RESEARCH ARTICLE

The kaleidoscope of the glass ceiling: experiences of Pakistani female doctors – a qualitative narrative inquiry

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Abstract

Objective: To explore the extent and factors leading to the glass ceiling for Pakistani female doctors in leadership positions.

Method: The qualitative narrative study was conducted the Department of Medical Education, Riphah International University, Islamabad, Pakistan from March to July 2021, and comprised female doctors with 10-15 years of professional experience who were either currently at top leadership position or had retired from such a position in public and private medical clinical setups and medical colleges. Data was collected using in-depth interviews conducted through Zoom due to the coronavirus disease-2019 pandemic. The transcribed data was processed using ATLAS.ti.9 software for thematic analysis with an inductive approach.

Results: Of the 9 subjects aged 47-72 years having professional experience of 11-39 years, 4(44.4%) were clinicians, 3(33.3%) had basic medical science background and 2(22.2%) were health profession educationists. In terms of qualifications, 4(44.4%) were PhDs, 4(44.4%) were Fellows of the College of Physicians and Surgeons, Pakistan, and 1(11.1%) had an M. Phil. Besides, 4(44.4%) subjects were from the public sector, and 5(55.5%) from the private sector, 1(11.1%) had retired from service. The extent of experiencing the glass ceiling was common to all but 1(11.1%) participant. Factors identified included 'institutional challenges', 'family support issues', 'personal challenges' and 'societal unacceptance'. Detailed analysis revealed that women in leadership positions faced 'malintent of seniors', 'discrimination', 'stereotyping', 'lack of mentors' and 'ethnic background conditioning' at the institutional level. On the personal front, they faced 'lack of support of in-laws', 'insecurity of husbands', 'need of personal attributes' and 'beauty as a barrier'.

Conclusion: The glass ceiling was found to be a challenge faced by Pakistani female doctors in leadership positions in both clinical settings and academia.

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Introduction

Leadership is not defined by gender though most leadership positions belong to men. This fact is statistically proven, socially acceptable and is not generally challenged along with the concept that men are better leaders than women.[1] Aspiring, ambitious and accomplished women leaders frequently face a lot more resistance and difficulties than men to reach top management positions.[2,3,4]

The glass ceiling is defined as a barrier faced by women and minorities to reach top management positions.[5] The glass ceiling is reported in all fields, including but not limited to science, technology, engineering, mathematics (STEM), law, accounting, finance, management and medicine.[6] The extent of the glass ceiling experience is not tangible as it is multi-dimensional, multi-faceted and different across cultures. Many factors govern its occurrence, perception and impact, compounded by each victim's personality type and coping mechanisms. The barriers reported include but are not limited to institutional challenges, gender inequality, discrimination, stereotyping and lack of family support.[6-9] Theoretical frameworks that fit into the domain of the glass ceiling include the wicked problem theory and the feminist theory.[10,11] The characteristics of wicked problems which conform to the glass ceiling phenomenon include its non-definitive form, being unique and indicative of other problems, having a limited number of better/worse solutions rather than true/false solutions, no definite elucidation, different perspectives of stakeholders and presence of discrepancy[10]. The need to address the glass ceiling is in conformity with feminist theory, which deals with 'stereotyping', 'discrimination', 'objectification', 'patriarchy' and 'oppression' of women.[11] Only a few studies reported the phenomenon among Pakistani women[12] and none has reported it among female doctors. The current study was conducted to

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explore the extent of the glass ceiling experienced by female doctors in leadership positions and to further explore, in conformity with theoretical frameworks, the factors leading to the glass ceiling experience.

Subjects and Methods

The qualitative narrative study was conducted the Department of Medical Education, Riphah International University, Islamabad, Pakistan from March to July 2021. The sample was raised using purposive sampling technique after approval from the institutional ethics review committee, and the number was kept open till saturation point was reached in data collection when no new sub-theme emerged and the identified factors kept getting repeated.[13] Those included were female doctors with 10-15 years of professional experience who were either currently at top leadership position or had retired from such a position in public and private medical clinical setups and medical colleges. Female doctors in early stages of their careers or in military service were excluded.

