Chapter 7
Childbearing, Adoption, Motherhood, and Eldercare by Women in Pediatrics

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Introduction

Women pediatricians assume a wide variety of key roles in their professional and individual lives which evolve significantly through the life course. In this chapter, we will follow a chronologic journey of different life stages: childbearing and adoption to motherhood to eldercare. We will discuss the current state as well as stage-specific barriers and discrepancies which are affecting women in our field at each phase. Ultimately, we will finalize with proposed systemic solutions which we hope to see in the future of pediatrics.

Fertility, Childbearing, and Adoption

> Some argue that women pediatricians work fewer hours per week than male pediatricians and take off months or years for childbearing and caring and therefore do not contribute as much as men. However, it can also be argued that men have more serious illnesses in later

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> life and live an average of 2 to 3 years less than women. Therefore, the overall total work hours might not be all that different. In any case, until men can bear children (not likely to happen), this is a moot point. In fact, if women stopped bearing children, there soon would be no need for pediatricians or, in fact, physicians. – Catherine DeAngelis, MD [1].

Fertility

Infertility disproportionately affects women in medicine; this is multifactorial and linked to the nature of our training which is extensive and spans the childbearing years. For women in medicine, the average age of first pregnancy is 30.4 years which is 7.4 years later than the general population. One out of four US women physicians have reported a diagnosis of infertility with an average diagnosis at 33.7 years. Approximately 30% reported diminished ovarian reserve as a cause [2]. Willet et al. examined gender differences among residents' plans to have children during residency and the most influential reasons for these differences. They found that after adjusting for age, institution, postgraduate year, and knowledge of parental leave policies, women were less likely to have children during residency with a threat to career explaining 67% of the gender variance [3]. For various reasons, many women in medicine feel pressure to defer pregnancy during their training, a period which correlates with their peak fertility years. Some of these reasons include stressors intrinsic to training, long hours and night shifts, high to low loan income ratio, and difficulties accessing high-quality childcare. Stentz et al. surveyed 600 women physicians and asked them to reflect on their reproductive and academic decision-making. When asked what they would do differently in retrospect, most respondents (56.8%) would do nothing differently regarding fertility/conception/childbearing, 28.6% would have attempted conception earlier, 17.1% would have gone into a different specialty, and 7.0% would have used cryopreservation to extend fertility [4].

Independent of the cause, it is important to note that infertility is linked to high psychological distress and is also associated with burnout among women in medicine [2]. Fertility coverage has been difficult to obtain with many obstacles in various states except for those few where coverage is legally mandated. Outside of medicine, the culture is changing as private companies such as Starbucks, Bank of America, and Tesla have shifted to include benefit packages which include multiple IVF cycles. However, the healthcare field has been slow to adopt these packages for physicians. As we build toward gender equity, diversity, and inclusion for women in medicine, it is important to bring up the inclusion of comprehensive fertility treatments. Providing comprehensive fertility benefits has been shown to yield improved physical and emotional well-being and job satisfaction, work force recruitment, and employee retention [2]. Comprehensive fertility treatments cultivate a family environment and helps attract and retain talent. These steps pave the way for women in medicine to advance to leadership positions.

The discrepancies and barriers for women in medicine continue from fertility into the childbearing stage. Stentz N et al. examined the level of perceived support for pregnancy at each level of training: before and during medical school, during training, and after training. Physicians who delivered their first child during medical school were significantly less likely to have perceived substantial workplace support than those delivering after completing medical training [4]. It is surprising to see this data as one may suspect residency training to have the lowest level of perceived support given its rigorous nature with long, inflexible work hours. It is important to note this point as we build interventions for women in medicine at each stage. We must take note that structural interventions must start as early as undergraduate medical education.

Childbearing

One thing which strengthens parental support during residency and fellowship training is the delineation of policies by residency programs as suggested by the AAP and ACGME. The pediatric AGCME requirements state that there are circumstances in which residents may be unable to attend work, including parental leave; each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities and the program must have policies and procedures in place to ensure coverage of patient care; these policies must be implemented without fear of negative consequences for the resident unable to provide clinical work and their fellow residents [5]. The ACGME points are vague and many argue there needs to be specific delineation of guaranteed minimum paid leave that will not require the extension of training [6].

