Sustaining Career through Maternity Leave

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**ABSTRACT** The focus of this paper is the expectations and plans relating to their return to work and subsequent career management of health professionals following a current period of maternity leave. A questionnaire was sent to staff in designated health professional occupations who were on payroll records of the Department of Health, Western Australia and one private sector healthcare provider as on maternity leave on a specified date. The data obtained point to a combination of organisational (employer) and institutional (professional associations and government regulation) factors which were perceived by these women as potentially restricting opportunities for them in the workplace on their return to work and hence slowing and restricting their longer-term career development.

**Keywords:** women and work, work and family, equal employment opportunity, work/life balance

**INTRODUCTION**

Empirical evidence shows that childbearing has a considerable impact on workforce outcomes and experiences for women. Estimates of forgone lifetime earnings of women who have children have identified considerable earnings penalties (Breusch & Gray 2004; Chapman, Dunlop, Gray, Liu & Mitchell 2001; Loughran & Zissimopoulos 2008; Napari 2010). Breusch and Gray (2004), using 2001 HILDA data, found there is a substantial effect on lifetime earnings which increases (at a declining rate) with number of children. They found that proportionately, women with higher levels of education forgo less; nevertheless, a woman with a university degree and two children, compared with the lifetime earnings of a childless university educated woman, forgoes around 40 percent in earnings. Loughran and Zissimopoulos (2008) and Napari (2010) considered the wage gap rather than lifetime earnings. The Human Capital model is called upon to explain these forgone earnings resulting from employment breaks and part-time work by mothers, plus depreciation of human capital resulting in re-employment in lower status occupations or positions (Breusch & Gray 2004; Napari 2010).

It would be easy to accept the Human Capital explanation for these measured long term workforce outcomes for women who are mothers. However, variability in outcomes suggests that it is important to explore further the workforce experience of women who are mothers. One critical aspect of this experience is the return to work by mothers following maternity leave. This paper focuses on the plans and expectations of women health professionals for their return to work following a period of maternity leave, with particular emphasis on their expectations relating to organisational and institutional support and career impediments. Their transition back into their profession following
maternity leave has long-term implications for their professional status and career and thus their earnings profile. Decisions had already been made by these women in relation to occupation, early career trajectory, childbearing and, by virtue of taking maternity leave, the intention to return to the workplace following child bearing. Thus it is not our intention to explore broader theoretical positions such as Hakim’s (Hakim 2000) preference theory or Crompton and Harris’s structuration approach to women’s work and career decisions (Crompton & Harris 1998). The focus is specifically on the impediments and problems faced by these women to effective resumption of their professional career following a period of planned maternity leave.

LITERATURE

Much of the research focus on women’s return to work after maternity leave has been on employment conditions, employee relations and instrumental issues such as breast feeding and child care as immediate adjustment issues. The ability to resume a career and related career management questions have received less attention. Research has shown that the support a woman receives from her supervisor and peers can impact significantly on her experience of maternity leave and her decision to return to work (Buzzanell & Liu 2007; Houston & Marks 2003; Lyness, Thompson, Francesco & Judiesch 1999). The management of maternity leave, involving managers, colleagues and the women themselves, has also been found to have a direct influence on an employee’s decision to return to work (Houston & Marks 2003; Millward 2006). Planning during pregnancy about how a woman will return to work can be an influencing factor on whether she does return after maternity leave and in what capacity. A longitudinal study by Houston and Marks (2003: 209) found that ‘if women make plans during pregnancy about how they will return to work, they are much more likely to do so. This has a greater effect on return to work than income’. The employer must also plan, organising cover for her position and deciding how much contact should be maintained with her during leave. Millward (2006) argues that organisations need to actively manage the transition of women to maternity leave and back into the workplace. If this is not done sympathetically and in consultation with the woman, Millward (2006: 329) suggests that she ‘may end up feeling like a disposable resource a long time before formal leave commences, contributing to feelings of alienation during the
leave period, followed by difficulties with work reintegration’. Buzzanell and Liu (2007) describe maternity leave as a ‘conflict management process’, made up of complex interactions and tensions.

