

# *Peering Over the Ether Screen: The Mommy Track*

*By Karen S. Sibert, M.D., Associate Editor*

The phone rang one recent Saturday, and on the line was a sweet-voiced young undergraduate from the East Coast university where my son is a junior. She was raising money for the university's annual fund drive. After I agreed to donate (thinking wistfully of all the money I already pay the school), she asked if I would mind answering a question. Not at all, I said. The rest of the conversation went like this:

**Student:** I see that you're a doctor. What specialty are you in?

**KS:** Anesthesiology.

**Student:** How is that? I'm thinking of doing premed, and I'm wondering what field to go into.

**KS:** You'll have lots of time to figure that out. Once you're in medical school, you'll rotate through all different areas, and eventually you'll find the field you really love. I was fascinated with pulmonary medicine and cardiology but loved being in the operating room, so anesthesia was the perfect fit.

**Student:** No, I mean how is anesthesia in terms of lifestyle? Like, I want to have kids some day and I want to find a specialty that will work out OK for that.

**KS:** That's the wrong way to approach that decision. You shouldn't pick a medical specialty that you aren't excited about just because you think it will be easier. That's a good way to have a very unhappy career.

**Student:** You have kids, right? Do you work full time? What are your hours like?

**KS (growing testy):** Yes, I have kids and I've always worked full time. In fact, my days at the hospital can be quite long, because it's impossible to predict how much time a major operation may take. And then there are emergency cases and night call.

**Student:** That's not what I was hoping to hear.

**KS:** If you want to be a doctor, be a doctor. If you want a hobby, open a bakeshop.

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After I got off the phone, my husband looked at me with a bemused smile. “Boy, she really poked the rattlesnake, didn’t she?” he said.

Yes, she did. I do realize that times have changed. When I started medical school in 1979, women were a minority in the class, and we were determined to work just as hard and prove that we were just as capable as any of the guys. It was the same during residency. Duty hour restrictions, of course, were unheard of then. We were mindful of the fact that if we failed, the doors that were opening up for women in medicine might well close.

That fear was unfounded. It’s unthinkable now that medical school admissions officers would discriminate on the basis of gender. As of 2010, the Accreditation Council for Graduate Medical Education (ACGME) reported that 42 percent of all residents are female. We have the opportunity to be just as dedicated—or not—as our male colleagues. So what are we doing with all of our new opportunities?

Apparently my young friend on the phone wasn’t alone in taking “lifestyle” into account as she considers medical specialties. In a 2006 article looking at gender distribution among anesthesiology residents, Steven Rose and his colleagues at the Mayo Clinic commented, “Lifestyle issues are often cited as an important consideration in the selection of a specialty for residency training, and anesthesiology is often included in lists of specialties said to be associated with favorable lifestyles.”<sup>1</sup> (I must be doing something wrong; clearly I’m working much too hard.)

However, women are still underrepresented in anesthesiology compared to some other specialties. Only 36 percent of current anesthesiology residents are women, which is about the same as the percentage of women residents in nuclear medicine and emergency medicine.<sup>2</sup> It may be, Rose speculates, that the “patient-physician relationship” isn’t considered rewarding enough to attract women into anesthesiology.

We all know where the female medical students are heading these days to look for rewarding patient-physician relationships. They go into obstetrics-gynecology, where the ACGME reports that 79 percent of residents now are women. They’re also going into medical genetics (65 percent), pediatrics (63 percent), dermatology (62 percent), allergy and immunology (56 percent), family medicine (53 percent), anatomic pathology (53 percent), internal medicine/pediatrics (52 percent), and psychiatry (51 percent).<sup>2</sup> That’s fine, although the patient-physician relationship in anatomic pathology does seem questionable.

## Peering Over the Ether Screen (cont'd)

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There is a problem, though, when so many women go into medicine and then decide to cut back to part time after their children are born—choosing the “mommy track.” You can tell this is a trend when *The New York Times* publishes a piece, as it did on April 7, headlined “The Doctor Is In...or Maybe She Isn't.”

The loss in productivity of working part time during prime years occurs disproportionately among primary care doctors,<sup>3</sup> and it has real consequences for the delivery of care. Any health care reform effort, like that in Massachusetts, sets its sights on improving access to primary care among poor, underserved populations. You can't provide better access to care if the primary care doctors aren't working.

