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WORK FAMILY CONFLICT ON FEMALE DOCTORS DURING COVID-19 PANDEMIC

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Abstract:.
This paper explores the impact of work-family conflict (WFC) on female healthcare professionals amidst the Covid-19 pandemic. WFC arises from an imbalance between work and family roles, exacerbated by evolving societal norms and demographic transitions. Categorized into time-based, strain-based, and behaviour-based conflicts, WFC disproportionately affects women, particularly in patriarchal societies like India. Our study, conducted via structured questionnaires, reveals high levels of stress and conflict among married female doctors, who often navigate dual roles as primary breadwinners and caregivers. Challenges such as transportation issues, odd duty hours, and lack of organizational support contribute significantly to work-related stress. We advocate for supportive policies and societal norms to mitigate WFC and promote the well-being of female healthcare professionals.

Index terms: work family conflict, female doctors, covid-19 pandemic, work related stress, gender dynamics.

Introduction

The changes in the workplace and the demographic transitions over the years have made it important to study and research upon the relationship between work and family. The conflict arising in this relation is known as the work-family conflict. Work Family Conflict is a conflict which occurs due to the high prevalence of lack of balance between work and family. As per traditional definition of WFC, the conflict occurs when meeting one's family role expectation is perceived to be incompatible with meeting the role demands of one's job, and vice versa. (Frone & Rice, 1987) [1] . WFC is emerging with time as the role of each member of family keeps evolving. Traditionally, the workplace did not demand as much as it does now, thereby leaving time for people to fulfill the demands of their family life. Participation of females in the workforce has now become a more generally acceptable norm and family structures have hence changed. The women of the house go out to earn bread thereby leaving lesser time for household chores, as well as family at large. These women face multiple challenges, especially in a patriarchal country like India. The demographic transition over time which includes a higher number of dependable now has also led to the rise of women participation in workforce and men's participation in family caregiving demand, particularly in developed and developing nations. (Kossek & Malaterre, 2013). The WFC is recorded at a higher level for older females than younger ones (Blair-Loy & Mary, 2009).
The work-family conflict has been categorized into three types (Greenhaus, H., & Beutell, 1985) based on the source of the conflict, namely- time-based, strain-based, and behavior-based. The time-based conflict refers to the conflicts which result from the lack of time devoted by an individual to a particular role and devoting more time to another role. These may occur due to long work hours or too many vacations. For instance, taking up longer work hours may result in lack of involvement of the individual with family leading time-based conflict. The second kind, strain-based conflict arises from the undue stress from one role which is carried on to or transferred to the other role. For instance, an

individual going through divorce may find it difficult to balance at work and hence a conflict may arise based on strain. The third source for WFC is the behavior- based conflict. As per (Greenhaus, H., Allen, & Spector, 2006) "in behavior-based conflict, a behavior that is effective in one role is inappropriately applied to the other role reducing one's effectiveness in the role". For instance, if a person is the head of their office and is required to be stern all the time, they may carry this behavior forward to their family, however, it will lead to a conflict at home if they continue to be stern and bossy instead of being polite towards their family members. These emotions may hamper the role they deliver at their home basing the fact that these emotions make them act negatively in their home environment or hamper their performance at work.

Female Healthcare Professionals and WFC

The role of women in workforce has been on a rise in the past few decades. The subject has been intensively debated upon and the participation has been generally more accepted over time. Females in workforce has been studied at a large extent for various reasons. Some studies have shown the there is a general acceptability to include more women in the workforce to increase the economic well-being of these women, and families too (Fogarty, Rapoport, & Rapoport , 1967). On the other hand, some family experts recommend against female labor force participation based on the fact that it leads to family disintegration (Bailyn, 1970). Family disintegration, according to this viewpoint, indicates that the traditional role of females has been hampered with and may lead to a dysfunctional society at large.

