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Survey of Female Gynecologic Oncologists and Fellows: Balancing Professional and Personal Life

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Objective. **The aim of this study was to determine how female gynecologic oncologists have dealt with the challenge of combining childbearing and a career in gynecologic oncology and to identify other issues which need to be addressed to improve job satisfaction.**

Methods. **This survey of female members of the Society of Gynecologic Oncologists and fellows addressed demographics, timing of childbearing, type and cost of childcare, satisfaction with childcare choices, and mentorship. Those without children were queried about plans and reservations. Open-ended questions investigated how female gynecologic oncologists felt job satisfaction could be improved.**

Results. **A total of 65/110 (59%) attendings and 18/36 (50%) fellows responded. Three-fourths of respondents felt that the ideal time to have children was postfellowship. Timing of childbearing caused moderate to severe stress in the personal relationships of 23% of respondents. Median maternity leave was 6 weeks (1–120 days). Seventy-eight percent of female gynecologic oncologists with children employed a nanny. Over half of the respondents estimated weekly childcare cost at over $400. A successful balance between family and full-time practice was the most commonly cited quality of an ideal mentor. Sixty-six percent of the respondents replied to open-ended questions with narrative answers, revealing three major areas for improvement: childcare issues, increased flexibility in hours and duties (clinical, surgical, and research), and the need for more female mentoring.**

Conclusions. **This survey highlighted the concerns of female gynecologic oncologists about achieving a successful balance between family and professional duties. It also revealed the ways in which women have responded and identified other issues that may be targeted to improve job satisfaction.**

Key Words: **job satisfaction; gender issues; childbearing; mentoring.**

INTRODUCTION

Sixteen percent of gynecologic oncologists are now women. Since 33% of current fellows are women, the percentage of female gynecologic oncologists should only continue to increase. Because of this dramatic growth, more women are facing the challenge of combining childbearing and a career in gynecologic oncology. Other surgical disciplines have examined the experiences of women in the field, describing personal and practice lifestyles, anticipating the effect of the increasing number of women surgeons, but this literature is limited [1, 2].

Knowledge of how others have dealt with the timing of childbearing, childcare, and division of time between profession and family may help other female gynecologic oncologists face these challenges in their own lives. Likewise, knowing how women view their decisions on these matters and whether they would make the same decisions again may be helpful to others facing these decisions. It is also instructive to find out what female gynecologic oncologists believe needs to be done to improve personal and professional job satisfaction. To understand how female gynecologic oncologists are dealing with the issues of childbearing, childcare, and other gender-related topics, we conducted a survey of female gynecologic oncologists and female gynecologic oncology fellows. To our knowledge, this is the first survey of its kind.

METHODS

Female gynecologic oncologists were identified from the 1998 directory of the Society of Gynecologic Oncologists (SGO), and female fellows in gynecologic oncology were identified from listings of the American Board of Obstetrics and Gynecology. Survey questions addressed demographics, marital status, timing of any divorces, and the perceived influence of career on the decision to divorce. Those with children were asked about the timing of their childbearing, what they believed was the most ideal time for childbearing, and how career might affect the timing of childbearing. They were also asked whether their partners desired children earlier or later than they did and to what degree the timing of childbearing caused stress in their relationship. Duration of maternity leave (actual and ideal), choice of childcare (actual and ideal), and the cost of childcare were also ascertained. Those without

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children were asked how training and career affected their decision to delay having children, if at all, and what they regarded as an ideal time for childbearing. The effect of not having children on personal relationships was also explored, as well as future childcare plans, preferences, and reservations.

In addition, respondents were asked whether they had a female mentor and whether they thought having a female mentor was important in serving as a role model and in empathizing with their situations. They were asked to describe the qualities of an ideal mentor. Respondents were also questioned about living apart from their spouse or significant other during training and career and whether that person was also a physician. The last questions were open-ended: Are there ways to improve fellowship and professional positions for women? Are there other questions that should be asked on a survey such as this?

