Medical parents and prevocational and vocational training

2020

The duration of medical training in Australia from medical school through to specialist qualification regularly exceeds 10 years. For many medical practitioners this period overlaps with the time they become parents.

While medical colleges and employers have developed policies to support medical parenting during training there is substantial variation in policy and implementation.

Doctors in training have minimal autonomy in structuring their work practices compared to most fellowed medical practitioners. Medical training pathways lack flexibility in accommodating trainees taking parental leave and managing childcare responsibilities.

Despite reaching parity in training numbers, women still take most parental leave in Australia and assume greater responsibility for childcare and domestic duties, while men have much greater difficulty accessing parental leave and flexible work arrangements.

There is a clear need to address persistent systemic and cultural norms that drive gender inequity in training and the workplace. Structured support at a systemic and personnel level is required to promote parity and equal opportunity and reduce the stress of balancing work and family life.[1]

In response to this the AMA has developed a set of overarching criteria and guidelines to support all paths to parenthood, parental leave, return to work, and ongoing work life balance for medical parents in prevocational and vocational training.

Standard expectations

1) Parental considerations should be understood to apply to:
    a) All genders, including non-binary genders.
    b) All paths to parenthood and related complications, including but not limited to:
        i) Pregnancy and adoption, including in vitro fertilisation (IVF), and all potential outcomes including miscarriage, termination, still birth, premature births, multiple births and any other not listed.
    c) Return to work after any of the events outlined above.
2) Policies and practices related to parental considerations should be:
    a) Comprehensive and at a minimum meet an organisation's legal responsibilities, enterprise bargaining agreement, awards, and fair work standards.
    b) Readily accessible and actively communicated.
    c) Gender neutral and use gender inclusive language.
    d) Flexible to account for the diverse circumstances and needs of trainees.
    e) Monitored, evaluated, and reported at regular intervals, including but not limited to:
        i) Annual reporting on uptake of paid and unpaid parental leave, flexible work and training arrangements and efficacy of return to work arrangements.

[1] Allen TD, Johnson RC, Kiburz, KM, Shockley KM. Work–Family Conflict and Flexible Work Arrangements: Deconstructing Flexibility. 2012. https://doi.org/10.1111/peps.12012

3) Leaders must be committed to promoting and supporting equal access to parental leave and flexible work arrangements for medical parents in training.

4) Clear pathways should be available to trainees seeking to apply for parental leave and flexible work arrangements.

5) Trainees should feel connected to an organisation during periods of parental leave without arrangements being mandatory or onerous. This could be via:

    a) Access to training and professional educational opportunities.

    b) Utilising 'keeping-in-touch' days before ultimate return to work.

6) Leave and return to training program/work arrangements should be planned such that:

    a) Expectations for managers and trainees are clear, with guidelines and training provided for managers and parents to navigate leave and return to work arrangements.

    b) They are flexible to unforeseen circumstances and individual trainee needs.

    c) There is no penalty for trainees taking time out of the workforce.

    d) Proactive and flexible approaches to support trainees returning from parental leave are developed and adopted. These could include:

        i) Extra support/supervision on return to work.[2]

        ii) Refresher courses organised jointly by the employer and/or relevant medical college and undertaken during working hours.[3]

7) Detailed, specific policies on parental leave and other parental considerations should be a requirement of public hospital and private practice accreditation standards and the standards for assessment and accreditation of specialist medical and professional development programs.

Guidelines - Specialist Medical Colleges

8) Medical colleges can make access to parental leave more equitable, flexible, and feasible to medical parents in training by:

    a) Developing and promoting a dedicated parental leave policy. Parental leave should be a consistently anticipated trainee need and should be considered differently to other reasons for interruptions to training. Policies must acknowledge the less predictable nature of the need for and timing of parental leave.

    b) Providing clear and comprehensive guidance about how parental leave will interact with training requirements to minimise opportunities for systemic discrimination. These include:

        i) Minimum accredited term length.

        ii) Volume of practice requirements.

        iii) Any assessment requirements such as exams or courses.

        iv) Maximum duration of training.

[2] NHS. Health Education England. Supported Return to Training. https://www.hee.nhs.uk/sites/default/files/documents/Supported%20Return%20to%20Training.pdf

[3] For example the CRASH (Critical care, Resuscitation and Airway Skills in High fidelity simulation) course for anaesthetists returning to work run by the Royal Melbourne Hospital and recognised by the Australian and New Zealand College of Anaesthetists as contributing to continuing professional development.

v) Any other relevant training requirements stipulated in College regulations.

c) Excluding parental leave from any time limit imposed on the total number of years allowed to complete training.

d) Ensuring considerations are made in planning training pathways for all paths to parenthood, parental leave, return to work and parenting responsibilities, such as:

(i) Scheduling away rotations to accommodate parental considerations, minimising geographical disruption in rotations where possible (unless requested by the trainee) and providing the maximum possible notice of rotations.

(ii) Scheduling regular education and training activities within usual rostered working hours and providing remote attendance options.

e) Incorporating parental considerations into training post accreditation standards, including requirements for accredited training sites to provide:

i) Support in accessing parental leave entitlements.

ii) High quality flexible training roles.

iii) Access to appropriate lactation facilities and childcare as per 9 (h) and 9 (i) respectively.