In England, where 76 percent of young general practitioners are women, the severe national shortage of physicians is blamed at least in part on the “increasing feminisation of the workforce.”<sup>4</sup> A spokesman for the British Medical Association presciently noted in 2001, “The newest recruits to general practice are not intending to follow the same full-time career path as their older colleagues.”<sup>5</sup>

A case in point is Carol Cassella, anesthesiologist and novelist, whose latest book is “Healer” (reviewed in this issue; see pages 87–88). She initially trained in internal medicine and worked in primary care at a Seattle public health clinic, but tired of that and completed a second residency in anesthesiology. Now she works part time as an anesthesiologist. Cassella wrote recently, “When my children ask me if I want them to become doctors, I have to tell them truthfully that I could not go back to doing that work full time. I found it too emotionally exhausting.”<sup>6</sup> Her point of view is understandable, but two residencies add up to a great deal of postdoctoral training that isn't being put to full use.

The fact is that the part-time route—the “mommy track”—is a choice for women in affluent families. Many have successful partners who make that choice possible. No doubt these women are sincere about wanting to spend time with their families, but I wonder how many of them fully considered the conflicting demands that medicine and motherhood would make before they accepted (and denied to others) sought-after positions in medical schools and residency.

Although it's hard to know what the numbers are, clearly some women are deciding to take the “mommy track” a step further and give up medicine altogether. Naturally there's a Web site devoted to this topic, [www.womenleavingmedicine.com](http://www.womenleavingmedicine.com). Its manifesto states, “Women physicians have the right to nurture their families to the extent they desire,” and it offers “stories and resources for women

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physicians who have decided to quit medicine, for all kinds of reasons.” The blog comments are illustrative: “There is so much more that defines women who chose medical careers than a medical degree.” A young mother writes, “My 16-month-old deserves his mommy more than my patients.”

Yet amid the celebration of staying at home, there’s another side to the blog story. A cautionary note comes from a young woman who finished residency and now is home with her toddler: “Part-time work has been harder to find than I thought, and now, I’m increasingly being told that if I don’t do something, anything, I may never be hired.” The saddest post is from a former pediatrician: “Long story short, I’m now 56, divorced, and need a job. My youngest child just turned 18. Getting back into medicine is prohibitively expensive and the route is unclear. My biggest problem is how demoralized I am. I once had it all.” The message is clear; once you leave medicine, it isn’t easy to opt back in.

In fairness, male physicians are leaving clinical medicine too, although few of them choose the “daddy track.” Their motives appear to be different. Joseph Kim, physician and founder of the Web site [www.NonClinicalJobs.com](http://www.NonClinicalJobs.com), lists money at the top of his list of reasons to leave clinical medicine, and writes, “Let’s face it. Some physicians love money. They may be good at their job, but they have a stronger passion for a higher salary.”<sup>7</sup> Some physicians get MBA degrees so that they can go into hospital administration, become entrepreneurs, or work for pharmaceutical corporations. But they too are leaving years of clinical training behind.

Medical education and residency training are not financially self-supporting. Your tax dollars and mine help train the next generations of doctors. In 2008, hospitals with graduate medical education programs received \$3 billion in direct support from Medicare to help cover stipends for residents, salaries for teaching physicians, and related overhead expenses.<sup>8</sup> Are we expected to support the education of more doctors each year to compensate for those who don’t want to use their medical training to take care of patients? Or will we allow advanced practice nurses to do what should be our work?

Perhaps we need to take a more active role in guiding young premedical students *before* they apply to medical school. At 21, many are not prepared to make a decision as profound as the one to become a physician. Certainly there are those who know from an early age that they want to be doctors. They play with plastic doctor kits and junior microscopes, read books about great medical discoveries, and volunteer in hospitals as soon as they’re old enough. These students are ready when the time comes to go straight to medical school.

Other college students, however, may not truly be ready to make the commitment that medicine deserves. They may not understand the financial realities of clinical practice, and how difficult it may be to combine medicine and motherhood. Undergraduates who are ambivalent, or already looking for ways to work less, should be encouraged to take some extra time. They should find jobs, see the real world, talk with working physicians, and decide from a more mature vantage point if the life of a physician is what they really want.

Despite reduced payments and infinite paperwork, medicine is a noble profession. It shouldn't be either a hobby or an overused steppingstone to a more lucrative nonclinical career. In the simplest terms, patients need us to take care of them. We have an obligation to do the work we promised to do when we wrote those essays for our medical school applications. If a young college student is already drawn to the "mommy track" before she's seen her first patient, maybe medicine isn't her true vocation. Maybe next year's place in medical school should go to someone—male or female—more dedicated to patient care.

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