Response options were designed for ease of the respondent, with few open-ended questions. Several questions included four-point Likert scale responses, for example, 1 might equal "not at all" and 4 "greatly." The survey was mailed with a self-addressed, stamped envelope in September 1998 to the women gynecologic oncologists listed in the 1998 SGO Directory. All returned envelopes were discarded to protect the anonymity of the respondents. Survey data were entered into Microsoft Excel (Indianapolis, IN, 1997) for analysis.

RESULTS

Of 146 surveys mailed to 110 female gynecologic oncologists and 36 fellows, there were 84 responses, for a response rate of 58%. Sixty-five of the attending physicians (59%) surveyed responded, and 18 (50%) of the fellows responded. Two of the attending physician respondents did not wish to participate, both citing the lack of an introductory letter identifying the authors and the forum where the data would be made available as their reason for not participating. One respondent did not identify herself as a fellow or attending physician. Seventy-seven percent of those responding to the survey questions were attending physicians, while the remainder were fellows. Of the attending physicians, 70% worked in an academic setting and 30% were in private practice.

The majority of respondents (72%, $n = 59$) identified themselves as married, 11% ($n = 9$) identified themselves as single, 9% ($n = 7$) as divorced, 4% ($n = 3$) as remarried, and 4% ($n = 3$) as having a same-sex partner. Eleven women (13% of total respondents) had obtained a divorce at some point during training or practice. The breakdown of respondents by the time when the divorce occurred was as follows: residency ($n = 2$), fellowship ($n = 5$), and practice ($n = 4$). The degree to which these women felt career influenced their decision to divorce also varied; two believed the influence was great, 3 thought career moderately influenced the decision to divorce, 2 thought it had little influence, and 4 thought it had no influence.

TABLE 1
Similarity of Desired Timing of Childbearing within Couples and Perceived Stress within Relationships Caused by This Issue

	With children ($n = 50$) (%)	Without children ($n = 32$) (%)
Timing of childbearing		
Partners desired children at the same time as they did	78	47
Partners desired children earlier than they did	18	19
Partners desired children later than they did	2	2
No answer	2	28
Stress within the relationship caused by timing of childbearing		
Negligible to small	80	65
Moderate	16	19
Severe	4	9
No answer	0	7

Fifty of the respondents (61%) had children. Most had only one (34%) or two (50%) children. The majority (62%) had had their children after completing their fellowship in gynecologic oncology. When asked what they regarded as an ideal time to have children, 74% cited the time after the fellowship. For 88%, training and career had a moderate to great effect in determining the timing of childbearing. Table 1 summarizes the perceptions of the respondents regarding the differences of opinion within couples with respect to the timing of childbearing and the amount of stress in the relationship that this issue caused. Notably, 20% of respondents with children felt that the timing of childbearing caused moderate to severe stress in their relationship.

Those without children were also queried about what they felt was the ideal time to have children. Seventy-five percent felt that the ideal time was after the fellowship and 16% felt residency was the preferred time. Only 56% felt that training and career played a large role in this decision, with 22% believing that the role of training and career in the decision was negligible.

The duration of the maternity leave varied, as expected (Fig. 1). While three respondents took off 1 week or less, the majority took a maternity leave lasting between 3 and 7 weeks. Six took off 3 months or more. When asked if they would in retrospect have taken off more, less, or the same amount of time, 62% said they would have taken more time and 36% said they would not have changed the length of their maternity leave. None wanted less time for their maternity leave than they had taken.

Although a range of childcare choices were described by the 50 respondents with children, more than three-fourths (78%) employed a nanny. Eight percent depended on a relative, and another 8% relied on a partner or spouse. Only 6% of the