Guidelines - Employers

9) Employers can support all paths to parenthood, parental leave, access to flexible work and return to work arrangements by:

a) Ensuring non-discriminatory recruitment and appointment processes are in place.

b) Ensuring a safe working environment is in place for pregnant trainees. This may include periodic review of the scientific evidence of specific occupational risks in pregnancy e.g. exposure to volatile agents, as well as individual medical assessment, with strategies developed and implemented to address identified needs and allow pregnant trainees to continue working safely.

c) Adopting rostering patterns in line with evidence based practice that support good pregnancy outcomes and consider the needs and wishes of pregnant trainees and parents e.g. reduced night shift work,[4, 5] facilitating access to childcare through regular shifts, or limiting the number of consecutive days on duty.

d) Providing part-time training and assisting trainees in the organisation of job-share arrangements.

e) Offering remote access via quality video/teleconference, to support medical parents in training to participate in teaching and training and other events.

f) Supporting trainees' return to work by ensuring access to an induction/orientation process regardless of timing of return to work with respect to the usual clinical year.

g) Ensuring a trainee's family are supported to move with them where rotation to a geographically distant location is a requisite part of training, and/or provide practical, financial, and rostering support to allow the trainee to return home at regular intervals.

[4] Infante-Rivard, Claire, et al. "Pregnancy Loss and Work Schedule during Pregnancy." Epidemiology, vol. 4, no. 1, 1993, pp. 73–75. JSTOR, www.jstor.org/stable/3702987. Accessed 7 May 2020.

[5] Whelan, Elizabeth A., et al. "Work Schedule during Pregnancy and Spontaneous Abortion." Epidemiology, vol. 18, no. 3, 2007, pp. 350–355. JSTOR, www.jstor.org/stable/20486376. Accessed 7 May 2020.

h) Ensuring provision of appropriate lactation room facilities within reasonable proximity of clinical areas, especially critical care settings and operating theatres. Essential criteria to support maintaining breastfeeding[6,7] include:

   i) A designated private, safe, clean and quiet room separate from bathrooms; seating; hot and cold water and hand drying; fridge for storage of breast milk; power outlets; waste disposal; easily marked; accessible by any parent, which is smoke free and advertising free. [8]

i) Supporting affordable and accessible childcare services, for example by:

   i) Subsidising the cost through salary packaging.

   ii) Identifying and developing relationships to facilitate entry to childcare services close to work, including for trainees on rotation.

   iii) Providing in-house care that meets the needs of trainees working shifts.

j) Appropriately resourcing and supporting Managers/Heads of Units/Departments, inclusive of Medical Administrators and Rostering Departments, to implement policies and systems that coordinate access to parental leave e.g. rostering, backfilling of positions, etc.

Trainees in private practice settings

10) General Practice (GP) registrars and trainees in private practice settings are particularly vulnerable to disadvantage when considering access to parental leave during training due to:

   a) Limited access to paid parental leave other than the Government scheme, and lack of accrual of benefits such as sick and carers leave associated with continuous service.

   b) Highly variable remuneration packages.

   c) Suspension of Medicare provider numbers whilst on parental leave.

11) When on parental leave it is important that GP registrars and trainees in private practice settings retain access to their place of work and provider number to facilitate ongoing skills maintenance, 'keeping in touch' days, and a potential income stream if the trainee wishes to work additional shifts or fill rostering gaps.

12) The AMA calls on Government to commit to the development of a 'single' employer model in consultation with the profession, to deliver equitable remuneration and employment conditions for GP registrars and between GP and non-GP registrars, inclusive of access to all forms of leave, while also ensuring adequate support and funding for supervising practices. This model is also applicable to other trainees in private practice settings.

A list of Employment Entitlements as a minimum standard is at Annex A.

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[6] Smith J, McIntyre E, Craig L, et al. Workplace support, breastfeeding and health. 2013. https://aifs.gov.au/publications/family-matters/issue-93/workplace-support-breastfeeding-and-health

[7] American Institute of Architects. Best practices. Lactation Room Design. 2008. http://www.breastfeeding.org/wp-content/uploads/2016/09/18.-LSE-AIA-Lactation-Room-Design.pdf. Specific architectural considerations are discussed and should be considered in any new building design.

[8] Australian Breastfeeding Association. Essential Criteria for a Baby Care Room. 2015. https://www.breastfeeding.asn.au/system/files/content/INFO-Baby%20Care%20Room%20Essential%20Criteria-V2-201503.pdf

Annex A. Employment entitlements

13) Enterprise agreements or Awards applying to trainees must as a minimum incorporate:

a) Non-gender specific language and entitlements.

b) Access to equal and reasonable paid parental leave entitlements for each parent.[9]

c) Access to flexible work arrangements for each parent.

d) Recognition of service accrual or service eligibility for parental leave entitlements between different health jurisdictions including hospitals, health services and States and Territories.

e) Service continuity for trainees on unpaid leave, particularly for trainees rotating to different hospitals or health services.

f) No requirement for 12 months of service to be eligible to access full parental leave entitlements

g) The ability for trainees to access and be paid their full parental leave entitlement in circumstances where their contract may expire in the period of leave.

h) Where a contract does not underwrite the entire period of parental leave, the trainee should be offered a contract time extension equal to the parental leave period and the period remaining on the contract at the time of beginning parental leave.

i) Employer superannuation to be paid during any unpaid parental leave component.

j) Mechanisms to maintain access to teaching, training, and experience opportunities whilst on parental leave.

k) Workplace infrastructure and/or financial allowance is available to support care for a child, such as:

i) Lactation facilities as specified in point 9 (h).

ii) Access to childcare on site or nearby as specified in 9 (i).

iii) Reimbursements or allowances to defray costs of childcare incurred due to irregular work patterns.

iv) Suitable accommodation for trainees who have parenting responsibilities, where accommodation is provided.

[9] Reference to “primary” and “secondary” caregivers should be removed as leave provision should not be contingent on assuming these designations.