Occupational Commitment Among Women Clinical Educators in Pakistan: The Impact of Social Status and Work-Family Interference

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ABSTRACT

Women clinical educators play a vital role in strengthening a nation's healthcare system by training future doctors and healthcare professionals. Despite the fact that more than 80% of medical graduates are females, less than 50% are practicing clinicians, and even less are engaged as clinical educators. To complicate matters, the retention of women clinical educators in the health sector and their occupational commitment is also low, due to challenges such as low social status and work interference with family. The aim of this research was to identify the relationship between social status and occupational commitment in woman clinical educators, and also to identify the influence of work interference with family on social status and occupational commitment. A survey was administered to 200 currently working woman clinical educators from three cities through a purposive sampling technique. Multiple linear regression results revealed that (i) the higher social status, the higher the occupational commitment [$F(11, 196) = 4.181$, $p < 0.000$], (ii) the higher the work interference with family, the lower the social status [$F(11, 196) = 5.870$, $p < 0.000$], and (iii) the higher the work interference with family, the lower the occupational commitment [$F(11, 193) = 3.263$, $p > 0.000$]. Pakistan is in dire need to increase and retain woman clinical educators in the health sector. This is possible if policies are launched to support improved social status and work family balance for woman clinical educators in the country. Improvement in occupational commitment of women clinical educators will have wider implications on job satisfaction, patient safety practices, teaching quality, family quality of life, and the quality of care provided to patients and family attendants.

Keywords: Social status, Occupational commitment, Women clinical educators, Role burden, Work interference with family.

1. Introduction

In Pakistan, the representation of women in medical colleges surpasses that of men, yet a staggering 50% of female medical graduates abandon their careers after completing their coursework (Mohsin & Syed, 2020). Despite women constituting over 80% of medical graduates,

less than 50% actively practice as clinicians, and even fewer serve as clinical educators. This stark disparity is rooted in socio-cultural challenges, including work-family interference and societal expectations that prioritize domestic roles for women (Ahmed et al., 2021).

The lack of women clinical educators is a critical issue for Pakistan's healthcare system, as these professionals are essential in training future doctors and enhancing the quality of patient care. Women's leadership in medical education not only strengthens the healthcare sector but also promotes gender diversity and equity. However, barriers such as low occupational commitment, role burden, organizational discrimination, and cultural norms that limit women's autonomy after marriage further hinder their retention in the field (Jafree, 2020). Occupational commitment, defined as the psychological bond and dedication to professional goals (Meyer & Allen, 1993), is influenced by social status. Higher social status positively impacts women's commitment, yet Pakistani female doctors face immense stress due to heavy workloads and low job satisfaction. Married women clinical educators, in particular, struggle to balance work demands with family responsibilities, leading to either part-time work or complete career abandonment (Alhazemi & Ali, 2016). Moreover, patriarchal traditions and lack of organizational support exacerbate the situation. Women clinical educators often encounter violence, discrimination, and limited opportunities for career advancement (Raza et al., 2023). The pressure to prioritize family and childcare responsibilities further limits their ability to excel as clinical educators. Those who attempt to manage both professional and personal lives experience high levels of stress, which negatively affects their performance and marital stability (Iqbal et al., 2022). To add to the issue, Pakistan's healthcare sector does not have any clear interventions or policies to support work-life balance for women clinical educators (Raza et al., 2023).

The underrepresentation of women doctors in clinical education prevents the diversity of perspectives from entering in the healthcare sector, which is important for a culturally pluralistic society such as Pakistan, and also reduces the availability of female mentors for future clinicians and educators. According to Ahmed et al. (2021), women medical students are more likely to show interest and commit to advanced clinical and surgical roles when they are taught by women doctors. However, the lack of supportive employers and work-family balance policies dissuade women from opting from teaching positions and advancing their professional roles (Siddiqui & Sajid, 2020). In addition, the absence of flexible work hours and maternity and child-care policies contributes to high drop-out rates among women educators (Ali & Khan, 2019). Understanding the challenges women clinical educators face and which gender-sensitive policies can play a pivotal role in their retention and professional growth is vital for the growth of the medical sector.

Developing a supportive and inclusive work culture is crucial for improving and sustaining women clinical educator's occupational commitment. Research by Fatima and Rehman (2021) highlights that women doctors who receive institutional and emotional support from employer and supervisors are more likely to stay committed to their careers and perform optimally in their roles as clinicians and educators. Moreover, professional development opportunities and leadership training programs can empower women clinical educators to overcome structural barriers and excel in their roles (Yasir & Hussain, 2020). By addressing these challenges, Pakistan's healthcare system can not only retain talented women clinical educators but also improve the quality of medical education and patient care services.