The rate of work family conflict is generally higher for the female workforce in India and globally as well. The burden of the family well-being and children, stereotypically falls on women. Another aspect which may be considered is the fact that women are naturally more inclined towards being caregivers as well as have higher emotional attachment to family and loved ones than men. Several studies have shown overtime that in India the women are more involved with the family role rather than their work role, meaning that they take up more responsibility. This is true even in comparison with their male counterparts. (Tan, Aryee, & Srinivasan , 2005) (Bharat, 1995) (Kanungo & Misra, 1998) (Larson, Verma, & Dworkin, 2001) (Rajadhyaksha & Bhatnagar, 2000).

Juggling family and work is one of the most important concern for females in workforce. The stress and burnout for the healthcare professionals is always high as they have to deal with death, high emotional expectations of parents, demanding job schedules and work overload (Allen & Mellor, 2002) (Demerouti, Bakker, & Nachriener, 2000) (Wilson, et al., 2020) (Lembrechts, Dekocker, & Zanoni, 2015) (Bogaert, Adriaenssens, Dilles, Martens, & Rompaey, 2014). The healthcare professionals have been the frontline warriors during the pandemic and their stress level owing to this health emergency was also on a rise. Increased work family conflict has been associated with the lower levels of marital satisfaction and life satisfaction, as well as the poor health outcomes such as depression, burnout, etc. The lower satisfaction generally leads to the depression and conflict in majority cases. The excessive impact of the WFC leads to challenges for the professionals.

Literature Review:

(Frone & Rice, 1987) in their study tried to find the relationship between the job involvement and WFC. Family involvement of spouse and parents has been studied in the paper via conducting a primary study amongst a sample of non-teaching professionals employed by a large public university in USA. It was found that the hypothesis of the study was true, and that job conflict was high for respondents who has

spousal involvement and vice versa. Parental involvement on the other hand had moderate impact on the job conflict. The relationships studied in this paper have been

central to the relationships studied in the present study. The impact however will be focusing on just stress and slight light on the job productivity and burnout. The paper used the Job Involvement Scale for the measurement of WFC. It was found that gender was unrelated to the outcomes of WFC. The role of spousal involvement directly impacts the job involvement conflict, if there is a rise in the spousal involvement there will be a rise in WFC. This study provided a critical step forward by examining the interaction between job and family, especially spousal and parental relationships.

(Khanam, Dar, Wani, & Shah, 2020) has focused on the frontline healthcare workers and how the increased risk of Covid-19 for them played a part in their increased stress. The study is based on sample of 133 responses from doctors and nurses who were posted in emergency and in-patient department during the pandemic. The area under study was Kashmir. The paper was more of a psychological study which tried to study the impact of Covid-19 on the doctors and other healthcare staff. It was found that about 60.9% of the participants faced a severe phycological impact and that the impact was significantly higher for male respondents than their female counterparts. Further that, the stress was higher for married respondents and, for nurses than doctors. The paper used snow-ball sampling technique and used an e-questionnaire using google forms, which has now been adopted for this present study. It found out that anxiety was higher amongst the respondents due to factors such as "due to colleagues testing positive" and "anxiety about infecting family". The limitation of the study was the lack of generalizability based on the fact that it was done using convenient sampling technique. The paper recommended the use of psychological interventions in order to help.

(Ahmad, 2008) is a paper which presents a predictive model of WFC. It is predicted in this study that expectations of roles from other people increase the inter-role conflict. The model in the study is based on the stress-strain model by Dunham, social identity theory by Lobel, and the works of other researchers. It identified three predictors, namely-Job-related, family related and individual related. The factors identified under these sub heads were job type, work time commitment, job involvement, role overload, job flexibility (under job-related factors); number of children, life-cycle stage, family involvement, and childcare arrangements (under family-related factors); and life role values, gender role orientation, locus of control and perfectionism (under individual-related Factors). These factors have been used in the present study in order to assess the work-family conflict.