Of significance for employment outcomes is the level and type of employment to which a woman is able to return following maternity leave. Lyness et al. (1999: 501) found that women who were guaranteed jobs similar to or the same as the one they were leaving ‘planned to work later into their pregnancies and return more quickly after childbirth than women without guaranteed jobs’. This is a critical issue for women who have consciously developed a career path and who expect to have continued access to promotion and training (Barron & West 2005). The fact that the status of work done is often reduced amongst those who return to part-time work is also an influencing factor, in terms of career, self-esteem and income (Houston & Marks 2003). Millward (2006) argues that the decision to return to work following maternity leave can be affected by feelings of guilt and self-doubt by women about whether they can be both a good mother and a good employee. These attitudes can be reflective of those of society. Attitudes towards returning to work may change during maternity leave if the woman experiences dissonance between her attitudes and her behaviour (Houston & Marks 2003). Her original preferences and ambitions may change as a result of limitations and constraints that are put upon her.

A number of researchers have looked specifically at issues around professional status and career advancement for women with children (Bullock & Morales Waugh 2004; Carney 2009; Whittard 2003). In particular, professional/workplace cultural issues involving work norms of long hours and availability result in disadvantages for women with children, with such women assigned to positions where lower training and career prospects apply when these norms hold sway (Carney 2009; Reed, Allen, Castleman & Coulthard 2003). Carney (2009) argues that, on the basis that these women divert from the ‘ideal worker’ model, it is the result of systemic discrimination.

While the return to work following maternity leave is significant for all mothers, professional women working in the health industry face industry specific difficulties. Nurses, Allied Health Professionals
(AHPs), and medical doctors work in a stressful environment often requiring shift work or on-call arrangements that are not conducive to arranging stable childcare. Medical doctors face additional difficulties when combining motherhood with specialist training. As with other professions, there appears to be a correlation between the amount of pre-maternity leave preparation and the successful transition back to the work place. Khalil and Davies (2000) emphasise the need for discussions at unit level, outlining options and negotiating flexible work patterns. They emphasise the need to include work colleagues in these discussions to avoid the perception that the working mothers are receiving preferential treatment, and the perception of the mothers themselves that they are resented. Durand and Randhawa (2002) caution that the relationship between existing full-time nursing staff and returning mothers needs to be managed to avoid creating a two-tier system, and that ‘family-friendliness and flexibility are applied equally to all employees’ (Durand & Randhawa 2002: 485).

The culture and expectations of the professions are important institutional influences on the experience of return from maternity leave. In the past, the working hours of the medical profession have been skewed towards long hours because the majority of medical doctors were men (Verlander 2004). In a study by Mayer, Ho & Goodnight jr. (2001) 26 percent of male surgical graduates described their wives as homemakers, while all of the female graduates had a spouse working in the same or another profession. Women medical doctors who must balance the needs of family and work may be forced to choose those specialties that offer the most flexibility, such as general practice and psychiatry, rather than those such as surgery (Verlander 2004). From a study of graduates from a university general surgical training program, Mayer et al. (2001:652) conclude that ‘A comprehensive policy on maternity and paternity leave could require profound changes in the structure of surgery residency training and the practice of surgery’. Potee, Gerber & Ickovics (1999: 918) argued that ‘possible real changes in medical training are infrequently addressed, or, when they are, the changes emanate from legislative action or union negotiations and not from the medical establishment’.