The AAP Parental Leave for Residents and Pediatric Training Programs policy statement requests that pediatric residency programs should have an accessible, written policy for leave to avoid residents having to rely on departmental policies which may not be clear or not relevant for resident training. It delineates that at a minimum parental leave for residents and fellows should conform legally with the Family and Medical Leave Act (FMLA) and respective state laws and meet institutional requirements for ACGME. Regardless of gender, residents who become parents should be guaranteed 6–8 weeks at a minimum of parental leave with pay after the infant's birth. Coparenting, adopting, or fostering of a child should entitle the resident, regardless of gender to the same amount of paid leave as a person who takes maternity/paternity leave. In addition, the American Board of Medical Specialties (ABMS) has established policies requiring its member boards, which include the American Board of Pediatrics, to establish eligibility requirements that allow for at least 6 weeks of parental leave [7].

FMLA requires employers to grant workers up to 12 weeks of annual unpaid leave for the birth or adoption of a child. In order to receive this benefit, an employee must be employed for 12 months which means that residents during their first year of training or first year faculty members would not be eligible for FMLA.

A 2018 JAMA study reviewed childbearing and family leave policies for 15 graduate medical education institutions, and the study found that the average resident duration of childbirth leave was 6.6 weeks [8]. Comparatively, a JAMA 2018 study of academic faculty members at 12 US medical schools found that paid childbearing leave for childbearing mothers was 2 weeks longer with a mean of 8.6 weeks (range of 6–16 weeks) [9]. There is scarce data on average childbirth leave for private pediatricians, but one can infer that given challenges in the private practice world (RVU-based salaries, bonuses, and patient satisfaction score) that private practice pediatricians are not taking the leave they recommend for their patients.

Fertility and Childbearing Next Steps

The AAP has publicly endorsed 12 weeks of paid maternity leave based on the health benefits provided to the child; research in high-income countries show that prolonged parental leave is associated with higher rates of exclusive breastfeeding, on time immunizations, and decreases in neonatal mortality [10–12]. Despite pediatricians being experts in development and understanding the critical parent-child bond in the first 6 months of life, there is a discrepancy between what we recommend to our patients and what we do. However, it is important to highlight that the need for change needs to focus on systemic, institutional change which protect women as early as undergraduate medical education.

Each institution should have written policies with a minimum parental policy which at minimum conform legally with the FMLA state laws. These policies will allow for institutions to be proactive instead of reactive when a pregnancy is announced. Furthermore, written, accessible policies should be widely disseminated by human resource departments to promote early planning which can help reduce anxiety and feelings of guilt by the parent taking leave or any resentment from colleagues for extra work they may need to do in the physician's absence. Most of all given the individual needs of varied pediatric practices (private practice vs academic), it is important for institutional leaders to hold meetings with their faculty to determine the most satisfactory and cost-effective way to provide appropriate coverage during parental leave. This may mean temporary staffing with locum physicians or advanced practice nurses depending on the clinical scenarios. Advance planning may allow for planning to include incentives for physicians who take on additional work during a peer's parental leave. For practices to run smoothly, it is also imperative for the expecting physician to be professional and responsible and notify either the program director or department leadership far in advance when possible, to allow for proper planning. These steps will help cultivate equity in sharing workloads and protect physicians from overly strenuous experiences during their pregnancies which can influence physician wellness and gender equity.

Motherhood

Current State: Challenges and Barriers Faced by Pediatrician Mothers

As pediatrician mothers transition from maternity/family leave and reenter the pediatric workforce, a number of new challenges present themselves. In a recent systematic review of challenges and solutions for physician mothers, Chesak et al. described that these barriers can be organized into individual, organizational/systemic, as well as societal levels [13]. Individually, physician mothers face challenges related to work-life integration, threats to career success, and burnout and mood disorders. Organizational challenges were identified to include a lack of mentorship from and role models who are women to support professional development as well as family leave policies and other policies and/or expectations that affect activities such as breastfeeding, part-time work opportunities, and other expectations surrounding work hours. Finally, on a societal level, factors including gender/sex inequities, maternal discrimination, and challenges related to childcare were noted to reflect society perceptions of physician mothers.

