Director's Corner

Families matter and families usually start with babies!

By Adina Kalet, MD, MPH

In honor of Mother's Day, Dr. Kalet describes how the old tradition of all-but-ignoring women physicians' pregnancies, childbirths, and parenting was neither right, good, nor effective in creating a health care culture of care and compassion. While things are getting better, it has taken too long, and there is still a ways to go ...

In the 1980s, no residency training program had a maternity or parenting leave policy. It was not until enactment of The Family and Medical Leave Act of 1993 that employers were required to provide job-protected—albeit unpaid—leave for qualified medical and family reasons. A pregnant resident was seen as a disaster and, at the minimum, a scheduling nightmare for the program leadership. Here are some stories from the bad old days. You might notice that some things haven't changed as much as they should have.

Shoshana's story

I was a junior resident in Medicine in the mid-1980s and was stoked to finally work with one of only three woman senior residents in our program. Three weeks into our rotation together, Shoshana and I were on call admitting ten new patients to the hospital while covering over thirty other sick patients. Early in the evening, when things had finally calmed down a bit, I paged her to grab dinner and review our unfinished tasks.

"I'm fasting at the moment," she said. "Can we meet in the doctor's station instead? I need a favor." *Fasting??? That's curious*, I thought. It was not Ramadan or Yom Kippur and, anyway, based on what I had gleaned, she was an avowed atheist.

When I found her, she asked, rather commanded, me, "I need you to follow me around and draw my blood for my three-hour GTT. Okay?" I watched her chug the eight syrupy ounces of pure glucose from a small plastic container. That is when I made the connections: the new fashion of loose overalls, the constant snacking on saltines, her avoidance of all things radiology. "You're pregnant?!" I blurted, not a bit surprised that she had not said anything about this before.

“Yup. Don’t say anything, please! I just need you to be my ‘wingman’ on this...Cannot do it myself, after all...Anyway, no one knows yet...And you know how *they* get …” I had been around long enough to know that none of us was allowed to call in sick (or pregnant) without unduly burdening—and risking the resentment of—our compatriots.

“Okay, of course! How are you feeling? Should you be on your feet tonight? Are you happy? How exciting!” I fumbled with this novel situation, searching my memory bank for all I knew about the indications for and implications of this Glucose Tolerance Test.

She clearly had “failed” the the routine one-hour GTT. She was an “elderly primigravida,” doctor parlance for a first pregnancy over age 35, facing the possibility of gestational diabetes in the second trimester of pregnancy. This was risky and a hassle for the average pregnant woman, let alone for a physician working 80-hour weeks with 36-hour shifts every four days. Yikes! I also knew her to be a tough-as-nails, whip-smart resident, with no family nearby and no spouse. It was a marginally good thing that she had me to draw her blood and run it to the lab while she worked. There was no way she had time for doctor’s visits during the day.

Even I knew that a maternity leave of longer than her annual allotted four weeks of vacation would mean that Shoshana would be ineligible to “sit” for the American Board of Internal Medicine certification exam unless she completed an extra rotation. This would delay starting the job about which she was very excited.

I did not think to ask how she was planning to swing all this. It was not something we had time to talk about. I did, however, diligently track her down every hour for the next three to draw her blood. I did not see the lab results but, happily, she had a healthy baby just before residency graduation.

Jane’s story

While sitting on the couch in our call room, I returned a page from Rashida, a medical school friend and intern in the OB/Gyn program in our hospital. She asked me to check on Jane, one of only four other women interns in my Internal Medicine program. At that very moment, Jane was sitting right across the room from me. She looked peaked, exhausted, and mildly unkempt, but that was not unusual after a day of work.

I lowered my voice and asked Rashida to explain. “Jane had a dilation & curettage (D&C) last night,” Rashida said. “She had a miscarriage.”