(Reddy, Vranda, Ahmed, Nirmala, & Siddaramu, 2010) aims to study the various factors which lead to WFC and FWC among married women employees in India. The sample for the study included 90 married and working women in the age bracket of 20-
50 years. The women included in the sample were married for at least 3 years, living with their spouse and were engaged in work for at least 1 year. Using the Carl Pearson's Correlation, the relationship between different variable was studied. The study found that women with children had lower occupational commitment in relative to the ones with no children. Also, women with younger children outperformed those with older children. This relationship of children and the impact it has on occupational commitment has been identified from this study and has been used in the current paper as a factor. The paper states that women with multiple roles face adverse effects of these roles in the mental and physical health. Women also have to face "cultural contradictions of motherhood" and thereby have to provide "intensive parenting" by involving themselves in childrearing and development. It was also found through the study that women working in hospital setting had higher level of WFC, compared to those in industrial setting. The role demands by husband were also a factor which led to high WFC and the support and involvement of husband

positively relates to the lower level of role conflict experience by married working women. In India, women are working now to augment the family income,

especially those from the lower middle class. Such women, who took up jobs for financial assistance and needs reported high level of WFC as compared to those working due to other reasons. It was found that in such cases, "women need to be careful to not bring home her frustration and unhappiness, which can affect family relations." This has been covered in the present study as a factor for why women were working during the pandemic as well. The limitation of the study was that the sample size was quite small, so the study could not be generalized and there is a need to explore the relationship between WFC and quality of life among married women employees.

(Somashekher, 2018) studies the women employees in the organized sector in Bangalore city of Karnataka. The aim of the study was to assess the degree and nature of WFC and to analyze its impact on the social and psychological well-being of the women at work. There were 280 respondents to the survey and 70 respondents were randomly selected for the study via interview method. The results indicated that 52.8% of the respondents has high degree of WFC, moderate degree was present in 33.6% and low WFC for 13.6%, indicating that work-family conflict has a high occurrence for women employees in Bangalore city. Additionally, 91.5% of the respondents suffered stress and only a small percentage (8.5%) were stress free. The paper further tried to assess the factors which help reduce the stress such as spending time with family members, friends, etc. and watching TV, shopping, etc. It was concluded that WFC affects the career goals and lives of these women employees and their family members as well. The study also found that Indian women are more likely to take their family obligations seriously as compared to their professional responsibilities and in the process, they endure high level of stress and high level of WFC.

(Asiedu, Annor, Amponsah-Tawiah, & Dartey-Baah, 2018) studied the nurses from Ghana from five public hospitals through convenience sampling. The participants responded to structured questionnaires focusing on the impact of WFC and burnout. The study tried to examine if the family demands impact WFC and burnout. It studied Family-Work Conflict as well, that is the how work-role needed to be changed in order to fulfill the demands of family role. The measures in the study were work demands, family demands and burnout along with certain control variable such as age, gender, marital status, etc. It was found via this study that the long work hours and weekend schedules were major factors which lead to WFC and that there is a positive relationship between family relations with WFC.

(Gupta, et al., 2020) have studied the impact of pandemic in terms of depression and anxiety for armed forces. The study was conducted under 3 days using a self-administered questionnaire using the Hospital Anxiety and Depression Scale (HADS). The survey having 769 respondents was conducted using google forms. The prevalence of anxiety and depressive symptoms were found in doctors at 35.2% and 28.2% respectively, with 21.4% respondents having both. It was also compared to Chinese studies and shown that the prevalence in India was lower than that in China, probably owing to the social structure present in our country. The prevalence of anxiety and depressive symptoms is higher in doctors as compared to the general population, in India. The doctors are in general overworked owing to factors such as medicolegal issues, limited resources, long duty hours, apprehension of transmitting disease to family members, inadequate emotional support from the family members, less family time, leading to a higher level of burnout, anxiety and depression. (Dai, Hu, Xiong, Qiu, & Yuan, 2020) (Dai, Hu, Xiong, Qiu, & Yuan, 2020), (Zigmond & Snaith, 1983) (Sagar, et al., 2020). This study was one of a kind as it included an armed forces in the sample size and no such study has been conducted in the past. However, this may also be seen as a limitation as it was only conducted in armed hospitals which leads to lack of generalizability. The other main limitation of the study was that it was conducted in a

very short time in the early phase of the pandemic which might have caused underestimation of psychological stress.

