

# 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 employed by the Department of Health Western Australia and one private sector healthcare provider. Employees selected were on the payroll as on maternity leave on a specified date. Data obtained pointed to the interaction of systemic discrimination, embedded 'technologies' of work organisation and attitudes and practices reflective of broader societal attitudes to women, as factors restricting the potential opportunities for the longer-term career development of these women. The authors propose that the service delivery model in the health sector should be organised around formal recognition of a range of work-hours options rather than maintaining full-time as the norm for working hours. The objective in doing this would be to undermine current patterns of systemic discrimination which operate through restricted access to training and development for part-timers and the reservation of senior positions for employees working only one standard (full-time) set of hours.*

JEL Classification: J290; J810; J160

## 1. Introduction

Empirical evidence shows that childbearing has an impact on lifetime earnings and the career trajectories of women. Estimates of forgone lifetime earnings of women who have children have identified considerable earnings penalties (Breusch and Gray, 2004; Chapman *et al.*, 2001; Loughran and Zissimopoulos, 2008; Napari, 2010). Breusch and Gray (2004), using 2001 HILDA data, found 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 per cent in earnings. Loughran and Zissimopoulos (2008) and Napari (2010) considered

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the wage gap rather than lifetime earnings. The Human Capital model is called upon to explain forgone earnings resulting from employment breaks and part-time work by mothers, plus depreciation of human capital resulting in employment in lower status occupations or positions (Breusch and 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, evidence such as the finding by Charlesworth *et al.* (2011) that the current form of the part-time jobs undertaken by Australian mothers tends to lock them into short hours jobs without prospects of career advancement and the persistence of the earnings penalty in the face of increasing workforce attachment by women suggests that it is important to explore further their workforce experience.

The return to work by mothers following maternity leave is a critical transition point in the career and earning potential of women who have children. The immediate career impact and longer term career outcomes for women who are now mothers have received little attention in the literature. 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 and Harris, 1998) or to explore the applicability of broader career theory such as kaleidoscope careers (Cabrera, 2007) or the protean career model (Hall, 2002; Valcour and Ladge, 2008). 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.

## 2. 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 and Liu, 2007; Houston and Marks, 2003; Lyness *et al.*, 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 and 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. Houston and Marks (2003, p. 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, p. 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 career outcomes is the level and type of employment to which a woman is able to return following maternity leave. Lyness *et al.* (1999, p. 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 and 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 and 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 and 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 and 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 *et al.*, 2003). Carney (2009, p. 127) has considered the impact of both part-time work and breaks in employment on career maintenance and concluded that the higher the mother's occupational status the more likely she was to become excluded from her occupation. Carney (2009) argues that, on the basis that these women divert from the 'ideal worker' model, their treatment could be characterised as systemic discrimination. Craig (2007, p. 116) defines systemic discrimination in employment as patterns of behaviour that are part of the social and administrative structures of the workplace and that unjustifiably create or perpetuate a position of relative disadvantage for some groups. 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; including work colleagues

in these discussions avoids the perception that the working mothers are receiving preferential treatment. Durand and Randhawa (2002) caution that the relationship between existing full-time 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 and Randhawa, 2002, p. 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 and Goodnight jr. (2001) 26 per cent 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). Mayer, Ho and Goodnight jr. (2001, p. 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 and Ickovics (1999, p. 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, Gerber and Ickovics (1999, p. 914) found that of those women who did not have children, 35 per cent 'felt as though they had to choose between medicine and motherhood'. The careers of 62 per cent of those with children had slowed or markedly slowed. Jagsi, Tarbell and Weinstein (2007, p. 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 largely mirrors the broader literature in placing the focus on management of the return to work by the organisation and on institutional impediments to career progress. Many of the 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, to understand their experiences and to identify institutional and organisational factors which they consider are 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 a forthcoming paper. The ongoing labour shortages within some health professions, the high initial training costs 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 a critical issue for the health industry and the economy.

### **3. Methodology and Data Collection**

The study used a mixed methods design. Questionnaire design included both open-ended questions and opportunities to explain the reasons for the answers. It was designed to explore the varied individual situations, experiences 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 respondents wished to raise relating to return to work. The qualitative approach aimed to consider how the respondents interpret and make sense of their world. The researchers sought to understand the reality of planned return to work and career for those studied (Holloway, 1997; Morse and Richards, 2002).