There is no doubt that many women are choosing to study medicine in Pakistan. However, the concern is whether they choose to work in the profession, stay in the profession, and assume leadership and training roles within the field. Unfortunately, women in the country face complex social and institutional challenges which prevents them occupational commitment and progress in their field (Moazam & Shekhani, 2018). Women in leadership and academic positions face more

unique problems such as frequent discrimination, harassment, and unfavorable work placement (Yaghmour et al., 2021). Other scholarship suggests that women doctors are negatively stereotyping and labelled as inferior instructors compared to male colleagues, with some even refusing to take their services (Ahmad et al., 2022). A systematic literature review confirms that women doctors lack mentorship opportunities which contributes to glass ceilings and also high drop-outs (Farkas et al., 2019). Furthermore, postgraduate training systems are not easily accessible for women, preventing them from assuming mentorship and training roles (Moazam & Shekhani, 2018).

2. Research aim, questions, and significance

The aim of this research is to investigate the relationship between social status, work interference with family, and occupational commitment in women clinical educators. The specific research questions include: R1. How does social status affect occupational commitment in woman clinical educators? And R2. What is the influence of work interference with family on social status and occupational commitment of woman clinical educators? Women clinical educators play a significant role in a conservative country like Pakistan, where majority women patients and families prefer women healthcare providers to treat females, and majority families prefer women instructors for female medical students. In addition, a country's development and progress is linked to equal participation of both genders at the workplace and in the education sector (Kabeer, 2021).

Yet, Pakistan suffers from the lowest ratios of women doctors currently working in the health sector, and there is also concern about retention and drop-out of women doctors from the profession. There is further complexity when you add teaching, training and mentoring to the work burden of women clinicians. This is why local studies attempting to understand factors that motivate woman clinical educators to stay in the profession and influence organizational commitment are critical. This study has implications for woman clinical educator's retention and job satisfaction, and their productivity and dedication for teaching, patient safety, and error management. Based on the study findings we will be able to advise better social and employer support for women doctors and clinical educators in the country.

3. Theoretical Framework

For this study, we use Work-family border theory (Clark 2000) which proposes that work and family have separate borders, which need to be integrated and segmented to assure optimal outcomes in life. The theory argues for two factors- permeability and flexibility, as key components of boundaries. Permeability refers to the behavioral or psychological aspects of one role which are allowed to enter another, so for example if women clinical educators answer the texts and calls of their students' late night when they are at home with family it means they are highly permeable. Flexibility refers to the capacity of a role's boundary to accommodate the demands of another role, for example the ability of women clinical educators to work at a time and place of their choosing and help manage family demands. Based on this theory we are able to contextualize the job of woman clinical educator versus for example a woman online software developer. Whereas the online software developer may easily choose to be less permeable and more flexible, there would be less capability of women clinical educators to adopt those. Because of the nature of the job, the women clinical educator must remain highly permeable in case of student training doctors facing an emergency with the patient, and they cannot choose to work at home, as they must train students in the clinical setting. In this way, based on Work-family border theory it seems that women clinical educators may suffer from greater work-family conflict compared to women in other professions.

4. Methodology

We adopted a quantitative research design. All ethics were maintained by taking informed consent and interviewing women clinical educators after taking informed consent and maintaining anonymity and confidentiality. No identification information was taken, and respondents were assured their right to withdraw at any point. Women were surveyed at times when they were not engaged in work or duties for patient care. Care was taken that women were surveyed in a private space.

i. Sampling

For this study women clinical educators currently providing clinical services and teaching at both public and private tertiary care hospital in Punjab were sampled. Convenience sampling was used to sample women clinical educators from three cities of Punjab- Lahore, Gujranwala, and Wazirabad. In addition, sampled women clinical educators were also asked to refer colleagues who may be interested in participating in the study.

ii. Data Collection

Data collection was done in the month of December 2023 at the hospital settings, based on the willingness and time of women clinical educators. We were dependent on the hospital to provide us with a private room and we ensured that women clinical educators answered the survey either before work or after work so that patients or work duties were not compromised in anyway. A final 200 women respondents were part of the study.

iii. Survey

Three internationally standardized scales were used to collect the data. The first section of the questionnaire consisted of demographic questions. The second section was consisted of three scales measured on 5-points Likert scale to measure the variables ‘Social status”, “occupational commitment” and “ Work interference with family”

5. Data Analysis

For this study data was analyzed by using SPSS 25.0. Multivariate regression analysis was used to measure the relationship and direction between study variables. P values of less than 0.05 were considered significant. The hypotheses of the study included: H1: The higher the perceived social status the greater the occupational commitment in women clinical educators; and H2: The higher the work interference with family, the lower the social status and occupational commitment in women clinical educators.