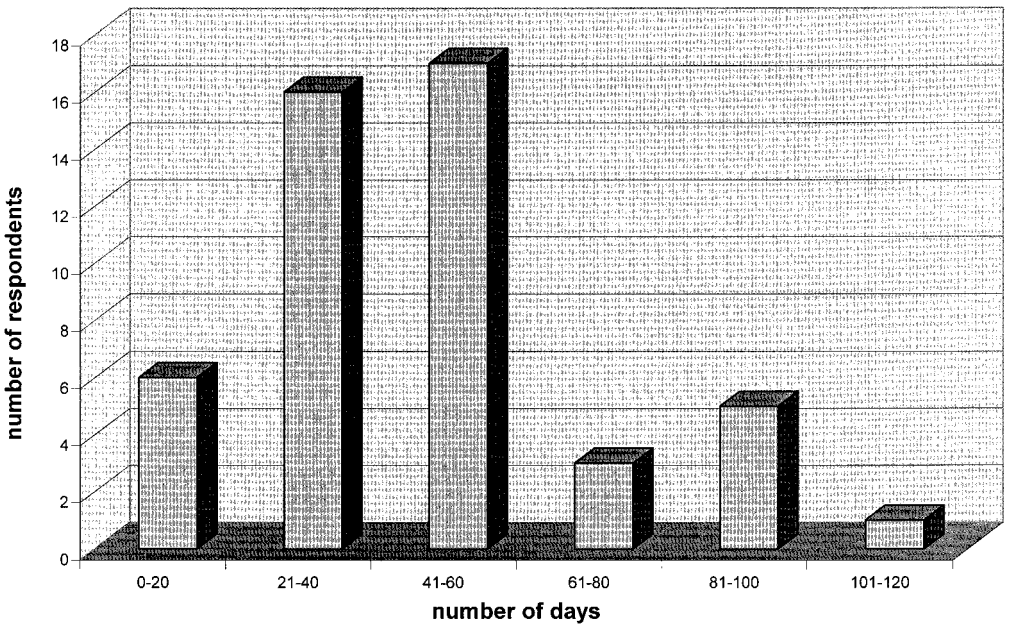

FIG. 1. Duration of maternity leave.

respondents used daycare. Of those with a nanny or relative providing childcare ($n = 43$), an equal percentage of childcare providers lived in the home or outside the home (49% for both; 2% declined to answer this question). When questioned regarding their ideal preference for childcare, 52% considered a nanny the ideal childcare provider. Sixty-two percent considered their current childcare situation to be an ideal childcare situation. Over half of the respondents estimated their childcare costs at over $400 per week (Fig. 2).

Gynecologic oncologists currently without children considered ideal childcare to be that furnished by the partner or spouse (29%), nanny (29%), or relative (16%). Twenty-five percent of these respondents said they would prefer a nanny or relative to live in; the others did not prefer this. Fifty-five percent of respondents without children did not answer this question.

Only 35% of respondents had a female mentor in gynecologic oncology, yet 71% felt that having a female mentor was

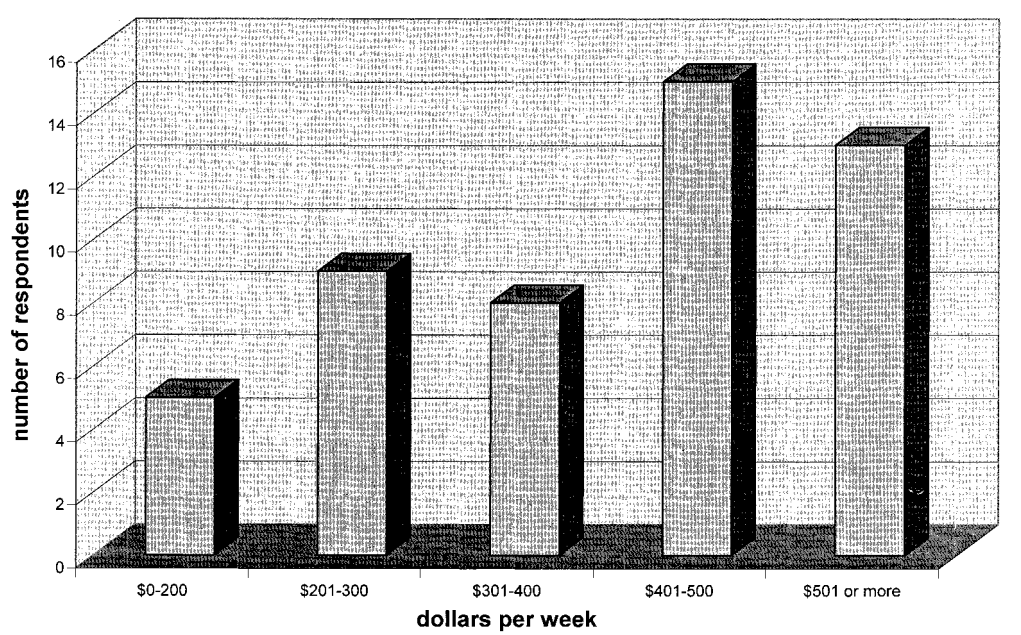

FIG. 2. Childcare cost per week.