After obtaining written, informed consent from all the subjects, data was collected using in-depth interviews that were conducted through Zoom due to the coronavirus disease-2019 (COVID-19) pandemic. The saturation point was reached at the 7th interview, but additional participants were included to confirm the saturation point.

Regarding the glass ceiling, a questionnaire was initially formulated with open-ended questions in line with theoretical frameworks. It was sent to five subject specialists for validation. A pilot interview was carried out to test the questionnaire, to do initial analysis and to add probe questions. The interview-guide questions were constantly reviewed in the light of the interviewee's narrations, and probe questions were added accordingly. All interviews, conducted one-on-one in complete privacy, were audio-recorded. The language of the interviews was English and the duration was for 30-60 minutes each.

The recorded data was manually transcribed verbatim by the principal researcher. The 're-storying' of data, still verbatim, was carried out manually to arrange the chronological sequence of events in terms of time, place, occurrence and effect, and were counter-checked by the 2nd author. The data was then transported to the software Atlas.ti.[9] after familiarisation through repeated readings. Using the software, the 1st cycle of coding was conducted and a total of 209 codes were identified. Redundant codes were removed, a few were renamed and repeated codes were combined in the 2nd cycle of coding, making a total of 122 codes. 'Code groups' were created, and themes and sub-themes were identified and organised. The data was analysed using the inductive approach and by the thematic interactional method[13]. Triangulation in data analysis was ensured.

The entire process was conducted in accordance with the World Medical Association's Declaration of Helsinki.[14] The audio recordings were kept confidential and in safe custody. The identities of the participants and their institutions were removed from the transcripts and were assigned identification numbers while re-storying. The transcribed data was shared with the participants and they had the liberty to amend it if they so wished.

Results

Of the 9 subjects aged 47-72 years having professional experience of 11-39 years, 4(44.4%) were clinicians, 3(33.3%) had basic medical science (BMS) background, and 2(22.2%) were health profession educationists. In terms of qualifications, 4(44.4%) were PhDs, 4(44.4%) were Fellows of the College of Physicians and Surgeons, Pakistan (FCPS), and 1(11.1%) had an M. Phil. Additionally, 4(44.4%) subjects had either a diploma or a Master's degree in Health Profession Education (HPE). Besides, 4(44.4%) subjects were from the public sector, and 5(55.5%) from the private sector, 1(11.1%) had retired from service.

Of the total, 4(44.4%) were heads of departments (HODs) in BMS in public and private medical colleges, 2(22.2%) were programme directors (PDs) as well as HODs of the Departments of Medical Education (DMEs), 2(22.2%) were HODs of clinical subjects, and 1(11.1%) was retired from service from a public medical university as Dean BMS and HOD.

Figure: Concept map of factors leading to 'glass ceiling' among Pakistani female doctors.

Of all the participants, 8(88.8%) said they had faced glass ceiling during their professional careers, and 2(22.2%) faced it at two different institutions. All 9(100%) said they had faced the phenomenon to varying extents.

On the basis of the data, 4 main themes were identified; institutional challenges, personal challenges, family support issues, and societal unacceptance. Besides, 10 sub-themes were also identified (Table; Figure 1).

The first theme Institutional challenges had 5 sub-themes, and the most frequent of them was 'mal-intent of seniors' (Figure 2). The extent of malicious intent, as identified by grouping codes together as categories, included depriving women of the senior-most status in the department, allocating authority to junior faculty, deliberately keeping women out of the loop in co-curricular and extra-curricular activities, excluding women from research activities, exhibiting demotivating behaviours, posing hurdles in academic promotion, taking away due credit and giving unfair treatment.

