Promoting parental leave for female and male physicians

Barbara Lent, Susan P. Phillips, Beverley Richardson, Donna Stewart, on behalf of the Gender Issues Committee of the Council of Ontario Faculties of Medicine

The increasing number of women entering medicine in the past 15 years share many characteristics with women in other professions: their rates of child rearing are the same,[1] and they carry primary responsibility for family and household,[2] while juggling childbearing and career. Men are now playing a more active role in child rearing. All employers, in the health care sector and elsewhere, should be encouraged to facilitate the efforts of both women and men to balance work and family responsibilities, and we laud the recent initiative by the Medical Society of Nova Scotia to provide parental leave benefits to physicians in private practice. Similarly, the recent agreement between the Ontario Medical Association and the government of Ontario provides for 17 weeks of maternity benefits.

Maternity leave allows women time to adapt to the emotional and physical demands of motherhood and the change in family dynamics, gives them time to spend with their newborn and provides the opportunity for 4 months of exclusive breast-feeding, as recommended by the Canadian Paediatric Society.[3] Ideally, the length of parental leave should be determined by the needs and well-being of the child, rather than by individual financial need or workplace imperatives. Women without paid maternity leave return to work much earlier than women with paid maternity and parental leave.[4] Therefore, because of their relatively high incomes, physicians would appear better positioned to take parental leaves of optimal duration than many other new parents. What, though, is the reality, and if physicians are "rushing" back to work despite being highly paid, why are they doing so?

Currently, Canada's Employment Insurance Program provides for 15 weeks of paid maternity benefits and 10 weeks of parental benefits at 55% salary (to a maximum of $413 per week). Academic physicians in some provinces may be entitled to some additional government benefits for the university component of their income. For example, medical faculty in Ontario can receive benefits equivalent to 95% of the portion of their income paid by a university. In addition, 18 weeks of parental leave can be taken by either parent.

No studies have considered the perspective of male physicians or addressed the specific issues that concern physicians practising in either academic or community settings. For example, the duration of parental leave allowed, the amount of compensation received during leave, the need for a temporary replacement and the funding of these initiatives must be addressed. Some studies[5–7] have looked at the issues and problems for residents, whose years of postgraduate training and childbearing coincide, and made recommendations for explicit maternity-leave policies in residency training programs to reduce the amount of stress on pregnant residents and minimize the disruption to colleagues.

In 1996 the Gender Issues Committee of the Council of Ontario Faculties of Medicine (GIC:COFM) undertook a survey to examine the experiences and views of all male and female faculty at the 5 Ontario medical schools with regard to parental leave during the previous 5 years. The study showed that the arrangements for parental leave varied considerably across departments and universities with respect to length of leave, remuneration and temporary replacements.[8] Of women faculty who took maternity leave, 46% took 16 weeks or less and 12% took 5 weeks or less. The proportion of usual income received during maternity leave was related to the length of leave taken. Moreover, the men and women who took parental leave generally thought that the leave had a slightly negative impact on their academic work, particularly on their research endeavours and the course of their careers. They also reported feeling that their parental leave had a negative effect on colleagues' workloads. Interestingly, however, they felt that parental leave taken by others had less of a negative effect on their own academic career or clinical workload.[9]

Undoubtedly, one of the most complicated issues related to parental leave is how to fund it. The is no easy answer. In the GIC study, most faculty who responded to questions about paid leave and temporary replacements supported both, but respondents were divided on whether to include or exclude clinical earnings in the "equation" to calculate remuneration amounts. Many suggested that all faculty should contribute to a central risk pool that could be used to provide remuneration in a uniform and equitable manner.

Although the results of this study cannot be generalized across the country or to nonacademic physicians, the study does provide important data and draws attention to the kinds of questions policy makers and clinicians must grapple with. Further research is needed to determine if the length of leave taken by physicians who are new parents is related to the amount of income they receive, as was the case for the 367 000 working women surveyed in a recent Statistics Canada study,[4] to the culture of an institution that sees maternity leave as vacation time and a "slacking off" from career advancement, or to both.

Parental leave is an important issue, not only for young female physicians but also for their partners and colleagues.

Women now make up 50% of the Canadian medical student population, and 36% of women physicians and 12% of men physicians are married to a physician.[10] Parental leave should be part of all discussions about physician human resource planning for the future. These discussions are particularly relevant and timely in view of the recent federal proposal to offer longer parental leaves. When physicians encounter less conflict between their personal and professional lives, they may be better able to manage the greater and more complex patient care demands of the next millennium.

Dr. Lent is Assistant Professor, Department of Family Medicine, University of Western Ontario, and Staff Physician, Victoria Family Medical Centre, London, Ont.; Dr. Phillips is Associate Professor and Coordinator of the Women's Health Program, Department of Family Medicine, Queen's University, Kingston, Ont.; Dr. Richardson is with Sunnybrook & Women's College Health Sciences Centre, University of Toronto; and Dr. Stewart is Professor and Chair of Women's Health, University Health Network, University of Toronto, Toronto, Ont.

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Correspondence to: *Dr. Barbara Lent, The Victoria Family Medical Centre, 60 Chesley Ave., London ON N5Z 2C1; fax 519 433-2244; blent@julian.uwo.ca*