Although Jane had been advised to go home and rest, she had checked herself out of the hospital and walked across the street for early morning rounds. Rashida and a fellow female resident, knowing that Jane was likely both physically and emotionally fragile, tried to convince

her to take the day off. The attending physician, though, warned them not to interfere. Rashida reached out to me, hoping I could keep an eye on her.

I asked Jane if she was feeling okay because she looked “worse than usual” (which was considered a loving thing to say in those days). I hoped she would tell me herself about the loss of the pregnancy. She did not. I did not push Jane out of respect for her privacy.

Things needed to change

Although becoming a physician is meaningful and personally satisfying, medical school and residency occur smack dab during a person’s peak reproductive years. While most physicians become parents, women-physicians tend to delay childbearing and are more likely to seek infertility treatment. I did. Until recently, these treatments were not covered by house staff medical insurance. Even with coverage, infertility treatment is time consuming, expensive, and difficult, both physically and psychologically. Women residents can be reluctant to share that they are pregnant and, because of the culture, feel compelled to make poor choices. The silence limits us taking care of each other, and impacts our health and wellbeing.

Why aren’t we better at planning for pregnant and parenting trainees?

Over the years, I became increasingly uncomfortable and aggravated with how our work culture muscularly, robustly, and intentionally ignores the personal challenges and basic physical needs of residents. Spurred by both my very personal interest and by the increased numbers of women in medicine, I became a bold advocate for the transformation of our training culture. I am proud that things are much better now, although it has taken decades too long.

How residency programs “handle” pregnancy

Suffice it to say you can learn a lot about a program’s core values by looking at its leave policies, staffing models, and available resources, such as flexible, low-cost childcare. While large programs in specialty areas that have historically had many women have experimented with creative models (Gordon, 2019), fields where there are still relatively few women, like cardiovascular surgery, still have work to do (Gemmato, 2022).

A 2022 comprehensive scoping literature review on physician pregnancy revealed persistent stigmatization and discrimination against physician pregnancy, despite evidence that work productivity and academic metrics are not negatively impacted. The authors point out that the higher obstetric and fetal complication rates for physicians compared to non-physician partners of physicians, as controls, are not found outside of the United States. They conclude, and I agree, that we need to better understand how physician pregnancy impacts colleagues and health care systems.

Doctors who are mothers deserve to be celebrated

We have a great deal to learn from cultural and societal contexts that are more family-friendly, and we need to address how pregnancy elicits negative perceptions of productivity which may lead to discrimination. Rigorous studies of physician pregnancy will guide effective and compassionate policies, ensuring a resilient, diverse future physician workforce in all clinical specialties and geographic regions.

No matter their gender, understanding the best ways to integrate childbirth and child rearing into clinical education and training is an investment that improves the lives of our future physicians and adds value by boosting physician wellbeing, enhancing clinical care, and recruiting our future generations.

To all of our colleagues who are also parents and young parents-to-be, I say, “We see you. We pledge to support you and celebrate your journey.” Happy Mother's Day!

The residents’ name in the stories told above have been changed.

For further reading:

Cusimano MC, Baxter NN, Sutradhar R, et al. Evaluation of Adverse Pregnancy Outcomes in Physicians Compared With Nonphysicians. *JAMA Netw Open.* 2022;5(5):e2213521. doi:10.1001/jamanetworkopen.2022.13521
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2792533

Gemmato, C. J., & Baldwin, A. C. (2022). Yes, we are both cardiac surgeons: One family's unique perspective on work–life balance. *The Journal of Thoracic and Cardiovascular Surgery*, *163*(1), 179-183. https://www.jtcvs.org/article/S0022-5223(20)33042-7/fulltext

Gordon, A. J., Sebok-Syer, S. S., Dohn, A. M., Smith-Coggins, R., Ewen Wang, N., Williams, S. R., & Gisondi, M. A. (2019). The birth of a return to work policy for new resident parents in emergency medicine. *Academic Emergency Medicine*, *26*(3), 317-326. https://onlinelibrary.wiley.com/doi/10.1111/acem.13684

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