Table: Codes, sub-themes, themes and representative quotes regarding glass ceiling experience among Pakistani lady-doctors.

S.No.	Theme	Sub-Theme	Codes	Representative Statements
	Institutional Challenges			
1		Malicious intentof seniors	45	"My ex-bosses left no stone unturned to destroy my career. They acted like mafia. They were extremely annoyed on my leaving the job".
2		Discrimination	27	"I gradually realized that my salary was really a joke. On the other hand, they were males in the institution getting full perks and privileges and not doing half of the hard work I was putting in".
3		Stereotyping	10	"Men like submissive women at home, and the same type at work. Men don't like to be told to do things by the women. The submissive women at office who keep obeying male bosses will be liked by them. Those women who are out-spoken and professional are not tolerated by men".
4		Lack of mentors	6	"Actually during my struggling time and the current problems that I am facing, I really needed and wanted a mentor. And I tell you the truth that I never got one. I want to be a mentor, because I know how it felt not to have one".
5		Ethnic backgroundConditioning	4	Some of my seniors were religious personalities. They didn't like females at workplace. I was not covering my head or you can say, that I was a little bit modern-looking lady. So there was targeting due to this factor also".
	Family Support Issues			
6		Non-supporting in-laws	12	"My in-laws stayed with me throughout and I was not given any respite at home. I had to do all the cooking and other household chores. If my kids got ill, my mother-in-law never looked after them and I had to take leave from work".
7		Insecure husbands	6	"Instead of having some support from my spouse, there was always resentment, lack of attention or torture".
	Personal Challenges			
8		Need of personal attributes	9	"You know, it took me some time to learn that subtle things like dress code and spoken language has connotations if you want to be taken seriously. Only those females' opinions are given importance or I dare say thought worthy of listening by men who put across their point forcefully and those who have good spoken English language".
9		Beauty as barrier	3	"Once someone said to me in office that you are too pretty to be taken seriously. Just imagine! That even my good looks were a disadvantage to me. I am judged not by my work but by my looks. So for men, beauty and brains can't, you know! go together".
10	**Societal un-acceptance**	Stereotyping	7	"So there are so many hurdles women face. And I tell you only those women succeed in reaching top leadership positions who have the courage to face these men in a male-dominated society in which it (society) does not approve of women as leaders".

* Sub-theme 'stereotyping' was common in all 4 themes.
* Sub-theme 'beauty as barrier' was common in 2 themes.