(Wilson, et al., 2020) studies 433 healthcare professionals and tried to analyze the level of stress, anxiety and depression they had. The study was conducted in April 2020 via an online questionnaire shared through WhatsApp. It used questions from the Generalized Anxiety Disorder Item -7 (GAD-7), Patient Health Questionnaire-9 (PHQ-9), Perceived Stress Scale-10 (PSS-10) and other miscellaneous psychological questions. It was found that 78% of the respondents had serious concerns about the spread of coronavirus to their family members and friends via them. The prevalence of high-level stress was low amongst the respondents (3.7% only). The paper suggested that the government should take new measures and continue the previous measures as well in order to maintain mental health and well-being of healthcare professionals.

Research Methodology

Participants

The participants in the study have been cautiously selected to fit a particular requirement. The major identification factor for the study was women healthcare workers and they were further selected on the basis that they:

1. Were on duty full time or partially during the coronavirus in 2020.
2. Have been vaccinated
3. Have been working post vaccination

Procedure

The study was conducted using a structured questionnaire. The questions developed were based on the Hospital Anxiety and Depression Scale (HADS) and Perceived Stress Scale-10 (PSS-10). In the questionnaire, after the demographic information, the information regarding their employment during covid and their vaccination status was obtained. Further the respondents were questioned about the work-related stress and family related stress that they faced during the pandemic. The Cronbach alpha value for the questionnaire was 0.791for work conflict and 0.856 for family conflict.

ANOVA

Source of Variation	SS	df	MS	F	P-value	F crit
Rows	194.319728	48	4.0483276	4.5199735	1.0895E-18	1.382183631
Columns	61.6785714	11	5.6071428	6.2603967	9.5688E-10	1.8067851
Error	472.904762	528	0.8956529			

	728.90	58
Total	3061	7

	0.77
Cronbach alpha	87 59 77

Variables

The variables selected in the study are based on work family conflict. The study was conducted using cross sectional survey design. This paper tries to identify the WFC that these female healthcare workers faced during the pandemic. The study focuses on female healthcare professionals who have responsibility towards family. The respondents were chosen based on the fact they were female doctors who were providing their services during the coronavirus pandemic. The aim of the study is to find out whether these respondents face WFC due to family pressure. The relationships the paper tries to focus on are husband-wife, mother-children, and the relationship with in-laws of the female doctors (if present in the family set up). The impact of this has been studied based on the responses of these professionals. The findings have been discussed further in the paper. On the family front the variables were – intervention from family, household work pressure, family pressure of quitting job, risking family members to Covid-19, Frustration reflecting in family life, unhealthy relationships, higher time commitment to work, gender discrimination, lack of support from organization. On the work front variables were – mode of transportation to work, odd duty hours, incentives, timely payment of salaries, allowed leaves, accommodation at work, confidence of being well-cared for by organization if contracted Covid-19.

Finding and Discussions

During the Covid-19 pandemic, there was a surplus demand of healthcare professionals all through the world. The doctors were on foot 24x7. A major portion of healthcare professionals is encompassed of females. It was found that nearly all these healthcare professionals faced at least one kind of work-family conflict. The major issues that were faced by the healthcare professionals were majorly linked to the fact that they were the primary bread earner in the family during the pandemic and thereby could not leave their job. The other issue was that they had to fulfill their commitments towards their family, be it children or their elderly in-laws. In the Indian society, females are expected to be the primary care givers in the house and fulfill their duty as the housewife first, rather than professional duties.

The respondents for this study encompassed of 75 per cent married female doctors along, the rest per cent being 20 per cent being single and 5 per cent being divorced or widow. The employment of these female doctors was majorly in the public sector, only 25 per cent of these respondents were employed at private hospitals. The age group bifurcation of respondents was 4% in age bracket 21-25, 28.3% in

age bracket 26-30 years, 37.7% in age bracket 31-40, 24% in age bracket 41-50, 6% in age bracket 51-60 years. About 60.4% of the respondents were employed in the healthcare sector for more than 10 years, followed by 13.2% respondents employed for 5-10 years and 26.4% respondents employed for less than 5 years.