The quantitative data collection involved a number of demographic questions plus 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 drawn from the literature. The non-demographic questions invited reflection and explanation by participants. The questionnaire was piloted using a sample of health professionals who had taken maternity leave. It took approximately 45 minutes to one hour to complete.

Data were collected via questionnaire from health professionals undertaking maternity leave. The Department of Health, Western Australia (DHWA) and one national 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. In 2010 DHWA staff were entitled, where they met qualifying requirements, to 14 weeks' paid leave and a further period of unpaid leave; the private provider provided 12 weeks' paid 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 per cent and 48 responses from staff of the private provider, a response rate of 31 per cent.

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. Where these data are used to support the themes and subthemes in the findings quotes are provided in italics separated by // to indicate different respondents.

## **4. Findings**

### ***Demographics and Work Experience***

Of the 388 respondents, 243 were in nursing/midwifery, 31 were medical doctors and 114 were AHPs. Almost all respondents were married or in a relationship (97 per cent). Most partners were in paid full-time employment; six per cent were in part-time employment, three per cent not in paid employment. Eighty five per cent of respondents had either one or two children. For almost 50 per cent this was their first child.

The data allow us a snapshot of the working life of these health professionals

up to the time they took leave. Of respondents, 12 per cent were aged 29 or less, while over 75 per cent 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 per cent of women who had their first child were aged 30 years or over. The women in our study 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 per cent had taken one or more career breaks. Of these, 67 per cent 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 per cent); seven per cent re-entered at a higher level and eight per cent 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 eight months.

The demographic data do indicate a strong clustering of the respondents in relation to work and family situation; almost all respondents were either married or in a relationship and most had one or two children. These women were predominantly in their thirties and had ten or more years of professional experience.

### ***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 and 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.

Table 1 - Attitudes to Women, Work and Family Responsibilities

<i>Your views on:</i>	<i>Strongly agree/ agree per cent</i>	<i>Agree per cent</i>	<i>Mean (1= strongly agree, 5=strongly disagree)</i>	<i>Standard Deviation</i>
Stay-at-home fathers are respected	0.8	23.4	3.39	1.01
Stay-at-home mothers are respected	1.6	25.9	3.25	0.96
Women have more career options than their mothers	26.8	66.1	1.82	0.61
Women have as many career choices as men	8.1	50.0	2.61	0.99
Women/men have the same promotion prospects	3.1	23.8	3.33	1.04
Difficult today for women to be mothers/have careers at the same time	25.0	52.3	2.13	0.96
Women/men have equal opportunities in the workforce	1.6	17.4	3.65	1.02
Workplace allows mothers flexibility for family responsibilities	0.5	39.8	3.05	1.03
Workplace allows fathers flexibility for family responsibilities	0.3	19.9	3.52	1.00

Their own and society's ideas about the ideal family are said to contribute to women's approach to work (Hakim, 1998). While 26 per cent of the respondents expected equal division of responsibility, by far the largest proportion of respondents (57 per cent) 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 per cent) indicated they would still choose to work. In choosing their profession 73 per cent 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 per cent, indicated that they had made a trade-off between family and career though only 46 per cent had anticipated making this trade-off. Proportionately, doctors were most likely to consider they had made a trade-off. Within each profession approximately 50 per cent had not anticipated the trade-off they would make. Over 38 per cent of these women said that they were career motivated while 27 per cent 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.

Table 2 - Career Motivation and Family

	<i>Career motivated</i>		<i>Family more important than promotion</i>	
	<i>Frequency</i>	<i>Per cent</i>	<i>Frequency</i>	<i>Per cent</i>
Strongly agree	13	3.4	261	67.3
Agree	132	34.0	113	29.3
Neither agree nor disagree	131	33.8	11	2.8
Disagree	91	23.5	-	-
Strongly disagree	14	3.6	1	0.3

Our data indicate that there is an expectation of continuing workforce attachment and a 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 commitment to profession 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***

Successful return to work following maternity leave is a precondition for women to sustain and develop their career. One theme from the literature relating to successful return to work following maternity leave revolved around the active management by organisations of the leave and return to work conditions (Houston and Marks, 2003; Millward, 2006).

In our study almost 40 per cent 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 for DHWA) and nationally determined six months' unpaid entitlement (at that time). Others obtained assurance that they would return to the same position or employment conditions. On the other hand, 60 per cent of our respondents had not had a discussion with management and thus not had the opportunity to build an understanding of how the return to work would be actively managed.