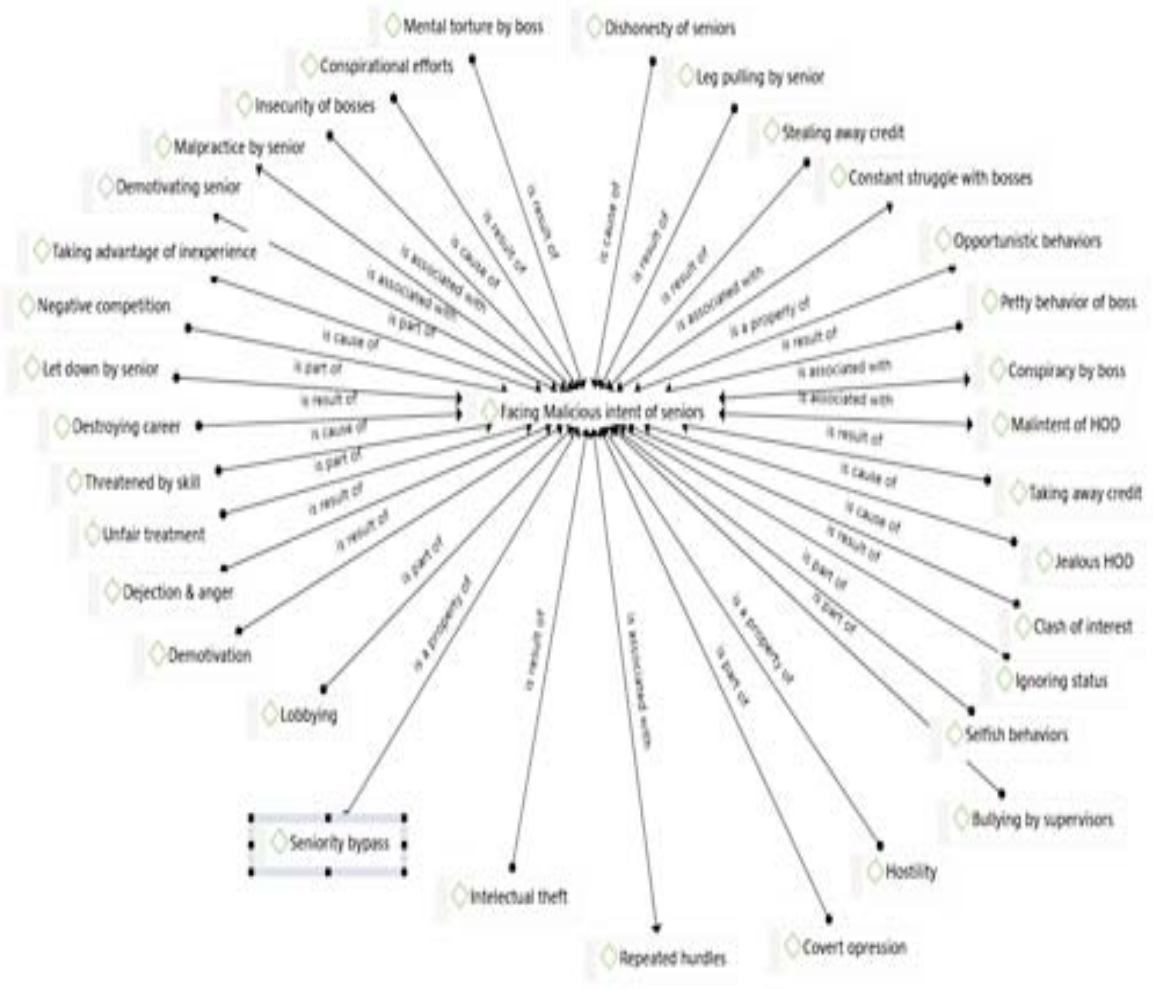

Figure-2: Codes leading to sub-theme of 'malicious intent by seniors' as part of the 'institutional challenges' theme.

Severe forms of malicious intent experienced by participants included leg-pulling, dishonesty, intellectual theft, jealousy, lobbying, bullying, hostility and even conspiracies to destroy their careers. The participants were encouraged to reflect on this particular aspect of their challenges in the workplace. It resulted in dejection, anger, mental torture, depression, demotivation and resignation from employment by 3(33.3%) of the participants who faced it.

Discrimination was the 2nd most frequently described sub-theme. There were many categories of discrimination, including gender inequality, unequal workload, gap in pay and privileges, unequal leave policy and unrecognition of status. The participants narrated various forms of workplace discrimination imposed by seniors, supervisors and the administration. It included ignoring their status of seniority, bypassing their seniority, preferring junior male faculty to make policy decisions, unfair promotion policies and undue covert oppression in departmental matters. In fact, 1(11.1%) participant reported discrimination based on her family background and she faced a loss of seniority in preference to a junior with a stronger family background. Also, 1(11.1%) clinician reported that she had to quit a job because her male junior with a lower but foreign qualification, in comparison to her FCPS from Pakistan, was given a senior status. She believed that this discrimination was gender-based, but it was declared as qualification-based.

Private-sector female employees did face a pay gap. The privileges gap was reported by 4(44.4%) participants and manifested as disparity in research opportunities, unfair leave policies, under-representation in scientific conferences, sidelining in co-curricular activities and unequal opportunities for attending courses and

workshops. Lack of accountability in this regard was the point of concern.

