Chapter 2

Parental Leave During Surgical Training: Gender Equity, Parental Leave, Parental Policies, Childbearing, Conciliation, Surgery

Patricia Maria Saez Carlin
Hospital Clínico San Carlos, Universidad Complutense de Madrid, Spain

ABSTRACT

Work-family conciliation is currently in vogue. However, reality demonstrates that there is still a long way to go before being forced to make a choice between work, family, or personal life. Can a balance be achieved among the three? In relation to the medical profession, is there currently an adequate conciliation policy? Can these strategies be extrapolated to the training period? The proposal in this chapter consists in carrying out an up-to-date analysis on the parental leave situation during medical training as one of the main aspects of conciliation, by analysing parental leave policies and barriers faced by surgical trainees.

CURRENT STATE OF GENDER PARITY IN THE HEALTH SYSTEM

Gender balance in the medical workforce is changing (World Health Organization [WHO], 2006) and currently, the presence of female doctors in daily medical care is a fact. However, it has taken many centuries to recognize women as medical professionals and to change people’s mindset in terms of gender equity.

The figure of a woman as a healer goes back to ancestral times. Yet, women’s role in the story of medicine has remained in the background for years and has not been recognized until a few decades ago. Because of women’s particularly feminine qualities such as altruism or delicacy, in combination with skills gained and fulfilled during motherhood and childcaring, they have been implicated throughout history in taking care of the sick and the needy, an occupation which has been described as “caring-
work”. However, due to traditional superiority of men over women, their work was usually disdained and relegated to the treatment of patients who lacked economic resources and could not afford the cost of a male doctor. Therefore, women-healers were mainly requested by patients as a last resort to treat their diseases and were, for a long period of time, dismissed and even considered to be witches.

The 19th century brought the era of “modern medicine” and the idea of professionalisation began to gain importance in every job sector (Witz, 1992). Yet, only men were included in the medical workforce as women were still not allowed to entry medical schools. Therefore, this major progress in the evolution of professional education implied the creation of new barriers for women, who were again excluded from training and from access to university. This situation led to women sometimes seeking their own opportunities and training and working incognito.

It was not until the end of the century that the first female medical school was created. From then on, there has been an increase in the number of women practicing medicine (Blackmore, 2013). This was mainly motivated by the arrival of global social changes during the 20th century in terms of improvements in gender equity. Additionally, female access to medical education was also favoured by the World Wars. The need for qualified personnel to join the armed forces resulted in opening the quota of women to access medical training. However, despite these advances, women continued to be economically dependent on their husbands and were limited by household chores. Their mandatory and sole responsibility over family and domestic chores has been, after their access to university education, one of the principal obstacles of women’s incorporation into the workplace. It must be highlighted that this obstacle remains unresolved as will be commented later in the chapter.

During the last decades, and linked to the idea of professionalization mentioned above, society has demanded a qualification system for professionals, in which doctors in the health sector have been equally included. This modus operandi promotes professional certification based on the results of impartial exams and on the achievement of career merits which has secondarily, decreased gender, sex or social class inequalities. Consequently, the improvements in gender barriers achieved by the mentioned system has increased the number of female medical university enrolments. The good marks accomplished by female students in school, better than male in the majority of centres, have consolidated a progressive entry of women in medical schools, once the gender restriction has been overcome.

With all this, the latest data reveal that female medical graduates in the United States reached 47.3% in 2017 (Association of American Medical College [AAMC], 2018) with similar statistics in European countries (45% in the United Kingdom, (Medical’s Women Federation [MWF], n.d.)) and comprised more than 40% of general surgery residents. Nevertheless, in many countries, the distribution of women by occupational category tends to lean in favour of nurses and midwives and other ‘care’ jobs as community health workers. Accordingly, women are often underrepresented in other categories, for example, doctors, dentists, pharmacists and managers (WHO, 2008).

However, although absolute barriers to women accessing the medical profession based on gender have disappeared in most countries, new barriers are coming to light (Elston, 2009). With regard to this, one of the principal barriers currently under debate is related to pregnancy and childcare. Motherhood is a reality that essentially affects the female sex and as a consequence, indirectly and mandatorily represents a challenge for women when deciding a professional career. Various studies show that even among the most highly educated women (those with a master’s degree or higher), 80% have had their first child by age 34 (Livingston, 2015), which coincides with the medical training period. Female medical students and trainees still face comments that discourage them from choosing surgery, with sexist comments such as “do you not want to have a family” not infrequent. Secondarily, lower rates of advancement of women
Related Content

Deconstructing Cultural Stereotypes to Improve International Students’ Interculturality: A Short-term Experimental Approach in a Malaysian Pre-France Programme
[www.igi-global.com/article/deconstructing-cultural-stereotypes-to-improve-international-students-interculturality/156497?camid=4v1a](www.igi-global.com/article/deconstructing-cultural-stereotypes-to-improve-international-students-interculturality/156497?camid=4v1a)

Using Digital Storytelling to Inform Students About Bullying: Results of a Pilot Program
[www.igi-global.com/article/using-digital-storytelling-to-inform-students-about-bullying-results-of-a-pilot-program/169967?camid=4v1a](www.igi-global.com/article/using-digital-storytelling-to-inform-students-about-bullying-results-of-a-pilot-program/169967?camid=4v1a)

Women-Founded Start-Ups: Bigger, Better, Faster, More!
[www.igi-global.com/chapter/women-founded-start-ups/233190?camid=4v1a](www.igi-global.com/chapter/women-founded-start-ups/233190?camid=4v1a)

Bridging Gender Gaps in Provision of Agricultural Extension Service Using ICT: Experiences from Sokoine University of Agriculture (SUA) Farmer Voice Radio (FVR) Project in Tanzania
[www.igi-global.com/chapter/bridging-gender-gaps-in-provision-of-agricultural-extension-service-using-ict/182110?camid=4v1a](www.igi-global.com/chapter/bridging-gender-gaps-in-provision-of-agricultural-extension-service-using-ict/182110?camid=4v1a)