PARENTAL LEAVE IMPACTS CAREER

Less than half of doctors feel supported taking time off

For doctors, maternity leave much more commonly taken than paternal leave: survey

BY EMILY HUGHES

"It felt as though it was an 'ask me about when I want to have kids session,'" is how Laura Faulkner, a second-year medical student at Dalhousie University in Halifax, described the career counselling offered to her and her colleagues by the faculty of medicine in first year. "It was a thing that only the females were asked—none of the males came out of those sessions saying that they were asked about what they wanted to do about family planning."

The implicit messages for medical students attending these sessions was: Maternity leave, or the potential thereof, has career implications as early as the first year of medical school. Less than half of respondents in our physician survey felt as though they would be supported taking time off for parental leave, with no marked difference between female and male respondents. Yet, the vast majority of respondents (90%) noted that, where they worked or trained, maternity leave was more common than paternity leave. Together, these results may, in part, explain why female physicians are not advancing in their careers to the same extent as their male colleagues. If less than half of all physicians feel supported in taking leave, with no marked difference between female and male respondents, it becomes: are physicians who take parental leave opting out of career advancement, or are they being forced out?

At the beginning of her residency, a surgeon in Kingston, Ont., who we’ve kept anonymous, was told by her program director that he expected her not to have any "accidents" because she was needed to cover the call schedule. Indeed, 66% of survey respondents agreed with the statement: "When a colleague at my workplace at a similar career stage to me takes parental leave my workload increases."

Dr. Arthur Zilbert, retired from his obstetrics/gynaecology practice in Halifax, noted: "The issue really is: who does the work when people are away? We had a surgeon whose wife had her third or fourth child and he took three or four months off, which I applauded him for wanting to do. Except there are only three other general surgeons and they used to work one in four and then suddenly they are working one in three. I mean, is that fair to them? It is absolutely appropriate for him to spend time with his family, but is it appropriate for him to dump his—if you like—private life’s affairs on his colleagues?"

If taking leave directly increases the workload of colleagues, and female physicians are much more likely to take leave than male physicians, does being a young female physician of childbearing age put one at a disadvantage when seeking job opportunities? "I really don’t know," Dr. Zilbert said. "I think it depends on the size of your department to some degree. So if you are a department of two people, and you hire a third person who had three kids in five years, clearly, you have to come to some sort of an arrangement. In today’s world there are options of trying to get locums to come in that weren’t available perhaps a generation ago, so the impact may not be quite as severe."

For Dr. Anna-Marie Mackinnon, a general practitioner in St. John, N.B., the career implications of taking leave may be subtle and show up after the leave. "Physicians without young kids or who have someone else to pick them up from daycare or bring them to sports, music, feed them, put them to bed (usually a wife) are the people with the extra time to take positions like department head, participate on committees, take on special issues and get involved with politics." In other words, the parents have less opportunity to be involved in many of the things that count for career advancement.

Returning to work after taking parental leave can be a challenge because not all workplaces are accommodating to new parents. Dr. Mackinnon discovered this when she moved to a new city. In her previous practice, she brought with her to department meetings her four-year-old daughter who would stay occupied by playing with LeapPad or colouring. After doing this in the new workplace, Dr. Mackinnon said, "I was brought into the office of the head of the department and told that one of the other members had complained about a child being there, saying that they didn’t want to have to do with their language. I was told I wouldn’t be expected to attend the meetings. So I stayed away. I wish I’d been ignignant enough to insist that I had every right to be there, that the other person should learn to use language that wasn’t offensive in a professional setting. But
I stayed home, and didn’t push for a change in attitude. If having a child quite literally removes one’s seat at the table where decisions are being made regarding promotions, governance and call schedules, the people who have the most to lose because of their responsibilities at home are silenced.

The concept of “opt-out moms” was introduced in a 2003 New York Times Magazine article to denote highly educated, high-achieving women who choose to “opt out, ratchet back and redefine work” after having children in order to focus on raising their families. So are female physicians who take leave, or who reduce their workload after returning to work, opting out of career advancement? Or are they being forced out?

The question may be answered in part by noting a difference in societal pressures surrounding childcare between the genders. Dr. Harriet Train, a general practitioner in north Toronto, said: “Gender inequality in medicine alone is not necessarily an issue. I think it’s more broadly a societal issue. . . . When my kids were little I was the one who always went to all of the plays, recitals, concerts and everything else; which was fine, I had no problem with it. But, I would say that 99% of people there were all the mothers, not the fathers.”

Perhaps “opting out” truly by free will can be achieved only when childcare responsibilities are shared equally between parents. Dr. Reena Pattani, a general internist in Toronto, said: “Gender inequality in medicine alone is not necessarily an issue. I think it’s more broadly a societal issue. . . . When my kids were little I was the one who always went to all of the plays, recitals, concerts and everything else; which was fine, I had no problem with it. But, I would say that 99% of people there were all the mothers, not the fathers.”

Perhaps “opting out” truly by free will can be achieved only when childcare responsibilities are shared equally between parents. Dr. Reena Pattani, a general internist in Toronto, cited evidence that a more equitable workplace starts with a more equitable home, and that this can, in part, happen through policy surrounding parental leave. On a panel at a summit for women in academic medicine held at the University of Toronto in March she discussed, with other physician leaders, the parental leave system in Iceland. In the 1990s a policy was developed where new parents—both mothers and fathers—were entitled to six weeks of fully paid and non-transferable parental leave that had to be taken within the first year of the child’s birth. Because it was structured in this way almost 90% of men took leave. Now, after 20 years of data, the downstream effects of this policy are becoming apparent. “Because those men were invested right at the early stages of the child’s development they are much more equal partners in the home,” said Dr. Pattani. “The impact in the workplace is that everyone is much more thoughtful on things like scheduling of meeting times in order to accommodate child pick-ups and drop-offs and elder care responsibility. How you divide call schedules, how you divide working holidays, March break, summer vacation—everyone is much more thoughtful about these things because of that equality in the household.”

Currently, in Canada, the message is that governments and medical associations could be doing more. The majority of survey respondents (66%) did not think that governments do enough surrounding parental leave for physicians and physicians in training. MP

Challenges in MD/MD relationships

IT IS WELL KNOWN THAT DOCTORS OFTEN MARRY OTHER DOCTORS and our gender equity survey also found this. Indeed, 20% of doctors and medical students said their significant other was also a physician or physician-in-training.

Dr. Sean Pierre, a urologist in Ottawa, noted that starting a family with a partner who is also a physician poses challenges. “For the person who will be pregnant, even which medical school to go to matters—some are not as accommodating or understanding as others both on rotations and the all-important evaluations/letters/recommendations. Then the choice of residency matters; both for maternity and childcare issues during residency (night call, shifts, etc.), and afterwards (mat leave coverage, financial impact of taking time off, etc.),” he said. “For the partner, having to continue to earn is a concern, especially if they too are physicians, and thus influences the time taken to be able to contribute to the situation.”

Type 2 diabetes: Can your patients’ kidneys keep up?

Up to half of diabetes patients will show signs of kidney damage in their lifetime.¹

It’s therefore important to remember that some T2D medications need to be dose-adjusted in patients with renal dysfunction while others are contraindicated in patients with significant disease. When changes in renal function occur, the usage and dosage of these medications should be reevaluated.¹

Consider renal function when selecting an oral antidiabetic agent that will be efficacious for your T2D patient.¹


T2D = type 2 diabetes.