While half of the respondents in our study had been in full-time work prior to their current maternity leave, only five per cent indicated that they would return to a full-time position. This is consistent with Australian patterns of part-time work for mothers of infants zero to four (Chalmers, Campbell and Charlesworth, 2005).

Just over 60 per cent of our sample who anticipated returning to part-time work expected to work for between 15 and 24 hours per week. A cluster of responses around eight hours per week suggests some would seek one day per week. The bulk (75 per cent) of respondents returning to work expected to return to the actual job they held before their maternity leave. Only four per cent 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 (nine per cent) 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.

Anticipated peer support made a considerable difference to willingness and 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 50s 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 and this can result in negative outcomes:

*//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 and Liu, 2007; Houston and Marks, 2003; Khalil and Davies, 2000; Millward, 2006). We conclude that, as anticipated, a workplace culture which is supportive of mothers who return from maternity leave is conducive to the retention of these employees following maternity leave.

### **Career Progression**

A second major theme identified related to career opportunities, the availability of conditions required for career progression and access to training and development. 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 were 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.//... like to do a paediatric post-grad course but not offered part-time//... professional registration requirement; in particular ...around recency of practice and ongoing training.//...foresee difficulties maintaining professional development hours to maintain registration.//.*

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 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 training at times which were unsuitable for shift workers. Other problems 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.

*//...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.//opportunities for further career development will not be available...given to permanent staff who were not pregnant.// ...lose ability to do study days and keep up*

*to date.//...continuing professional development often happens after hours or outside Perth.//...concerned about maintaining professional development requirements (for registration)... difficult to attend in-service (childcare).//*

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:

*//I have had to put post grad education off...//...have been supported in the commencement of further studies by my manager.//*

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. In some part this was attributed to a period of not being in the workforce. 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.

Many respondents noted that there were restrictive conditions in place around opportunities to take on or continue in senior roles. 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)//Career progression impossible unless you work full-time.//Job sharing at senior levels uncommon.//...lack of shared jobs...//*

Medical doctors and AHPs noted that they would expect to be restricted to work of a non-complex nature or had decided they must move to a less demanding specialty.

*//...no longer able to participate in complex cases...relegated to simple cases...not challenging or career enhancing.// Part-time work necessitates less acute work...// ... choose quieter, less stressful gerontology.//...difficult to pursue a career as a senior physio on a ward part-time...//*

These findings are consistent with the wider literature which has suggested that women with children experience a lowering in expected occupational status as a result of motherhood. Many of the respondents expressed a level of acceptance

that the restrictions they foresaw on their future career were a direct result of the decision they had taken to have a family. For some these restrictions were a matter of expressed frustration, while some took the position that they would not, in the future, be interested in a career.

### ***Movement to Lower Level Positions***

There was support in the data for the view that women who become mothers are frequently moved to lower level or less skilled positions. This was clearly the case for some medical doctors and AHPs noted above in respect of the complexity and pressure of work. Other comments included:

*//I was demoted when I returned to work.//...not being able to return to the position I was doing previously.//I have to take a lower level job rather than continuing in managerial/senior roles.//...unlikely management will allow me to return to that role.//*

### ***What Actions Assist with Career?***

Management and organisational support were important in the anecdotes of some of the respondents and bolstered their return to work and continued participation. This is consistent with the literature (Buzzanell and Liu, 2007; Houston and Marks, 2003; Lyness *et al.*, 1999). As one mother in our study noted, 'After my first child I would have left the profession except for the intervention of one dedicated female mother manager who recruits for experience and offers flexibility'. Those who felt supported by management were positive about their future while management support was high among the issues which would help mothers plan future leave and career moves. One mother noted that management was '...very supportive and I know my position will be held until I return'.

Nevertheless, one of our respondents commented that the health industry was bedevilled by short-term planning, 'not long-term planning or retaining employees'. Proposals by respondents in our study for supportive change which could be introduced were consistent with the issues raised above. Particular emphasis was placed on open minded, supportive and flexible management, 'managers who are approachable and caring'. Other suggestions included open communication with management and opportunities for early (prior to leave) discussions with management, ongoing training opportunities while on maternity leave, a refresher opportunity prior to return to work, support to attend professional development, and opportunities for job sharing. One respondent proposed a mentoring program where senior colleagues who have children can support those embarking on a family.