Reliability Analysis

Table 1 shows the reliability results for the three study domains- social status, occupational commitment, and work interference with family. The reliability (Cronbach Alpha results) for social status is $\alpha = 0.642$, for occupational commitment it is $\alpha = 0.829$, and for work interference with family it is $\alpha = 0.934$. These results show strong internal consistency for among the items of all variables.

Table 1

Reliability statistics for study domains

Variables	Source	No of items	Cronbach's Alpha
Social status	Browman et al., (2019)	8	.642
Occupational commitment	Meyer et al., (1993)	5	.829
Work interference with family	Netemeyer et al., (1996)	10	.934

6. Results

Table 2 shows the social demographics of the respondents. Majority of the women clinical educators fall between 29 to 38 years (67.0%) and are living in a nuclear family set-up (58.0%). Majority are also married (83.0%), have 1-2 children (53.0%), and live in their own house (83.0%). Majority also have done their FCPS degree or specialization (56.5%), are currently working as Assistant Professors (53.5%), and work an average per day of 5-7 hours (86.5%). Our sample is split equally between women clinical educators working in the public and private sector. Nearly all (95.0%) are full-time employees.

Table 2

Sociodemographic characteristics of women clinical educators (N = 200)

Variables	***f* (%)**
Age	
24 – 28	49(24.5%)
29 – 33	69(34.5%)
34 – 38	65(32.5%)
39 or Above	17(8.5%)
Marital Status	
Unmarried	10 (5.0%)
Married	166 (83.0%)
Divorced	09 (4.5%)
Widowed	15 (7.5%)
Number of Children	
1-2	106 (53.0%)
3-4	43 (21.5%)
None	51 (25.5%)
Education	
MBBS	87 (43.5%)
FCPS	113 (56.5%)
Housing Type	
Rented	34 (17.0%)
Owned	166 (83.0%)
Hospital Type	
Public	100 (50.0%)
Private	100 (50.0%)

Designation at Hospital	
Assistant Professor	107 (53.5%)
Consultant	69 (34.5%)
Surgeon	09 (4.5%)
Associate Professor	10 (5.0%)
Professor	05 (2.5%)
Working Hours in a day	
4 – 5	03 (1.5%)
5 – 6	75 (37.5%)
6 – 7	98 (49.0%)
7 – 8	24 (12.0%)
Currently Employed	
Full Time	190 (95.0%)
Part Time	10 (5.0%)
Family Setting	
Nuclear	116 (58.0%)
Joint	84 (42.0%)

Through this study, it was found that 58% young married women clinical educators were mother of two kids, all these woman clinical educators were specialized in their field, most of them working as assistant professors. And these women clinical educators were residing in nuclear family set-up. 83% of women clinical educators were having their own residence and working for 5 to 7 hours per day as full-time employees.

Through descriptive statistics for social status of women clinical educators showed that 40% of these women were in view that they have ability to do various tasks or activities but they can't change their social status. These women were also in view that their status in society is established already on the bases of their gender that can't be changed. One reason these women explained that the societal norms and value are more challengeable and it can't be broken or changed.

On the other hand, 93.5% of women clinical educator who believe that they can change their social status regardless of society's expectations they move up at any time or age in their life. These women believe in themselves and their abilities on this they are in view of doing anything to change their social status. 74.5% of women clinical educators that they can change their more basic status while 56% have believe that they can change much in their social status and can move up in the ladder of social status.

Further, descriptive statistics of occupational commitment of women doctor respondents we figure out that above 80% women clinical educators are passionate to their occupation, they feeling it important for their self-image and feeling proud of being a doctor. They feel that this occupation gave them an identity in the society. For which they feeling enthusiastic of being a women clinical educator. On the other hand, some women stated regretted on being a clinical educator and they disliked medical profession.