Studies have asked female medical doctors whether they had made a trade-off between family and career, and the impact of parenting on their levels of professional satisfaction. Potee et al. (1999: 914)
found that of those women who did not have children, 35 percent ‘felt as though they had to choose
between medicine and motherhood’. The careers of 62 percent of those with children had slowed or
markedly slowed. Jagsi, Tarbell & Weinstein (2007: 1889) suggest that ‘the personal and educational
needs of trainees with children often collide with their colleagues’ expectations [and] their hospitals’
workforce needs’; they may be perceived to be receiving special treatment or to have a diminished
dedication to medicine and their career (Verlander 2004). The research on maternity leave and health
professionals discussed above places the focus on enabling actions and barriers which are either
organisational or institutional. Many of these barriers appear to be reflective of broader professional
and community expectations and constraints.

The objective of this paper is to focus on the professional issues relating to return to work and career
management of health professionals on maternity leave and to identify whether there are institutional
and organisational actions and policies which are considered to be likely to impact their career
progress following maternity leave. Understanding of the perceived professional issues faced will
guide policy to enable improved outcomes for professionals who are mothers. Instrumental issues
such as child care are the subject of another paper. The ongoing labour shortages within some health
professions, the high initial training costs for these professions and the relatively high proportion of
women in these professions makes the decision by health professionals on maternity leave to return
and to pursue further career success also a critical issue for the health industry and the economy.

METHODOLOGY AND DATA COLLECTION

Data were collected via a questionnaire from health professionals undertaking maternity leave. The
Department of Health, Western Australia (DHWA) and one private sector healthcare provider
facilitated the study by sending the questionnaire to all staff in designated health professional
occupations who were currently (June 2010 for DHWA, September 2010 for the other provider) on
their payroll records as on maternity leave. Health professional was defined as all nurses, medical
doctors, physiotherapists, occupational and speech therapists, psychologists, social workers,
pharmacists, dieticians and medical imagers. Approximately 920 surveys were distributed by DHWA
and 150 by the private provider. We received 340 responses from DHWA staff, a response rate of 37 percent and 48 responses from staff of the private provider, a response rate of 31 percent.

The questionnaire was developed following analysis of the literature and was piloted using a sample of health professionals who had taken maternity leave. The quantitative data collection asked questions about personal decision-making, career planning, return to work, processes that facilitate or act as barriers to the return to work, continuity of training and career progression. Questionnaire design included open-ended questions for exploring the varied individual situations and decision making relating to return to work, professional training and other aspects of career, discussions with management, anticipated level of support on return from leave and other issues relating to return to work. The data from responses to open-ended questions were managed using NVivo software. These were analysed using qualitative analysis methods and data were coded into themes and subthemes.

**FINDINGS**

**Demographics and Work Experience**

Of the 388 respondents, 243 were in nursing/midwifery, 31 were medical doctors and 114 were AHPs. Of respondents, 12 percent were aged 29 or less, while over 75 percent were between 30 and 39 years of age. These data confirm the trend in Australia for women to have their families later. ABS data (Australian Bureau of Statistics, 2010) show that in 2008, 42 percent of women who had their first child were aged 30 years and over, up from 33 percent in 1998. These women were experienced professionals, likely to have occupied mid-career level positions prior to maternity leave and be at a pivotal point in their career development. The mean number of years that the respondents had practised their profession was 10.7. Of respondents, 191 reported that they were in full-time work and 190 in part-time work prior to their current maternity leave. Mean hours per week for those working part-time was 21.5 and the mean number of years of part-time work 2.7.

Before the current maternity leave over 50 percent had taken one or more career breaks. Of these, 67 percent had previously taken maternity leave and thus had previous experience to underpin their
perceptions of the issues relating to continued professional work and career. The majority of those with prior career breaks had re-entered the workplace at their prior level of employment (85 percent); 7 percent re-entered at a higher level and 8 percent at a lower level. The pre maternity leave work patterns of these women accord with our expectation for health professionals; they reported a high incidence of shift and on-call work. The mean length of the current maternity leave was 1.1 years (standard deviation 0.6 years), with a minimum of 8 months, a maximum of 8 years. It was apparent that some respondents originally took maternity leave and then deferred return to work for a number of years, because of a further pregnancy, or to wait for events such as a child starting school. However, overwhelmingly respondents expected to return to work after 1 to 2 years of leave.