In line with the comments relating to barriers placed by professional organisations it was also noted that employer and professional body flexibility was required. One respondent noted positively that 'flexibility in this profession allows me to increase my hours at any time without stress'.

## 5. Discussion

Carney (2009) noted that women who are mothers may depart from the workplace norm of long hours and 'availability' and as such may be subject to systemic discrimination. There is evidence for this interpretation, particularly in relation to comment by members of both the medical and allied health professions relating to the types of role which they expect will be available to them following maternity leave. Further support is provided from the respondents' views that they did not have access to more senior roles or that they may be restricted in returning to their previous role if it was a senior role.

We identified other factors at play, however. We interpret these as involving the interaction of systemic discrimination, embedded 'technologies' of work organisation and attitudes and practices reflective of the broader societal attitudes to women. Baird and Charlesworth (2007) highlight the existence of internal company practices and norms and opportunities for managerial discretion, in their case studies of return from maternity leave, which limit the practical operation of organisations' return to work policies. The employing organisations of the respondents for this study had strong policy statements relating to workplace flexibility and 'family friendly' practices (Department of Health, 2009). DHWA introduced a 'Work-Life Balance Policy' in 2006/7 which promotes flexible and responsive work practices and includes training for managers, a Child Care Program sourced through private providers and a Family Friendly Liaison Officer (Department of Health, 2007). At the same time, however, it is very clear that participation in the option of part-time work for health professionals in our study results in considerable constraints on the roles available, the type of work undertaken, professional development and training given and the future career opportunities which can follow.

The data suggest that many roles in health at senior or 'career level' have been defined as full-time roles; this may be the result of an embedded 'technology' of work organisation, which sees many senior or career positions and the operational requirements around the performance of those positions as fixed and immutable. As a result these positions are not designed for part-time employment and the prevailing orthodoxy is that they cannot be so designed. Bolstering this embedded technology may be the element of managerial discretion available. Flexible work and leave options are noted by the Department of Health (2012) to depend 'on operational requirements and Industrial Award provisions'. This enables managers to take a stance such as that noted of the manager who was 'not willing to allow more senior positions to people going on maternity leave'. It is very apparent, however, that some decisions are also reflective of broader community attitudes. One respondent noted 'Management have very out-dated views of females in the workforce'. Such attitudes are likely to reinforce the perception of certain senior roles as requiring full-time employees and reinforce preference to full-time employees for professional training and development opportunities.

It is nevertheless surprising to find that in the highly feminised health professions these rigidities and attitudes continue to prevail and that opportunities to design senior roles around the potential to attract skilled, experienced women and men to part-time career positions has not been taken. In part this may be because some managers do not know how to organise and manage the performance of part-time workers in a workplace where the norm is full-time work and lengthening work hours.

## 6. Conclusion

We have proposed that the experiences and expectations of the survey respondents relating to their return to work following maternity leave show the interaction of systemic discrimination, embedded 'technologies' of work organisation and attitudes and practices reflective of broader societal attitudes to women as potentially restricting opportunities and longer-term career development possibilities of these women health professionals. We note that the women in this study were experienced mid-career professionals and thus have much to contribute to the future in the health sector.

Issues for workplaces and health sector organisations involve embedded workplace 'technologies' or ways of organising the work and issues of workplace culture and practice. It is interesting to note, in particular, that the issues arising for mothers who anticipated working part-time on their return to work resonated strongly with the findings of Baird and Charlesworth (2007) which related to quite different industries in Australia. It seems likely that such issues will linger while part-time working remains a pattern of work participation which is managed as outside the normal flow of the workplace, to be tolerated and worked around but not integrated into the organisation's operational pattern. Were part-time work to become integrated into the service delivery model then other aspects of systemic discrimination, such as lack of access to training and development opportunities for part-time workers along with the reservation of senior positions to full-time employees, would likely also become untenable.

With the exception of issues raised around training in medical specialties (Potee, Gerber and Ickovics, 1999; Verlander, 2004) the literature is largely silent on the broader professional practice and training restrictions noted. 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, as it appears, simply represent restrictive professional practice.

Further research to understand the link between women's immediate employment conditions following maternity leave and longer term career development may include a longitudinal study to assist us to understand the link between part-time and full-time hours, training and development opportunities and career opportunities in the longer term.

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