Parenting, puppies and practice: juggling and gender in medicine

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See related article page 637

During a Sunday of baking cookies, puppy training, child chauffeuring and vacuuming, I slipped away to write this editorial on medical careers and parenting. As the kids ask what's for lunch, I reread the study by Bibiana Cujec and colleagues (page 637).[1] In it the authors examine professional and parenting dissatisfaction among medical students, residents and faculty members at a Canadian medical school. Their measure, a "dissatisfaction score" derived from responses to 25 questions (only 4 of which addressed parenting), indicates their anticipated findings. With a reasonable response rate from all but the faculty members, who nevertheless formed 39% of the respondents, Cujec and colleagues compared responses by level of training and sex. At all levels of career stage women were more likely than men to be single, to be childless, to lack time for family, to hire household help and to discourage their peers from becoming parents. Childless physicians, whether male or female, had a lower level of job satisfaction than their colleagues with children. Married women also had a lower level of job satisfaction than married men. The least professionally satisfying career stage was residency training.

These findings are in keeping with the growing literature on career satisfaction among physicians. Being married and having children are good for men and their careers, but they can have the opposite effect on women.[1–7] While women sacrifice productivity to parenting (or vice versa), men seem to increase their work hours as their families grow in size.[1,3] A higher level of career dissatisfaction among female physicians than among male physicians likely reflects gender differences that extend beyond relative parenting responsibilities. Women's slower advancement through the ranks of academia may also affect the career satisfaction of university-based female physicians.

These dilemmas are the "luxuries" that follow a century of emancipatory changes for Canadian women. It was not until 1969 that contraception became legal in Canada, an entitlement not shared by most of the world's women. When Dr. James Barry died during an epidemic in 1865, it was discovered that the deceased inspector-general of the British Army hospitals was actually Canada's first known woman physician, and a mother, who had disguised herself as a man to gain entry to the medical profession. In contrast, in 1998, 44% of North American medical school entrants were women.[8]

Historically biology has been used as an excuse to limit women's careers in medicine. "Women may be useful in some departments of medicine, but in the difficult work, in surgery for instance, they would not have the nerve," stated Montreal's *The Gazette* in 1889.[9] The research by Cujec and colleagues suggests that, currently, careers control sex. In their study female medical trainees and academics were less likely than their male counterparts to have children. In a survey of female Yale medical graduates from 1922 to 1999,[5] 35% of those without children felt that they had had to choose between medicine and motherhood, and 46% said that they could not be both good mothers and good doctors. A survey of Ontario's medical faculty showed that women felt guilty about taking parental leaves and thereby increasing their colleagues' workloads while slowing their own career advancement;[10] they limited their maternity leaves to durations far shorter than that offered by their universities or the law. Perhaps a popular 1980s' T-shirt slogan "Oops — I forgot to have kids" should now read "I just never had time."

Why do male physicians who become parents seem to be able to increase their work hours? Hochschild, an American sociologist, found that work is becoming more and more a friendly, family-like refuge from the conflict-ridden, unrelenting "workplace" at home.[11] Perhaps male physicians retreat to the intellectual stimulation and order of the clinic rather than committing increasing hours to the routine and sometimes monotonous work of the home. For women, shaking off their traditional role of keeper of the family is a challenge fraught with guilt. Perhaps that is why married women and those with children spend more time on parenting than do men, and suffer more dual career conflict.

Cujec and colleagues found that residents had the highest level of career dissatisfaction of those surveyed. Job stress is greatest when demands are high and when control and decision authority are low.[12,13] In general, medicine offers remarkable job control and a stimulating environment. However, according to the Karasek model,[12] residency training is the most stressful stage of most medical careers.

But again, I must maintain some perspective. The majority of physicians spend some of their income to hire nan-

nies and house cleaners.[1,5] Our privilege does not extend to these hired women (and it is virtually always women), who are also juggling earning a salary and caring for their families — generally earning in a day what the average doctor earns in under 1 hour. Their work defines stressful in Karasek's model.

The solutions are both obvious and elusive. Equalize parents' psychological and time commitment to home work when both work outside the home. Put an end to the trend in the late 20th century of ever-expanding work hours; the 40-hour work week that unions fought for decades ago has never been the norm in clinical or academic medicine. Foster workplace flexibility to accommodate parenting. We can appreciate our privilege yet strive to improve inequities within it.

The puppy needs to be walked, supper time is looming with no menu planned as yet, and the costume for the school play needs some last-minute adjustment. Most editorials end with the statement "further studies are needed." I will end mine by saying "No more studies are needed. It's time for action."

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Competing interests: None declared.

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