Stereotyping women was another frequently quoted challenge at the workplace, reported by (77.7%) participants. The participants faced objectification and judgmental behaviours, both overt and covert, from men at the workplace. This typecasting was narrated as a continuation of the concepts men are taught since childhood, as one participant stated. One of the participants labelled the display of stereotyping by men as 'sugar-coated'. The manifestation of stereotyping is objectification, judgment, mistrust of ability, subtle comments, unfair treatment, emotional blackmail and even bullying. This stereotyping of women resulted in the participants' need to exert extra effort to prove themselves, as well as demotivation and dejection. Stereotyping was the identified sub-theme in the study that provided the foundation for a lack of family support, personal challenges and societal un-acceptance.

Further, 8(88.8%) participants claimed that they never had female mentors at times when they needed one the most, and believed that the career progression of women is affected by paucity of role models, resulting in a lack of moral courage among working women, lack of guidance, problems in medical education, lack of career pathways, demotivation and difficulties in gaining better knowledge of their own disciplines, to name a few.

The last sub-theme was ethnic background conditioning, and 3(33.3%) participants said they faced it at the workplace either by the seniors or as a part of institutional policy, like 1(11.1%) participant said that covering the head with a scarf was linked to career progression for women even though it was an unwritten policy. In other instances, participants with a modern outlook faced hurdles by seniors with more religious inclinations.

The second main theme was family support issues. None of the participants denied the role of family support and many experienced [n = 7 (77.7%)] a lack of it, leading to hurdles in their career advancement. Most participants [n = 5 (55.5%)]; reported unsupportive in-laws, whereas 2 (22.2%) participants had to deal with insecurity from their husbands. The manifestation of family as a sinking weight included lack of understanding, conservative ideology, negative competition, jealousy, dual responsibilities and non-appreciation. Among the participants, 1(11.1%) experienced the dwindling support of her husband due to feelings of insecurity, jealousy and competition as she kept advancing in her career.

The third man theme was personal challenges. It included requirements for personal traits which, although needed for both men and women to thrive in the workplace, had more bearing on the latter. The personal attributes needed by women at the workplace included confident body language, good vernacular, professional dress code, emotional quotient (EQ) and behaving 'like men'. Another challenge narrated by 2(22.2%) participants was their good looks. They believed that because of their good looks, they were not taken seriously by people at the workplace, which echoed the belief that beauty and brains in women do not go together. Another common but disconcerting challenge at the workplace reported by 1(11.1%) participant was facing flirting from male colleagues.

The final main theme was societal un-acceptance. According to the participants, societal un-acceptance towards women in top leadership positions translates into lack of family support and trickles down to the individual level, resulting in lack of support from husbands or in the mal-intent of seniors.

Discussion

The study revealed that various factors related to professional and personal life contributed to the experience of the glass ceiling among Pakistani female doctors in leadership positions. The factors/themes included institutional challenges, family support issues, personal challenges and societal un-acceptance. The new sub-themes that emerged included mal-intent of seniors, ethnic background conditioning and beauty as a barrier, which have not previously been reported in literature. The current study is the first to report data from Pakistan in the medical profession regarding the glass ceiling.

The existence of a glaring gender gap in top leadership and management positions is found in general surgery[15], plastic surgery[3,9], endoscopic surgery[16], neurosurgery[17], cardiology[18], medicine[2], biomedical sciences[19], radiology[20], dentistry[1,21], clinical neuropsychology[22], academia[4] and many more fields. Differences in academic qualifications, teaching experience, training and academic productivity were suggested to be the causes of the leadership gap in academic plastic surgery.[3] Very limited studies have been done in the South Asian region on the subject. In a study done among faculty of academic dentistry in India, 67% of women reported having experienced the glass ceiling.[23] Institutional challenges were the most frequent factor in the experience of the glass ceiling identified by all participants of the current study. The mal-intent of seniors has not been reported in international literature. Among European women neurosurgeons, 30% believed unequal

opportunities for career progression and attainment of leadership positions were the greatest obstacles in their careers, whereas an overwhelming 72% believed being a woman was a disadvantage in this specialty.[17] Unequal workloads was another form of discrimination, as one of the current participants stated: "Horrendous workload for women compared to men". This discrimination in workload have been reported in cardiology[18], medicine[2], biomedical sciences[19], radiology[20] and dentistry[1,21] as well.