In a related systematic review on the experiences of mothers who are doctors, Hoffman et al. identified three core themes relevant to motherhood and medicine as follows [14]. These themes included the impact of being a doctor on raising children, the impact of being a mother on a medical career, and the strategies and policies that are needed to assist women as they balance motherhood and a medical career.

Regardless of the organizational framework, it is clear that many challenges exist for women pediatricians. In a large cross-sectional nationwide survey of 844 physician mothers, Juengst et al. noted that the most frequently negative experiences when returning to work after family leave as lack of breast pumping facilities (32%), time for breast pumping (48%), difficulty obtaining childcare (35%), and discrimination (18%) [15].

While these national studies have identified important themes relevant to the challenges of motherhood and medicine, the specialty of pediatrics is unique as the majority of early career pediatricians are now women with young children. The American Academy of Pediatrics Pediatrician Life and Career Experience Study (PLACES) is an ongoing longitudinal study monitoring the personal and professional experiences of early and mid-career pediatricians that provides a unique opportunity to examine the perspectives of many pediatrician mothers. While Starmer et al. found that having children was not associated with differences in rates of burnout, work-life balance, or career or life satisfaction, these analyses did not compare these outcomes according to gender [16]. In a companion study, women pediatricians were found to be significantly more likely than male pediatricians to report having primary responsibility for most household responsibilities including routine care of children, cooking, and cleaning. Furthermore, women pediatricians

were less satisfied with how responsibilities were shared [17]. PLACES pediatricians participating in the study who have children less than 18 years of age also had a higher odds of always feeling rushed (aOR 2.83, 95% CI 2.05–3.92) [17].

Impact of COVID-19

An important contextual factor that has been shown to increase existing disparities including the challenges faced by pediatrician mothers is the COVID-19 pandemic. A cross-sectional study of 266 physicians in Japan noted that physician mothers demonstrated an increased domestic burden as compared to physician fathers during the pandemic [18]. Specifically, 58% of physician fathers surveyed were from two-income families and had a partner that primarily cared for children, whereas 97% of physician mothers were from two-income families and 95% of the physician mothers reported having to primarily take care of children by themselves. A mixed methods survey of 1806 members of the Physician Moms Group noted that parents with elementary school-aged children frequently raised concerns about homeschooling (44%) and work-life balance (28%), citing qualitative examples of physician mothers who noted, "I'm coming home to a full day of schoolwork after I worked a full day." Additional commentaries and studies noted concern for challenges for women physicians during the pandemic related to decreased academic productivity and compensation, as well as increased mental health and safety concerns such as anxiety and the unknown likelihood of transmission of COVID-19 while breastfeeding [19, 20]. Significant concern has been raised that the family-related care disruptions due to COVID-19 will likely have a profound long-term impact on academic advancement for women working within academic medicine [21].

Solutions and Policies Supporting Pediatrician Mothers

To address and surmount the many challenges and barriers faced by pediatrician mothers both historically and in the context of the COVID-19 pandemic, many strategies and policies have been suggested and trialed to assist women who are working to balance the often-competing demands of a medical career and motherhood. These strategies frequently include mention of the need for policies to expand childcare and breastfeeding facilities. One survey of pediatricians noted that child-friendly workplaces that offered on-site childcare and lactation rooms were considered more likely to be seen as a preferred site for residency training [22]. This notion of having ready access to quality, reliable childcare including off-hours care was identified in multiple additional studies of physician mothers generally as being a key factor to support completion of training as well as career satisfaction [13].

Policies that allow for increased flexibility, such as the inclusion of part-time training options, as well as having increased flexibility in scheduling and call schedules are essential to support pediatrician mothers. In the PLACES study of early and mid-career pediatricians, having advance notification of work schedule was noted to be more likely to be associated with life satisfaction, whereas working in a hectic/chaotic work setting was more likely to be associated with experiencing burnout and lower perceived work-life balance [16].

Mentorship and the support of physician colleagues has also been identified in multiple studies to be a key factor associated with the general well-being and success of pediatrician mothers. Opportunities along these lines include ensuring access to physician mothers as mentors who have demonstrated success at achieving work-life balance as well as implementing facilitated support groups. In a study examining the qualities of ideal mentors, the most common quality was the ability to successfully balance family and full-time practice.