Moreover, descriptive statistics for work interference with family of women doctors shows that most of the women clinical educators facing unfavorable interference of family which affects their occupational performance. Statistics shows that 78.5% women clinical doctors claimed that they have much occupational duties thus left no time for their family and due to this, they change most the family plans or activities. Women clinical educators (71%) claimed that due to the load

of their occupational duties they are unable to do any activity at home. Above 60% of the women clinical educators mentioned their occupation takes up much time and they are unable to do family responsibilities. Likewise, above 60% of the women clinical educators finds the demands of family or spouse effects their occupational responsibilities.

Table 6.

Multivariate regression model for occupational commitment with social status and demographic variables

Model	**Unstandardized Coefficients**		**Standardized Coefficients**	**T**	**Sig.**	**95.0% Confidence Interval for B**	
	B	**Std. Error**	**Beta**			**Lower Bound**	**Upper Bound**
(constant)	18.266	3.200		5.708	.000	11.953	24.580
Social status	.173	.058	.215	2.981	.003	.058	.287
Age	-.639	.342	-.160	-1.869	.050	-1.313	-.036
Marital Status	-.205	.440	-.033	-.464	.643	-1.073	.664
Children	-.463	.225	-.157	-2.055	.041	-.907	-.018
Qualification	2.266	.721	.305	3.143	.002	.844	3.688
Hospital Type	-.315	.529	-.043	-.596	.552	-1.358	.728
Designation	-.602	.358	-.157	-1.683	.094	-1.307	.104
Home	-.720	.678	-.072	-1.062	.289	-2.057	.617
Work Hours	.511	.385	.096	1.325	.187	-.250	1.271
Employment	-.119	1.163	-.007	-.102	.919	-2.414	2.176
Family System	.833	.517	.112	-1.611	.109	-1.853	.187

Table 6 shows the multiple regression analysis results for the dependent variable occupational commitment among women clinical educators, with respect to social status and a range of demographic variables as independent variables. We found a statistically significant model, with $F(11, 196) = 4.181$, $p = 0.000$, and $R^2 = 0.199$, indicating that the combination of predictors in the model reliably explain the variation in occupational commitment. In all, the model explained 44.6% of the variance in occupational commitment, with four significant predictors of high occupational commitment. First, social status emerged as a positive and statistically significant predictor ($B = 0.173$, $p = 0.003$), suggesting that women clinical educators who perceive themselves to have a higher social standing are more likely to report stronger commitment to their occupation. Second, age showed a statistically significant negative association with occupational commitment ($B = -0.639$, $p = 0.050$). This counterintuitive finding suggests that older educators may report slightly lower commitment levels. Third, the number of children was negatively associated with occupational commitment ($B = -0.463$, $p = 0.041$), indicating that women with fewer children reported higher commitment to their profession. Fourth, educational qualification or specialization had a strong and positive effect on occupational commitment ($B = 2.266$, $p = 0.002$), implying that women who hold higher degrees or professional specializations are more committed to their work.

Other demographic variables included in the model, such as marital status, type of hospital,

job designation, home ownership, work hours, employment type, and family system, did not show. statistical significance, indicating that they do not independently predict occupational commitment within this sample. However, bigger samples across Pakistan may show different results with regards to these independent variables.

Table 7 shows the multiple regression model for the dependent variable social status with respect to work interference with family and demographic variables of women clinical educators. We found a statistically significant model, with F (11, 196) = 5.870, p= 0.000, and R^2= 0.259. The model explained 50.9% of the variance in social status. Four variables emerged as significant contributors to perceived higher social status among the participants. First, lower work interference with family is a strong and statistically significant predictor (B = 0.157, p = 0.000), indicating that women who reported fewer conflicts between their work and family responsibilities tended to perceive themselves as having higher social status. Second, age is also a significant predictor (B = -1.305, p = 0.001), although the negative coefficient indicates a complex relationship: as age increases, social status appears to decrease slightly within this sample.

Table 7.