The questionnaire was divided into two parts, firstly for family related stress and the later for work related stress. Each question was amicably scored, and the results thereof were used to understand the level of stress each of the respondent faced based on the average and extreme score for each section of the questionnaire. For family related stress the extreme score was 51, average score was 33 and least stress score was 15. For work related stress the extreme score was 45, the average score was 29 and the least stress score was 11. To understand this better, if any respondent scored closer to 55 for family related stress or 45 in the work-related stress questionnaire it is concluded that the degree of stress, they faced from these two sources is very high. Similarly, it can be interpreted for the lowest degree stress score of 15 for family related stress and 11 for work related stress. The average score in both the scenarios being 33 and 29 respectively. Keeping in mind the average score of both the segments would come in handy to understand the further context of this paper.

Out of all these respondents it was found that married female doctors faced the highest degree of work-family conflict. They had higher number of dependents and thereby they felt more dutiful towards family. These female doctors felt more responsible towards their family members and owing to that they felt that were not very efficient at work. The percentage of respondents who had no dependents was only 24%. They also registered an average score of 26 in family related stress and 29 in work related stress. This score is lower than the average for both the segments.

There were 24% respondents who were sole bread earners for their family during covid-19. These respondents had an average score of 29.5 owing to family stress, which is a below average and 29.8 owing to work. 29.5 is a below average score in family stress which indicated that this factor was not as important in identifying the stress owing to family. Even the score for work related stress is only at par with average score (29), also indicating that this factor did not induce work related stress. However, through additional comments it was found that the female healthcare respondents highlighted the fact, that even though they were the primary bread earners during the pandemic, they were often criticized to be working in the healthcare sector during that time. This criticism was since these healthcare professionals could become a carrier of the virus and put the life of their family in jeopardy. The lack of support from the family members took quite a toll on the mental health of most of these healthcare professionals. They often felt that if they had been of the opposite gender (i.e., male) they would not have to face such criticism. And more than that, they would have probably fetched praise for being the Covid warriors. 22 per cent of the respondents faced severe level of family related stress. The main cause of this was that the time requirement from work made them tried to provide time to their family, they brought back frustration and unhappiness home, and that they had to do household chores apart from providing services as healthcare professionals.

71 per cent of the respondents had high levels of work-related stress. The work- related stress generally encompasses reasons at work which induce the stress levels. The respondents majorly identified these as the major factors which induced their stress during covid-19. The transportation to work was a source of stress for most of the respondents. This is majorly since public transportation was suspended during covid-19 pandemic. Lockdown was imposed in all the country, but these healthcare professionals had to go to work daily. Nearly 56% respondents had high level of stress owing to transportation to work. Only 32% of the respondents had arrangements made by the hospital for their transportation, the rest were on their own for transportation to hospitals, which was troublesome for

them.

Nearly 55 per cent of the respondents had odd duty hour which made them face more work-related stress resulting in conflict. The odd duty hours made 61% of the respondents feel that it added stress. Only 6% of the respondents had incentives provided by the hospitals

the other 94% had no incentives from the hospitals. Additionally, it was observed that 93 per cent of the respondents did not receive timely salaries, this increased their stress. Overall, it was observed that only 42 per cent of the respondents felt that their hospitals did the best it could in order to ease their work life and help reduce their work-related stress during the pandemic.

Conclusions

Even though the female healthcare professionals were dutiful in their responsibilities towards work, they would have found it better if there was a lower level of family conflict. We, as a society, should have better standards for female healthcare professionals, when it comes to their family life and responsibility towards their families. The work-family conflict might not have been completely avoided however, the degree of WFC would have been comparatively lower foe men. It is the upbringings of the society which makes principles in the families which turn out be acceptable norms of conduct. With the change in the demographic over time along with changes in role of women in the workforce and family, we must encourage and support women's participation. To reduce work-family conflict it is important to develop inclusively with open mindsets.

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