Selection of Profession and Attitudes to Profession and Career

The decisions which are involved with the choices made about post-secondary education, selection of profession and career are complex and ongoing (Poole & Langan-Fox 1997). They involve the influence of institutional, cultural and social parameters as well as the range of personal preferences and opportunities. This study included attitudinal questions relating to women and work, workforce attachment and prior expectations of a career/family trade-off, as these attitudes constitute important input into women’s professional and career choices. While the respondents strongly supported a view that women today have more career options than their mothers, it was apparent that they also believed that the workplace did not provide equal opportunities and that women’s promotional prospects were not the same as for men. They also perceived that it is difficult to be a mother and have a career. At the same time, many perceived that stay-at-home mothers and fathers are not respected. The majority did not see workplaces as allowing reasonable flexibility to attend to family responsibilities, though women were seen as more likely to have flexibility than men. Overall, these professional women perceived that women face very considerable difficulties in combining family and career.

Insert Table 1: Attitudes to women, work and family responsibilities

Their own and society’s ideas about the ideal family are said to contribute to women’s approach to work (Hakim 1998). While 26 percent expected equal division of responsibility, by far the largest proportion of respondents (57 percent) expected that child care and house work would fall largely or
wholly to the woman. We asked respondents whether, if they were assured of a reasonable income without having to work, they would still prefer to have a paid job; almost three quarters of respondents (72 percent) indicated they would still choose to work. In choosing their profession 73 percent of the respondents indicated they had given some consideration to the potential to combine their profession with family responsibilities. The potential for part-time work was the chief of these, though perceptions of family friendly hours being available, perceptions that this career and family responsibilities could be combined and ease of obtaining work after child bearing were also rated as important. Apart from a strong recognition by doctors of the private practice option there was no significant difference in the weight given to these considerations by the different professions.

The majority of respondents, 59 percent, indicated that they had made a trade-off between family and career though only 46 percent had anticipated making this trade-off. Proportionately, doctors were most likely to consider they had made a trade-off. Within each profession approximately 50 percent had not anticipated the trade-off they would make. Over 38 percent of these women say that they are career motivated while 27 percent were not career motivated. However, virtually all these women indicated that time with family was more important than promotion at the time of their response.

**Insert Table 2: Career motivation and family**

Such responses are influenced by the particular situation of the respondent in their work life-cycle. A 2002 study of the WA nursing workforce (McCabe, Nowak & Preston 2003) found that 29 percent of respondents agreed that they were career motivated, compared with 37 percent found here for all health professionals. However, a study of nurses one to three years after graduation (Nowak & Thomas 2008) found that 58 percent were career motivated. The data indicate that there is strong commitment to their profession from most respondents, though this commitment is tempered by understanding of the difficulties they face as mothers. Their responses indicated that this commitment results from enthusiasm for, and enjoyment of, their profession along with feelings of pride and self image invested in their profession.

**Return from Maternity Leave: Conditions and Organisational Support**
Almost 40 percent of respondents had discussed conditions of return with their management prior to taking leave. The discussions related variously to options to decrease hours, to be allocated set shifts, or to extend their maternity leave beyond the paid leave (14 weeks) and nationally determined 6 months’ unpaid entitlement (at that time). Others obtained assurance that they would return to the same position or employment conditions. While half of the respondents had been in full-time work prior to their current maternity leave, only 5 percent indicated that they would return to a full-time position. Just over 60 percent of those returning to part-time work expected to work for between 15 and 24 hours per week. A cluster of responses around 8 hours per week suggests some would seek 1 day per week. The bulk (75 percent) of respondents returning to work expected to return to the actual job they held before their maternity leave. Only 4 percent expected to return to work at a lower level. In some cases the decision depended on availability; casual work was the option expected by some.