Multivariate regression model for social status with work interference with family (WIF) and demographic variables

Model	**Unstandardized Coefficients**		**Standardized Coefficients**	**T**	**Sig.**	**95.0% Confidence Interval for B**	
	B	**Std. Error**	**Beta**			**Lower Bound**	**Upper Bound**
Constant)	23.048	3.402		6.775	.000	16.337	29.759
WIF	.157	.035	.312	-4.446	**.000**	.088	.227
Age	-1.305	.389	-.274	3.352	**.001**	-2.074	-.537
Marital Status	.345	.495	.048	.696	.487	-.632	1.322
Children	.090	.268	.026	.337	.736	-.438	.619
Qualification	4.047	.792	.455	5.110	**.000**	-2.484	5.609
Hospital Type	-.388	.611	-.044	-.636	.526	-1.594	.817
Designation	-1.742	.395	-.378	4.406	**.000**	-2.522	-.962
Home	-.759	.770	-.065	-.985	.326	-2.279	.761
Work Hours	-.111	.453	-.017	-.244	.807	-1.005	.784
Employment	-.424	1.345	-.021	-.315	.753	-3.077	2.228
Family System	.256	.598	.029	.428	.669	-.924	1.436

Third, educational qualification showed a strong and positive relationship with social status (B = 4.047, p = 0.000), indicating that women with advanced degrees or professional specializations perceive themselves, or are perceived by others, as holding higher social status. This could be attributed to the symbolic and material benefits of higher education, including enhanced expertise, greater autonomy, and improved career opportunities. Fourth, designation, or job rank, is another strong and significant predictor (B = -1.742, p = 0.000), suggesting that women in higher-ranking roles (e.g., senior educators or department heads) have higher social status. The remaining demographic variables, like marital status, number of children, hospital type, home ownership, work hours, employment type, and family system did not show statistically significant

effects.

Table 8 shows the multiple regression model for the dependent variable occupational commitment with respect to work interference with family and demographic variables of women clinical educators. We found a statistically significant model, with F (11, 193) = 3.263, p= 0.000, and R^2= 0.165. The model explained 40.6% of the variance in occupational commitment. Four variables emerge as statistically significant contributors to higher occupational commitment. First, age is significantly associated with occupational commitment (B = -0.861, p = 0.014), with a negative coefficient suggesting that, as age increases, occupational commitment slightly decreases. Second, number of children shows a negative and statistically significant relationship with occupational commitment (B = -0.498, p = 0.038), implying that women with fewer children tend to exhibit higher commitment to their careers.

Table 8.

Multivariate regression model for occupational commitment with work interference with family (WIF)and demographic variables

Model	**Unstandardized Coefficients**		**Standardized Coefficients**	**T**	**Sig.**	**95.0% Confidence Interval for B**	
	B	**Std. Error**	**Beta**			**Lower Bound**	**Upper Bound**
(Constant)	20.805	2.996		6.945	.000	14.894	26.717
WIF	.005	.031	.011	.153	.878	-.057	.067
Age	-.861	.349	-.216	2.470	**.014**	-1.549	-173
Marital Status	-.134	.451	-.022	-.297	.767	-1.024	.756
Children	-.498	.239	-.170	-2.086	**.038**	-.969	-.027
Qualification	3.093	.710	.417	4.354	**.000**	1.692	4.495
Hospital	-.274	.548	-.037	-.500	.618	-1.354	.807
Designation at Hospital	-.949	.351	-.248	2.704	**.007**	-1.641	-.257
Home	-.821	.697	-.083	-1.178	.240	-2.198	.555
Work Hours	.370	.406	.069	.909	.364	-.432	1.171
Employment	-.321	1.194	-.019	-.269	.789	-2.676	2.035
Family System	.785	.533	.106	1.473	.142	-.266	1.837

Third, educational qualification is a strong and positive predictor of occupational commitment (B = 3.093, p = 0.000), indicating that women with higher levels of education or specialized training are more likely to demonstrate stronger commitment to their occupation. Fourth, designation at the hospital also significantly predicts occupational commitment (B = -0.949, p = 0.007), suggesting women in more senior designations have higher occupational commitment. Other demographic variables—such as marital status, hospital type, home ownership, work hours, employment type, and family system—do not show statistically significant relationships with occupational commitment, indicating limited explanatory power in this context.

7. Discussion

We aimed to understand the challenges facing women clinical educators in Pakistan with respect to occupational commitment, specifically with regards to two domain areas of social status and work interference with family. We found that a significant number of women indicate they have high occupational commitment, but that the problems exist first in work interference with family and at second level with low social status. Other studies confirm that women doctors face excessive issues related to work-family conflict, due to lack of help in managing their children and other dependents, and excessive home and domestic responsibilities (Raukar, et al., 2020). Scholarship also confirms that women doctors in Pakistan have low social status due to working long hours, working and interacting with non-relative males, and travelling to and from work at post-dusk hours (Masood, 2019). Though earning a medical degree is valued and honored in Muslim societies, the complexity is that when women start practicing at hospital settings family and community start to shame them for working outside the home and neglecting their domestic duties (Syed & Ali, 2013).