of moderate to great importance. Having a female mentor was mildly important to 18%; only 6% felt that their mentor's gender was not important at all. Achieving a successful balance between family and full-time practice was the most commonly cited quality of the ideal mentor. Nineteen respondents commented on the importance of this balance. Respondents also believed that the ideal mentor is helpful in advising about the balance between work and family life and is a successful role model in this respect. He or she should also have the ability to define realistic goals in both of these areas. The next most commonly cited quality was a genuine interest in the mentee, with a willingness to mentor and to enjoy the protégé's success. Other desirable qualities mentioned by multiple respondents were that the mentor be approachable and respected, a leader in the field, and a good surgeon.

The training of a gynecologic oncologist often requires relocating several times, which may involve living apart from a spouse or significant other. Twenty-three of the respondents (28%) indicated that they chose to live apart from their significant other during training; 11 chose to live apart at some point during their career. Time spent living apart varied from 2 to 48 months, with a mean of 23 months. Respondents indicated that this separation affected personal relationships in a variety of ways, with responses that ranged from "It strengthened the relationship" and "Separation did not adversely affect us" to "It limited the opportunity to grow together" and "We managed but are not willing to do it again" to "Career goals versus relationship caused division" and "Separation solidified the rationale for divorce." Thirty-eight respondents stated that their spouse or significant other was also a physician, while 32 stated that their spouse or significant other was not a physician.

Perhaps the most interesting information yielded by this survey was that contained in the responses to the two open-ended questions: "Do you feel there are ways to improve the fellowship and professional positions for women?" and "Are there other questions you think should be asked on a survey such as this?" Fifty-four female gynecologic oncologists and fellows (66% of respondents) replied to these questions with narrative answers. Three major areas for improvement emerged from their responses: childcare issues, increased flexibility in hours and duties (clinical, surgical, and research), and the need for more female mentoring.

Respondents cited increased attention to childcare issues as a significant way to enhance job satisfaction. They remarked on a need for increased access to quality childcare, with many suggesting on-site childcare for the office or hospital. The lack of maternity leave policies within the subspecialty was of concern. Others made the following comments: "We need more understanding of the stresses on mothers with young children" and "We need to treat childbearing as desirable instead of undesirable."

For many of the respondents the need for increased flexibility was entwined with the childcare issue. They indicated in their responses that flexible schedules would potentially accommodate family time and desires not to work full-time. The option of job sharing was mentioned by several respondents. One respondent stated that "recognition of the need for flexible schedules and decreased overall workload for working mothers, without major academic penalties [is necessary]." Another commented that "[there is a need to] remove expectations for everyone to do it all: research, teaching, clinic, and surgery. Jobs have to be more flexible to allow you to do what you do best. The stigma of not doing it all has to be removed."

A final idea for improvement, the need for more mentoring, was echoed by many respondents. "More female role models," "more women in leadership positions," and "more support and encouragement of women" were typical responses of many. One commented that "we need a networking system." Another stated "I hope this [survey] will lead to open discussion. Consider the possibility of SGO small groups."

Other frequently mentioned issues were the need for discrimination awareness and the importance of fostering career promotion for women. Some suggested courses on discrimination or gender sensitivity training for gynecologic oncologists. One flatly stated: "Start with the basics: recognize and stop sexual harassment."

In response to the second question, "What other questions should be asked in a survey like this?", many wanted to further explore the conflicts between career and childbearing and childcare. Some questions that were suggested included: "What is the most difficult aspect of arranging childcare?", "What effects has pregnancy had on your career?", "Do you have a fear of being pregnant due to job concerns?", "Have you ever terminated a pregnancy during or after training, and why?", and "How was your pregnancy viewed by your superiors?".