Finally, it is important to note that while policies supporting mentorship, flexibility in work-hours, and access to childcare and breastfeeding support are critical steps toward enhanced support for physician mothers, bias and stigma may still be present that contribute to maternal discrimination [13].

Eldercare

Introduction

An additional challenge for the pediatric workforce is eldercare. By the year 2030, it is projected that 20% of Americans will be 65 or over, exceeding the number of Americans that will be children under 18 [23]. Women pediatricians may be disproportionately affected by this trend. In 2020, the AARP conducted a quantitative study of caregiving. 1392 households were surveyed demonstrating that 16.8% US adults care for someone over 50, up from 14.3% in 2015. Of these caregivers, 61% are women. Women experience caregiving differently as well, increasing the potential demands on them [24]. The 2008 National Study of the Changing Workforce noted that although in their sample men and women were equally likely to have been caregivers, the women provided more regular rather than intermittent care and for more hours per week. Almost half of the women caregivers (46%) were part of the “sandwich generation” caring for children under 18 at home as well [25].

Studies looking at the population at large have demonstrated work impacts for caregivers providing eldercare. The AARP survey in 2020 found that 60% of caregivers were still working and of those 61% experienced some form of a work impact such as going in late or needing to leave early [24]. These types of work impacts have the potential to be even more challenging for physicians as flexibility to adjust one’s schedule on short notice is generally lacking with the responsibility to provide

clinical coverage and direct patient care. The 2011 National Health and Aging Trends Study found that caregivers providing substantial help, representing 44.1% of caregivers in their sample, were 3x more likely to experience work productivity loss [26].

Current State

Little is published to date about physicians in general as well as pediatricians about the impact of the need to provide eldercare. Much of the literature about women pediatricians focuses on the need to provide childcare and the early career impacts. Templeton, in 2020, surveyed senior women physicians in all disciplines to evaluate their readiness and attitudes toward retirement. Like other data looking at the workforce overall, 20% of the women physicians surveyed were caretakers, with 41% caring for grandchildren, 38% caring for aging parents, and 29% caring for a spouse. Of the group that identified as caretakers, 25% were caring for more than one category [27]. This study suggests that caretaking for women physicians is an issue across the career spectrum, not just for early career practitioners.

Yank et al. conducted a survey of a Physicians Mom's Group on social media, a group with 16,059 members from which there were 5613 responses.16.4% respondents reported additional caregiving responsibilities beyond caring for their children to a friend or family member with a long-term health issue. Of those 48.3% were caring for parents, 16.9% for children or infants, 7.7% for their partners, and 28.6% for other relatives. 16.7% cared for more than one person. Within the 5613 respondents, 989 were pediatricians. Of the 989, 172 (17.3%) had additional caretaking responsibilities, similar to the numbers reported rest of the group. Of note when they compared the group with additional caregiving responsibilities and the group without, while career satisfaction was equivalent, the rates of burnout and mood and anxiety disorders were higher among the women who had additional caregiving responsibilities [28]. Number of hours spent caregiving has been associated with depressive symptoms, with women reporting such symptoms more than men [29]. Wolf reported on data from the 2011 National Health and Aging Trends Study showing that caretakers providing substantial help (44.1% of caretakers in their sample) were at increased risk of emotional difficulty, physical difficulty, and restrictions in participation in valued activities, as well as work productivity loss [26].

In general, combining work and caregiving responsibilities often leads to conflict among the caregivers' work, family, and personal roles [24, 25, 28]. This leaves caregivers at risk for not having adequate energy for any of the roles. For physicians the timing of these demands may come when they are entering mid-late career leading to conflict with leadership positions and continuing on the pathway to promotion. Such demands may result in impediments to women pediatricians being able to take on leadership roles as they may find themselves geographically restricted

again as well as needing a more flexible schedule. This may create new barriers for women pediatricians serving in leadership roles even as some of the pipeline issues are addressed.