Only a small proportion (9 percent) of those returning to work had concerns they would not be well supported by their peers. The attendant comments provided were enthusiastic about the support that peers have provided or are expected to provide. While some respondents also expected strong support from their management, a number expressed concerns that management are not supportive of part-time work or the flexibility needed to manage family crises.

Peer support made a considerable difference to expectations about returning: // colleagues are extremely supportive...//the staff I work with have kids so we all understand...//I was well supported on my previous return...//peer support would be one of the main reasons for my return...//

On the other hand, peer support was not always expected: //considerable negative attitudes from older female colleagues...//those that don’t or haven’t had children less supportive...//my peers are in their 50’s they never worked in a family friendly environment...//... combination of short staff/high pressure does not encourage peers to be supportive//
Management Support was sometimes available and when this was so it had a positive impact: //...hierarchy also supportive/flexible.//Anaesthesia is very supportive of females...//I have a very supportive line manager and this has made the difference in my adjustment...//

Others did not expect support from Management: //Management are not happy with part-time workers.// Management have very out dated views of females in the workforce and family isn’t put first...//...Manager only concerned with filling the roster and will not be flexible.//...(doubt about)work part-time as “it may not suit the department”//...not a supportive environment...if it gets too hard I will leave.//

A related sub-theme for respondents was failure, in some workplaces, to provide opportunities for updating of skills through reorientation or for temporary supernumerary positions to enable returning mothers to regain confidence and be updated on new technology and workplace procedures. //...technology changes and the 4 hour rule would require a little time to adjust.// I would like 1-2 days supernumerary to get my feet back...//Need to brush up. Peers agree I would need support.//Finding my feet again...//

The responses relating to organisational support are consistent with the literature which suggests that where peers and management are supportive of the mother’s return to work after maternity leave the stresses of return and adjustment are eased and an unfavourable outcome, such as the employee resigning because it is all too hard, may be avoided (Buzzanell & Liu 2007; Houston & Marks 2003; Khalil & Davies 2000; Millward 2006).

**Career Progression**

A second major theme was issues raised around career progression and training. Sub-themes identified included restrictive provisions around professional registration and training, problems in accessing training and professional development, reduced opportunities to undertake further formal education and lack of opportunities to take on, or continue in, senior roles and to achieve career
advancement. Conditions placed on Professional registration and training was noted as an issue particularly, but not only, by medical doctors; //College requirements ... the amount of leave allowed and total amount of time spent training as an advanced trainee.// RANZCP has an expiry date for validity of exams – pressure to complete training...//.

Other issues raised included professional registration requirements around recency of practice, stringent requirements around ongoing training and professional development, and problems, particularly when in part-time positions, in accessing the number of hours of professional practice required to maintain professional registration (‘exact number of hours required by the board’). The women foresaw that their ability to access to training and professional development would raise many issues. A number of these related to constraints imposed by employers such as unwillingness to invest in training for women who were going on maternity leave or likely to be working part-time, along with provision of opportunities at times which were unsuitable for shift workers, especially those on night shift. Other problems raised stemmed from these women being time poor and unwilling to shoulder costs, for example the provision of childcare during training, inability to find time for courses, and problems with travel to courses. Typical responses included //...limited availability/opportunity to afford in-house education or training courses due to part-time and casual work//...inability to update self because of time pressures.//

There were conflicting positions from respondents in relation to formal educational training. On the one hand, a number of respondents noted that they had withdrawn from or placed on hold their formal education programs. However some had decided to undertake further study while on maternity leave. Another important subtheme focused on restricted opportunities for career advancement. A number of respondents noted that opportunities for career advancement had been reduced and their peers had overtaken them. They noted the loss of networking opportunities and the ability to be involved with panels, boards and committees, loss of ‘hard-earned reputation’ and potential reduction in responsibility on return to work as contributing factors. Restrictive conditions were also noted around opportunities to take on or continue in senior roles to achieve career advancement. Respondents
indicated that career progression when working in a part-time capacity was ‘too difficult’ and job sharing at senior levels uncommon. Some senior nursing positions were either not available as part-time positions or had a minimum number of work hours as a requirement. //Management positions in the public sector are generally full-time.//...manager not willing to allow more senior positions to people going on maternity leave.//...restricted as a level 2CN as to amount of hours needed...at least 20 a week.//barriers to senior nursing positions being available part-time(SRN 3)\

