that never let women out of their domestic duties no matter what. Pakistani female doctors also experience the same situation, which often leads them to brain waste. Female doctors have to perform double duties (both at the workplace and at home). Although domestic duty is unpaid work, it still holds more importance for women because of its social cost, which is determined by the rigid gender role, i.e., the woman is responsible for the family. Without any support from family, female doctors often experience burnout and leave their careers to avoid difficulty and hence become the victims of patriarchy.

**4.5 Patriarchy: Job a privilege for women**

It is significant to note that in Pakistan, a job for women is seen as a privilege rather than a need, as her primary duty is to look after the family. The set gender roles in Pakistani society that is "male" as a "breadwinner" and "woman" as a "homemaker" led these female doctors to be underrepresented and undervalued in their professional roles. Another respondent represents her views against the patriarchal tradition of society in the following words:

*"According to the functionalist or utility perspective, it is understandable that female must maintain their responsibilities as mothers and wives and males maintain their role of breadwinners. But how long can these fixed gender roles help us maintain the social order? With each day, the economic condition of the country is deteriorating; you cannot rely on the earnings of a single person. And the condition of the healthcare sector is no different. If more than half of the female doctors leave this profession only to fulfill their household duties, you can imagine how it all will end."*

Moreover, the typical approach that women can rely on their husbands for future expenses and social security reinforces economic dependence. Confining women to unpaid domestic labour highlights the economic exploitation of women and gender inequality in Pakistani society. (Folbre, 2006) also states that female departure from the workforce not only negatively affects their social standing but also has broader socio-economic implications for the whole society. It restricts the economic production of the country, intensifying economic challenges. In addition, it fortifies the gender inequality and gender wage gap and perpetuates economic dependence (Kabeer, 2012).

The findings are in strong compliance with the idea of the feminist political economy of health FPEH that states that material and cultural discrimination against females influences their social conditions. In Pakistan, feminity is confined to the domestic sphere, and masculinity is breadwinning. Thus, adhering to the male-dominant power structures. The power structure of patriarchy and unpaid domestic work are responsible for female subjugation and oppression (Armstrong & Braedley, 2013; Armstrong et al., 2001). The common narration of fixed gender roles deprives female doctors of excelling in professional careers and, hence, remaining in constant dependent positions. This idea is challenged by feminists (Butler, 2006) and (De Beauvoir, 2011). As both of them believe gender is not a fixed identity; rather, it is a series of performances based on social expectations. Their idea asserts that female roles are socially constructed to benefit the patriarchal setup of society. Pakistani female doctors are seen primarily as wives and mothers, and professional identities are considered secondary. These traditional societal norms are limiting the freedom and potential of female doctors by putting them into submissive positions and have a negative impact on the healthcare delivery system of Pakistan

**5.0 Discussion and Conclusion**

The power structure of the patriarchal society dictates the roles of women in Pakistan. According to this, women's prime responsibility is to perform domestic duties. Whereas secondary roles such as being a medical doctor can be overlooked to fulfil the cultural expectation of the female gender. The social fabric is designed in such a way that these female doctors often leave their career prospects willingly rather than challenging patriarchy, remain committed to their

profession and have economic independence. The feminist political economy of health blamed patriarchy for female oppression as the material and cultural conditions shape their social standing. Thus, emphasizing the point that to engage female doctors in the national health workforce society as a whole need to change its approach towards fixed gender roles. The family, being a basic unit of society, must play a positive role by providing support to the female workforce to curtail brain waste. And female doctors need to take on their professional duties seriously and break this cycle of patriarchy.

### 5.1 Policy Recommendations

Family counselling programs should be developed to educate families about the importance of supporting female doctors in professional careers. Career counselling services and mentorship programs should be provided to female doctors to help them navigate professional challenges and receive support. Furthermore, to engage the out-of-work female doctors, the government must invest in telemedicine to provide FD with more flexible and diverse work options.

### 5.2 Limitations of the research

The research is constrained by geographical restrictions as it focuses only on Islamabad and Rawalpindi. Future researchers could broaden the scope by adding respondents from different parts of the country to obtain comprehensive data. Furthermore, the article mainly focused on social factors related to patriarchy, marriage and family institutions. However, it may not fully capture the challenges experienced by female doctors in the workplace and their possible connection with the brain waste of FD, highlighting the need for further research in this area

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**Anwaar Mohyuddin:** Data Analysis, Supervision and Drafting
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### References

Ashraf, M., Ahmad Cheema, H., Farooq, M., Mustafa, B., Anwer, A., Shahid, S., & Ashraf, N. (2023). Gender bias and ‘doctor brides’. A social dilemma of medical students in Pakistan. Journal of the Pakistan Medical Association, 73(5), 1013-1023.

Armstrong, P., & Armstrong, H. (1994). The Double Ghetto: Canadian Women and Their Segregated Work.

Armstrong, P., & Braedley, S. (2013). Troubling Care: Critical Perspectives on Research and Practices. Toronto, Canada: Canadian Scholars Press.