COVID-19 has exacerbated these time challenges for women. A survey conducted by the National Academies of Sciences, Engineering, and Medicine found women in academic STEMM fields are experiencing increased workload and decreased productivity with the COVID-19 pandemic. The pandemic has exacerbated preexisting gendered division of household labor combined with increased needs for eldercare as well as difficulties with childcare that are disproportionately affecting women. While there have been some institutional accommodations such as extensions on evaluations or grant extensions, these may not be adequate to address the impact on women and may not be exactly what is needed from the institutions at this time to support women, who may need interventions such as a reduced work schedule rather than just extensions. The study calls for further research to prevent STEMM women faculty from falling behind [30].

Solutions

Similar to other challenges around childbearing, workers who are family caregivers in the expressed that what they needed most from the workplace to support them was flexibility in the work schedule – the ability to make schedule changes on short notice, occasional time off during the workday to attend to scheduling needs or appointments, and the ability to either compress one's schedule or work from home. Often, employees expressed that they wished they could access leave time without using vacation first (Table 7.1). One comment that came through in this survey was looking for understanding from management [25]. A commentary highlighted this need for flexibility from a pediatrician viewpoint, noting among the challenges or caring for aging parents being needing to spend time during the workday addressing issues with insurers or financial companies, creating a conflict between the need to make those calls and clinical and scholarly responsibilities [31]. We would anticipate similar themes would emerge from women pediatricians. Eldercare needs to be supported and discussed by leadership to facilitate retention of senior physicians. More study is needed to further explore the impact on women pediatricians.

Table 7.1 Common challenges faced by caregivers and possible solutions

Challenge	Solutions
Need for flexibility to attend appointments, make phone calls during workweek, as well as make schedule changes on short notice	Flexible scheduling such as allowing compression of one's schedule into fewer days or the ability to occasionally work from home
Need for flexibility in vacation time use	Ability to access leave time before vacation days when used for caregiving

Conclusions

Childbearing, motherhood, and eldercare have multiple impacts on women pediatricians that may impact their longitudinal success as well as work-life integration. There are reported impacts on finances. One in five workers providing eldercare report financial hardship [24]. For women pediatricians in general, data from the PLACES study, looking at self-reported earnings from a sample of 1213 early and mid-career pediatricians, demonstrated that women pediatricians were paid less than men. When looking at work-life factors, such as marital status, parental status, choices in work income, or hours for their children, women who had made choices for their children earned significantly less than those who did not, suggesting women are accepting lower salaries for nonmonetary considerations such as flexibility in schedules, fewer hours working, or geographic location [32]. There is impact on the career trajectory for women as well. Carr et al. reported that women faculty with children published less and had less support overall than their male colleagues [33].

Women pediatricians struggle with work-life integration as well. Tawfik looked at work-life integration in physicians and found lower work-life integration in physicians than in the general population, with lower levels in women physicians. Pediatrics was noted to be one of the specialties with the largest gap between men and women [34]. Starmer et al. reported that women pediatricians spend more time on household responsibilities than men [17].

A position paper by the women chairs of AMSPDC identified four areas of focus to improve work-life balance for early career pediatricians as well as to attempt to rectify the balance of women professors in pediatrics. The areas of focus suggested were:

1. The option to work part time – recognizing the need for flexible schedules as the optimal time for childbearing may also be the optimal time for career advancement
2. The need for high-quality childcare availability
3. The integration of flexibility in the physician scientist pathway to allow for "stopping the clock" in the tenure pathways
4. A desire for more women in leadership positions which would link to things like bias training in recruitment and support for formal leadership programs for women [35]

One crucial factor to bear in mind as we look for solutions to address the challenges women pediatricians face as they balance childbearing, motherhood, and eldercare with their career is to avoid solutions that put the burden on the women to fix the issues. McDonald noted the gender bias in literature discussing work-life balance issues, for example, describing how women face "tough choices" in balancing demands of career and family while men were "commendable" when they placed work obligations over home [36]. Often solutions in the literature focus on ways to "educate" women, and encouraging advice like hiring help and prioritizing relationships, without similar recommendations being made for male physicians [36]. Part of moving toward change is challenging these gendered inequities without putting

the burden back on women to fix the system, but rather implementing systemic change to allow women the flexibility needed in their schedules as well as the mentorship and leadership opportunities.

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