Many were curious whether others in their position were happy and why. Questions suggested by these respondents were: "Are you happy with your current job and family situation?", "Would you retrain in gynecologic oncology if you were just starting your career?", and "What do you like the most about your career? The least?".

Perception of success with respect to gender was also of interest to our respondents, as shown by questions such as "What is your impression of your success in your career compared to your male colleagues?" and "How do you feel gender has affected your career success? Do you feel as equally regarded as your male colleagues by referral gynecologists?".

Other interesting questions that respondents suggested included "Do you think that there should be means to facilitate female mentoring within the SGO, outside of individual institutions?" and "Do you think it would be helpful to have a female-only gynecologic oncology symposium or seminar at regional or national events?". One respondent suggested asking "Who is the primary source of income in the household?", commenting that there is frequently an impression that female physicians work purely by choice, while many are in fact the primary breadwinners. Suggestions were also made to ask

about teaching roles, to discuss practice problems, and to survey men about these issues.

DISCUSSION

This survey highlighted the concerns of female gynecologic oncologists about achieving a successful balance between family and professional duties. It also revealed the ways in which various women have responded to this situation and identified issues that may be targeted to improve personal and professional job satisfaction. Although we acknowledge that what is right for the majority is not necessarily what is right for the individual, we do believe that the experiences of others can serve as a guide for other women making similar choices.

Overall, the respondents felt that there is a need for increased attention to childcare issues. They wanted to know more about on-site childcare, maternity leave, arranging childcare, and the effects of pregnancy on career. While other studies have examined the availability of maternity leave for women surgeons [3] and have elicited information on marriage, divorce, and general job satisfaction [2], they have not explored these issues in depth. We therefore sought to gain more insight into these issues by asking female gynecologic oncologists their views on the timing of childbearing and how this decision may strain a relationship. We also obtained descriptive information about maternity leave, as well as specific childcare choices and the practical considerations of childcare cost.

Prior surveys have revealed that, among cardiothoracic surgeons, women practitioners are less likely to be married, or they are more likely to marry later in life and to have fewer children than they would otherwise have wished. Despite comparable work hours to those of their male counterparts, these women also have primary responsibility for childcare and household tasks [1]. It is interesting, however, that in this study career and family satisfaction among male and female cardiothoracic surgeons were equivalent. Of further note, another study investigating the career satisfaction of U.S. women physicians revealed a significant association between number of children and career satisfaction, which led the authors to postulate that multiple roles may bring benefits that mitigate strain [4].

The need for further attention to childcare issues raised by our respondents is not a new one in medicine. For example, a recent article titled “The Paradox of Critical Mass for Women in Science” concluded that environmental context needs to be considered, with attention to institutional policies and programs on childcare, parental leave, recruitment, retention, and promotion, rather than just a focus on increasing the numbers of women [5]. A study of career satisfaction among U.S. women physicians also showed that there are correctable factors that must be addressed to improve the recruitment and retention of women physicians, although childcare was not specifically cited as one of the factors [4]. However, the lack of a maternity leave policy identified in our survey may reflect a negative attitude toward childbearing. As an illustration of this, two-thirds of practicing female Canadian surgeons reported no maternity leave policy in residency or practice. The women in that study also perceived discrimination during their surgical training, although they reported that discrimination did not hinder their career development or advancement [3].

In a survey of full-time academic medical school faculty, female faculty with children were found to face major obstacles in their academic careers in the form of less institutional support, less research funding, less secretarial support, slower perceived career progress, and lower career satisfaction compared with female faculty without children and compared with men [6]. The authors felt that some of these problems could be modified by eliminating after-hours meetings and by creating part-time career tracks. However, they found that having children had little effect on faculty aspirations and goals [6].

Seventy-four percent of the female gynecologic oncologists in our survey reported that the ideal time for childbearing was after the period of fellowship. These findings are echoed by those from a study of the experiences of women in cardiothoracic surgery, in which two-thirds of the women reported having their first child during clinical practice. As in our study, the majority of these women indicated that they would not change the timing of their childbearing [1].