Armstrong, P., Armstrong, H., & Coburn, D. (2001). Unhealthy Times: Political Economy Perspectives on Health and Care in Canada. Toronto, Canada: Oxford University Press.

Barry, A., Osborne, T., & Rose, N. (1996). Foucault and political reason: Liberalism, neo-liberalism and rationalities of government. London: UCL Press.

Baig, L. (2020). Women Empowerment or Feminism: Facts and Myths about Feminization of Medical Education. Pak J Med Sci.36, 303-305.

Bratsberg, B., & Ragan, J. F. (2002). The impact of host-country schooling on earnings:

A study of male immigrants in the United States. Journal of Human Resources, 37(1), 63-105.

Butler, J. (2006). Gender Trouble: Feminism and the Subversion of Identity. Routledge. (Original work published 1990).

De Beauvoir, S. (2011). The second sex (C. Borde & S. Malovany-Chevallier, Trans.). New York, NY, USA: Vintage International. (Original book published in 1949).

Doyal, L. (1995). What makes women sick: Gender and the political economy of health. Bloomsbury Publishing.

Folbre, N. (2006). Measuring Care: Gender, Empowerment, and the Care Economy. Journal of Human Development, 7(2), 183-199.

Foucault, M. (1990). The will to knowledge: History of sexuality (vol. 1). London: Penguin.

Gallup. (2023). Gallup Pakistan Media Coverage Report on Unemployment among Women Doctors. Gallup Pakistan.

Hossain, P., Gupta, R., YarZar, P., Jalloh, M., Tasnim, N., & Afrin, A. (2019). 'Feminization'of physician workforce in Bangladesh, underlying factors and implications for health system: Insights from a mixedmethods study. PLoS One,14.

Iversen, T., Rosenbluth, F. M., & Rosenbluth, F. (2010). Women, work, and politics: The political economy of gender inequality. Yale University Press.

Jefferson, L., Bloor, K., & Spilsbury, K. (2015). Exploring gender differences in the working lives of UK hospital consultants. J R Soc Med, 108, 184-191.

Kabeer, N. (2012). Women's economic empowerment and inclusive growth: labor markets and enterprise development. International Development Research Centre.

Lopez, A., & Willis., D. G. (2004). Descriptive versus interpretive phenomenology: their contributions to nursing knowledge, Qualitative Health Research, vol. 14, no. 5, 726–735.

Mattoo, A., Neagu, I. C., & Ozden, Ç. (2008). Brain waste? Educated immigrants in the US labor market. Journal of Development Economics, 87(2), 255-269.

Moazam, F., & Shekhani, S. (2018). Why women go to medical college but fail to practise medicine: perspectives from the Islamic Republic of Pakistan. Med Educ. 52, 705-15.

Mohsin, M., & Syed, J. (2020). The missing doctors—an analysis of educated women and female domesticity in Pakistan. Gender, Work & Organization, 27(6), 1077-1102.

Mohyuddin, A., & Shehzad, Z. (2014). Women Representation and Development Discourse: An Anthropological Insight of Women Experiences. Pakistan Journal of History & Culture, 35(2).

Moustakas, C. (1994). Phenomenological research methods. Thousand Oaks, CA: Sage.

Qamar, W., Qayum, M., Sadiq, N., Khan, H. M., Pervaiz, N., Nisa, W. U., & Sawal, S. H. (2023). Assessing Staff Requirements And Workload Pressure Among Doctors Working In Obstetrics & Gynecology Department Of A Public Sector Hospital In Pakistan Using The World Health Organization's Workload Indicators Of Staffing Needs. Khyber Medical University Journal, 15(1), 9-15.

Raza, A., Jauhar, J., AbdulRahim, N., Memon, U., & Matloob, S. (2023). Unveiling the obstacles encountered by women doctors in the Pakistani healthcare system: A qualitative investigation. PLoS One. 18(10).

Reitz, J. G. (2001). Immigrant skill utilization in the Canadian labor market: Implications of human capital research. Journal of International Migration and Integration, 2(3), 347-378.

Shah, N. A., Nasreen, S., & Manzoor, A. (2014). Exploring The Reasons Of Discontinuation Of Practicing Medicine Among Female Medical Students In Karachi. Pakistan Journal of Gender Studies 9(1), 73-83. Retrieved from https://www.academia.edu/109143516/Exp

Starmer, A., Frintner, M., Matos, K., Somberg, C., Freed, G., & Byrne, B. (2019). Gender discrepancies related to pediatrician work-life balance and household responsibilities. Pediatrics.

Tahir, M. W., Kauser, R., & Tahir, M. A. (2011). Brain drain of doctors; causes and consequences in Pakistan. International Journal of Humanities and Social Sciences, 5(3), 302-308.

Weitsma, A. (2014 ). Barriers to Success for Female Physicians in Academic Medicine. Journal of Community Hospital Internal Medicine Perspectives:4, 1-3.

Weizblit, N., Noble, J., & Baerlocher, M. (2009). The feminization of Canadian medicine and its impact upon doctor productivity. Med Educ. 43, 442-8.

Young, I. M. (2011). Justice and the politics of difference. Princeton: Princeton University.

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