The first hypothesis of this study is proven correct, and we found that the higher the perceived social status, the greater the occupational commitment in women clinical educators. Other research confirms that social status and respect play an important role in motivating women doctors to remain in the profession, serve clients, and give their best at the workplace (Williams, 2023). The second hypothesis of this study is also proven correct, and we found that the higher the work interference with family, the lower the social status and occupational commitment. The findings imply that when there is less support from family members and too much burden in household responsibilities, women clinical educators suffer from lower social status and organizational commitment. Other studies confirm that women doctors are burdened by the triple-shift and that they also suffer from mental health challenges and stress (Fatima, et al., 2014).

Work interference with family is a serious issue for married working women doctors in the country, due to unfavorable work hours, rigid employer demands, and inflexible institutional environment (Khursheed, et al., 2019). Women doctors who face challenges in balancing their professional and personal lives are unable to perform their work duties to the best of their abilities, which is detrimental for patient safety (Asad & Masood, 2022). Other studies confirm that women doctors need employer support and protective work policies to support their organizational commitment and family quality of life (Curtis, et al., 2016). These findings highlight the urgent need for healthcare institutions to implement gender-sensitive policies and flexible work arrangements that support married women clinical educators in managing their dual roles. By fostering a supportive work environment, not only can the well-being and job satisfaction of women doctors be enhanced, but it can also lead to improved patient care and overall healthcare outcomes. Addressing these structural barriers is essential for promoting gender equity in the medical profession and ensuring the retention of talented women clinical educators in the workforce.

It is also important to consider that some women clinical educators indicated that they regretted entering the medical profession, and that they disliked being a women clinical educator. Though these women are few, we consider this to be an important finding as this figure may increase with a larger sample and may also be under-represented due to social desirability bias in answering surveys. Ultimately, if women clinical educators regret entering their profession and dislike their profession it has negative implications for their job commitment, patient services, error reporting, efforts to improve services and participation in governance, and overall quality of medical education imparted to juniors. Future researchers must explore this area in more detail to inform better policy support for women professionals who may be forced into professions that are

not of their choice, or may be struggling in professions due to lack of institutional or employer support and work-family balance.

8. Limitations and strengths

We were unable to collect data from more than three cities of Punjab due to lack of time and funding. We were also unable to collect qualitative data to understand other challenges women clinical educators of Pakistan may be facing. The use of standardized scales and a survey in the English language, meant that some women clinical educators who may have been more comfortable in the Urdu language did not choose to participate in the study. However, the strengths of this study include that it has attempted to identify factors that can help improve women clinical educator's commitment to work, job satisfaction, and retention.

9. Concluding Recommendations for Pakistan

This study concludes with the importance of improving social status and employer support for women clinical educators in Pakistan, which will ultimately improve retention, job satisfaction, commitment to patients and also improve training quality for junior doctors and medical students. We recommend two sided interventions for women clinical educators, and women doctors overall-family-level and community interventions to improve social status and social support; and employer-level interventions to improve employee support and reduce work burden. There is a need to create family and societal-level awareness about the importance of women clinical educators in the health sector and the need for symmetrical help in managing child and home duties. Religious leaders and social media can also play an important role in raising awareness about the important social role and status of women clinical educators by citing religious text and Islamic history as many notable Muslim women were healthcare providers honored by the Prophet Muhammad (Jafree, 2018).

The health sector needs to improve their support for women clinical educators through offering them better options for flexible work hours, day-care centers for children, reduced work hours, and better leave policies. Improved and fair employer policies for women clinical educators in the public and private sector must be monitored and regulated by the central health administrators (Jafree, 2023). Pakistan is in dire need to increase and retain women doctors in the health sector. This is possible if policies are launched to support improved social status and work family balance for women clinical educators and women doctors in the country. Improvement in occupational commitment of women clinical educators will have wider implications on job satisfaction, patient safety practices, teaching quality, family quality of life, and the quality of care provided to patients and family attendants

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Conflict of Interest

None to declare

Ethical Permissions

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Author Contribution

KM conceptualized the study and collected the data. SRJ supervised the project. Both authors conducted the data analysis and wrote and approved the final version of this manuscript.

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