Increased flexibility in both hours and duties was cited by many of our female gynecologic oncologist respondents as an improvement that would increase job satisfaction. In a similar vein, our respondents voice a need to learn more about how other female gynecologic oncologists have achieved what they feel is a balanced lifestyle. Women physicians in internal medicine, pediatrics, and family practice have paved the way for more creatively structured hours in the form of part-time, flex-time, and job-sharing options. However, these strategies have not been widely adopted by the surgical community [7]. For example, in a study of practicing female Canadian surgeons, 78% reported no job-sharing opportunities [3]. Of additional interest, a study of the characteristics of women surgeons in the United States revealed that women surgeons were more likely than other women physicians to practice in a medical school setting. Such an affiliation may be an attempt to increase job flexibility because it brings with it the availability of residents who can provide some patient management [2]. While it is true that the nature of a surgical profession requires regular practice to maintain skills, the option of a lower volume practice that allows more time off would accommodate both career and family. Several studies have looked at the gender of role models for women. In our study, 71% believed that a female mentor was of moderate to great importance, although only 35% had had a female mentor. This was also seen in a survey of the Association of Women Surgeons conducted in 1991, which revealed that 94% of the women surgeons surveyed believed that female medical students needed successful female surgeons as role models [8]. Similarly, 82% of practic-

ing female Canadian surgeons also believed that female medical students needed female role models, although 80% of these surgeons had never had a female mentor themselves [3]. Researchers have debated the importance of gender in mentors. Although some research suggests that high-ranking male mentors are less effective career sponsors for women than female mentors [9], other evidence suggests that these role models need not be female [10]. In fact, there is evidence that the most helpful mentors are male [11] and that the best role models may be of either sex [12].

We found the most interesting responses to mentorship questions to be those concerning the qualities of the ideal mentor, regardless of sex. For example, successful balance between family and full-time practice was the most commonly cited quality of an ideal mentor, underscoring the recurrent theme of the need to achieve a balance to achieve job satisfaction. The study of cardiothoracic surgeons also touched on this subject. Both men and women in that study reported that they did not have many opportunities to discuss ways to balance career and personal life, although 72% of the women and 56% of the men believed that they would have appreciated such opportunities [1]. A recent article addressing stress in gynecologic oncology underscores the importance of a balanced life, suggesting many of the strategies voiced by the respondents to our survey [13].

Job satisfaction is an important concern in gynecologic oncology, particularly with respect to the recruitment and retention of women. Results of the Women Physicians' Health Study revealed that despite the high stated career satisfaction, nearly one-third of women physicians indicated that they would not have become a physician if they had it to do all over. This shows that simple queries about job satisfaction may not fully assess the multiple variables contributing to professional happiness [4]. Women are also more likely than men to report that they have inadequate time for friendships and hobbies [1]. Correctable factors such as work stress, harassment, and poor control over work environment should therefore be addressed to improve the recruitment and retention of women physicians [4].

This study assessed women who have completed or plan to complete training and certification in gynecologic oncology. Although it is the first survey of female gynecologic oncologists, some aspects of the survey could be improved upon. For example, male gynecologic oncologists were not surveyed, so comparisons between male and female gynecologic oncologists could not be made. Although that was not an objective of this study, it would be an interesting subject to investigate in the future. The survey instrument can also be faulted for lacking full identification of the authors. In addition, the questionnaire was not extensively pretested, and some interpretation was therefore necessary to categorize the answers to the open-ended questions. Additionally, questions were not designed to check for reliability and validity. A further drawback of the survey was that we examined the respondents' perceptions but did not attempt to collect information on actual situations such as harassment, and consequently actual discrimination may have been overreported or underreported.

The results of this survey characterize female gynecologic oncologists and bring to light many of their concerns. This group of highly organized and logical women may find these data of benefit as they endeavor to make their own best choices. Future studies, using expanded demographic and philosophical data, could investigate expectations and household structures. These issues are not confined to the female gender; male gynecologic oncologists could also be queried on these subjects and other areas of focus that emerged from the open-ended questions in this study. Addressing these concerns, and thus augmenting job satisfaction, will likely benefit all gynecologic oncologists.

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