CONCLUSION

The data point to a combination of organisational (employer) and institutional (professional associations and government regulation) factors which were perceived by these women as potentially restricting opportunities for them in the workplace on their return to work from maternity leave and hence slowing and restricting their longer-term career development. Some of the organisational factors involve issues of workplace culture and practice at the level of the organisational unit. Such issues have also been identified in the literature (Baron & West 2005; Khalil & Davies 2000; Lyness et al. 1999). While resistant to change these can be overcome through leadership at the organisational level. Such leadership should address workplace culture issues, but also enabling policies such as the provision of skills updates for returning staff, options for training programs while on leave and non-discriminatory policies relating to the availability of training and mentoring opportunities.

Other restrictions, however, appear to involve a mix of overarching organisational practice and institutional conservatism. With the exception of issues raised around training in medical specialties (Potee et al. 1999; Verlander 2004) the literature is largely silent on these. It seems to us to be important that restrictions, such as those applying to professional training and breaks in professional training, professional practice registration requirements and restrictive requirements around eligibility to be employed in senior positions are considered openly by the employer and professional organisations to determine whether they add value or simply represent restrictive professional practice. Current debate about skilled workforce shortages and the importance of maintaining the workforce attachment of women makes this pertinent, particularly so for the health workforce.
REFERENCES


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Table 1: Attitudes to Women, Work and Family Responsibilities

<table>
<thead>
<tr>
<th>Your views on:-</th>
<th>Strongly agree/agree %</th>
<th>Mean (1=strongly agree, 5=strongly disagree)</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay-at-home fathers are respected</td>
<td>24.2</td>
<td>3.39</td>
<td>1.01</td>
</tr>
<tr>
<td>Stay-at-home mothers are respected</td>
<td>27.5</td>
<td>3.25</td>
<td>0.96</td>
</tr>
<tr>
<td>Women have more career options than their mothers</td>
<td>93.0</td>
<td>1.82</td>
<td>0.61</td>
</tr>
<tr>
<td>Women have as many career choices as men</td>
<td>58.1</td>
<td>2.61</td>
<td>0.99</td>
</tr>
<tr>
<td>Women/men have the same promotion prospects</td>
<td>26.9</td>
<td>3.33</td>
<td>1.04</td>
</tr>
<tr>
<td>Difficult today for women to be mothers/have careers at the same time</td>
<td>77.3</td>
<td>2.13</td>
<td>0.96</td>
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<td>Women/men have equal opportunities in the workforce</td>
<td>19.0</td>
<td>3.65</td>
<td>1.02</td>
</tr>
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<td>Workplace allows mothers flexibility for family responsibilities</td>
<td>40.3</td>
<td>3.05</td>
<td>1.03</td>
</tr>
<tr>
<td>Workplace allows fathers flexibility for family responsibilities</td>
<td>20.2</td>
<td>3.52</td>
<td>1.00</td>
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</table>
Table 2: Career Motivation and Family

<table>
<thead>
<tr>
<th></th>
<th>Career motivated</th>
<th>Career motivated</th>
<th>Family more important than promotion</th>
<th>Family more important than promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>Strongly agree</td>
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<td>3.4</td>
<td>261</td>
<td>67.3</td>
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<tr>
<td>Agree</td>
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<td>34.0</td>
<td>113</td>
<td>29.3</td>
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<tr>
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<td>131</td>
<td>33.8</td>
<td>11</td>
<td>2.8</td>
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<tr>
<td>Disagree</td>
<td>91</td>
<td>23.5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>14</td>
<td>3.6</td>
<td>1</td>
<td>0.3</td>
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