The pay gap was another concern for the current participants who worked in the private sector, though public-sector employees didn't face this discrimination. The European Union report documented that women earn 18% less compared to men in the field of scientific research.[24] In the United Kingdom, men getting more pay than women for the same amount of work is reported in the fields of radiology[25], academia[1] and biomedical sciences.[19]. Mexican women healthcare workers not only are under-represented in management positions, but also face a distinct pay gap from the lowest to the highest wages.[4] A double-blind study in the UK in 2012 discovered that both men and women participants declared men more competent and suitable for hiring than women applicants, and even recommended a higher starting pay as well.[24]

As narrated by the current participants, the privileges gap manifested as a disparity in research opportunities, unfair leave policies, under-representation in scientific conferences, sidelining in co-curricular activities and unequal opportunities for attending courses and workshops. The published data agrees on it[17]. In academic cardiology programmes in the United States, top leadership positions, academic ranks and number of research publications were higher among men, despite the fact that the number of women joining the department was on the rise. The reason for this gap was not explored.[18] A gender gap in the acquisition of research funding and number of research publications is also found in UK academicians as programme directors[1] as well as among American radiologists.[20] A screening of 2,254 articles by independent reviewers concluded that there is a gender bias in biomedical sciences in the areas of research collaboration, evaluation of research results and a lack of inclusion of women in decision-making.[19] In the field of ophthalmology, men obtained 5.6 times more research grants than women and also outnumbered women at positions in the editorial boards of 60 medical journals.[24] The research culture in clinical settings and medical colleges included in the current study was not very robust, but discrimination in obtaining research funding was not reported by any of the participants.

Stereotyping is widely reported in literature as a factor leading to the glass ceiling experience. Among US radiologists, conscious bias based on objectification of women led to losing women faculty for senior posts.[20] Among Indian dentistry academicians, 75% stated that women's role as home-makers has been reiterated to them time and again, and they believed that in order to have a career, women should either be single or delay child-bearing.[23] Facing stereotyping was reported by 88.8% of the current participants. The image of a meek subordinate woman, primarily a home-maker, is inculcated in the minds of men in our society since their childhoods. This is one of the causes leading to the stereotyping of women.

Regarding lack of mentorship as one of the factors aggravating the experience of the glass ceiling, 76% of European women neurosurgeons confided that they lacked female mentors, 58% believed that having a mentor is very important and 66% emphasised that at least one woman should be in policy-making committees.[17] An interventional study on American radiologists revealed a lack of mentors as one of the factors leading to the glass ceiling.[20] None of the current participants had female mentorship when they needed it the most and they all agreed on the need for it.

Ethnic background conditioning refers to priming the faculty to adopt cultural and religious norms. In Pakistani society, translating religious teachings into the topic of women's rights is a sensitive issue. This phenomenon is not reported in literature as such, although Muslim women facing stereotyping has been reported. A phenomenology study based on interviews from Malaysian and Saudi women revealed that men do not reconcile with the idea of women holding executive positions and Muslim women academicians face many challenges at the workplace, leading to resignation from employment by some.[26] In the current study, bias based on demonstrated religious practices and even dress codes has been reported.

There is no doubt that juggling personal and professional lives all the time has a negative bearing on performance[19], and a lack of family support is reported in the current study. Among Indian women in academic dentistry, 57.4% did not have any support from their husbands in domestic work, 62.7% did not have any help at home and 48.6% confided that they could not pay due attention to their research work due to family commitments.[23] A staggering 86% of female European neurosurgeons believed that family planning is very important if one

wants to pursue a career and 72% were worried that having babies would hinder their careers.[17] The combination of gender roles and career ambition leading to unconscious bias and the glass ceiling is reported in American women radiologists as well.[20] In Pakistani society, the joint family system is very robust and multiplies the responsibilities of working women, but if the in-laws are cooperative, it can provide women with family support, too. Unfortunately, 88.8% participants reported lack of family support from their in-laws and 22.2% faced insecurities from their husbands as well. The stereotypical role-casting of women, illiteracy and same-gender jealousy were a few of the causes of this lack of support from in-laws.

Sexual harassment was not reported by the participants in the current, though facing covert flirting by male colleagues was narrated by 11.1% participants. In a 2011 study, women radiologists reported 'inappropriate gender-related questions' in interviews and sexual harassment.[25] In academic dentistry, 6.5% of Indian women claimed having faced some form of sexual harassment at the workplace, leading to quitting their jobs.[23]

Among personal challenges, the need to possess certain personal traits in order to progress in the workplace emerged as a new sub-theme. Many participants reported that to survive in a man's world, they need to have a certain body language, dress code and even proper choice of words. Although these traits are essential for both men and women, the latter have to bear the brunt more than men do. Another surprising challenge narrated by 22.2% of the participants was their good looks as a hurdle. In a review from five databases of academic medicine and dentistry, it was highlighted that gender roles and leadership roles become conflicting for otherwise very able women. Excelling in one area leads to challenges in the other. Organisational demands, leadership expectations and cultural factors all become challenging to handle.[22] In a study, 46.7% of Indian dentists believed that they could have done much better in their careers if they were men.[23]

The importance of societal support for equal contributions by women and men to benefit their personal growth and society's overall progress is undeniable. Societal un-acceptance is a deeply rooted, complex, multi-faceted and dynamic phenomenon with interlacing domains of family structure and patriarchal social norms embedded in centuries-old culture with a religious backdrop. It is difficult to pinpoint a single cause of this un-acceptance. One of the facets is the mindset that leads to stereotyping women. Another facet is a misplaced translation of religious belief that a woman's place is in the home, and this path needs to be treaded carefully. To top it off, there is illiteracy in our country which compounds all these problems, including resistance to accepting women as leaders. However, there is a ripple of change emerging and for the first time in 74 years, we have a female Surgeon-General in the army as a top leadership position holder.

The glass ceiling has truly turned out to be a 'wicked problem' which indicates the existence of other problems. This theory provides a framework which helps in understanding the complex nature of the glass ceiling, the inter-relationship of institutional, personal and societal challenges which are woven together leading to hurdles for aspiring women to reach top leadership positions. The wicked problem theory has been used in medical education in various domains, including health policy and quality in higher education, to name a few[10].

The glass ceiling phenomenon in our country has its roots in a patriarchal society in which women are conditioned, sensitised and trained to be subordinates to men since childhood. Moreover, the role of men as the leaders and masters of the family is deep-rooted in their mindsets since childhood. The experiences of stereotyping, objectification and discrimination for women in general and working women in particular, and the need to address these, conform to feminist theory[11]. Despite a growing awareness of the need for women to participate equally in society, to pursue their professional careers, and to shun stereotyping, the ground reality is far from these claims.

Conclusion

The glass ceiling is a challenge Pakistani female doctors were found to be facing in leadership positions both in clinical settings and in the academia. Factors identified included institutional challenges, personal challenges, lack of family support and societal un-acceptance. These experiences need to be discussed, reflected upon and highlighted for the development of insight by all stakeholders, especially women themselves with the aim of finding possible solutions.

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MHPE – Master's in Health Profession Education

HOD – Head of Department

DME – Department of Medical Education

FCPS - Fellow of College of Physicians and Surgeons

EQ - Emotional Quotient

IRC – Institutional Review Committee

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