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Fatherhood and medicine

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ABSTRACT – Having children will inevitably, to a greater or lesser degree, have a negative impact on a woman doctor's career progression. It is a major challenge to create a working environment which optimises her career progression, and at the same time enables optimal parental care for her children. This is a multi-faceted issue, but the quality of childcare is rarely discussed, except in terms of nursery places and tax deductions. The perspective of the father, and his potential contribution to the sustenance of his wife's career and the welfare of his children, are rarely considered. The woman doctor's perspective as a mother is also put to one side. The major burden of childcare for the foreseeable future will fall on the mother, but the key issue (for parents and administrators) is that the period of intensive childcare is limited and, once complete, both careers can proceed at full pace.

KEY WORDS: childcare, parental leave, women in medicine

Fatherhood changed my life, but influenced my professional career hardly at all. On the other hand, my wife gave up her job in hospital medicine completely for approximately seven years, and re-entered the workforce via a part-time training programme in general practice. She now works as the senior full-time partner in a busy general practice, is heavily involved in medical politics, and plans to continue in this vein well past the age when many of her males colleagues have retired.

My wife and I met at a time when women comprised only 10–20% of medical students. In more recent times, with the proportion of women students rising to the present level of ~60%, doctors are more frequently marrying doctors. Many more male doctors now have a personal as well as a professional and general societal interest in the career of female doctors. This article is written mainly from the perspective of doctor/doctor marriages, but the principles apply equally well to most families where only the mother is a doctor.

The increasing proportion of women in medicine is seen in some quarters as a 'problem', with some doctors (including women doctors) supporting the notion that there are too many. Curiously enough, when men comprised 90% or more of doctors, nobody (certainly not men) argued for redressing the balance. It has been redressed neither by any change in government policy nor by any pressure from the profession, but simply by girls applying more frequently to medical school, and getting better A level grades than boys. However that may be, this is not a gender issue per se, but an issue centred on maternity.

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When a woman doctor has a child, a myriad of conflicting interests come into play (the baby's welfare, the sustenance of the mother's career, the employer's need to maintain a clinical service with minimal disruption, colleagues' concerns at shouldering additional burdens, society's wish not to lose an expensively trained doctor). Her problems are compounded by the unusual length of medical training (five or six years at university, five to eight years of postgraduate hospital training, and an additional two or three years for a research degree if she pursues a clinical academic career). Most pregnancies occur in the training period, a time when professional commitments are least flexible, and childcare prolongs this process. It is a formidable challenge to create an environment which addresses these issues in the best possible manner. Part-time work, flexible training and work–life balance are constantly discussed. However, the father's perspective and his potential contribution to the sustenance of his wife's career and the welfare of his child, are rarely considered.

Social circumstances, family finances and personal values vary widely and will heavily influence decisions about childcare. There are many permutations and combinations. If a couple are happy for their child to be cared for by a nanny or a nursery at a few months of age, the impact of parenthood is minimal. The father incurs no burden, and the mother the minimum burden that biology demands.

A common scenario is for the mother to take maternity leave for the maximum time permitted in the UK, enabling her to care for her child for the first year. Box 1 shows a model situation where a woman has three children with a two-year gap between pregnancies, and with one year of parental care for each child. If this option is chosen and the mother is solely responsible for childcare, the impact on her career is serious, but not catastrophic (left column). With three children she loses three years over a five-year period (four years if she works half-time between pregnancies) and works two years with the usually slight disadvantage of being pregnant for most of those two years. With two children, she loses two years over a three-year period (two and a half years if she works half-time between pregnancies). In this scenario, a contribution from the father is desirable but does not make a major difference, as the period of childcare covers the time when the child is very young, including usually the period of breast feeding. However, the mother might wish to go back to work half-time when her children are six to 12 months old (right column). Taking responsibility for one or two days per week for six months is not a major issue for the father, especially if this can be accommodated (in part) by shorter weeks within a full-time post, by the judicious use of annual leave, and by other means. The scenario in Box 1 requires that employers permit either parent to take parental leave until the child's first birthday.

However, an important challenge lies beyond this key date. The modern breakdown of the extended family has radically altered the environment of care for the very young and the very old. Whether the best environment for children during the first few years of their lives is within the family is constantly debated, but our instincts tell us that it is likely to be so. Research is difficult to interpret, as the things research measures are of necessity crude. And yet the welfare of our children, and ultimately of our society, depends on our getting this right. These issues apply equally to the children of intelligent, expensively trained women, for whom professional success is an important part of self-fulfillment, as to anyone else. Some nations take this seriously. For reference, in France two years of unpaid leave are permitted and in Germany three years, taken by either parent, are standard.

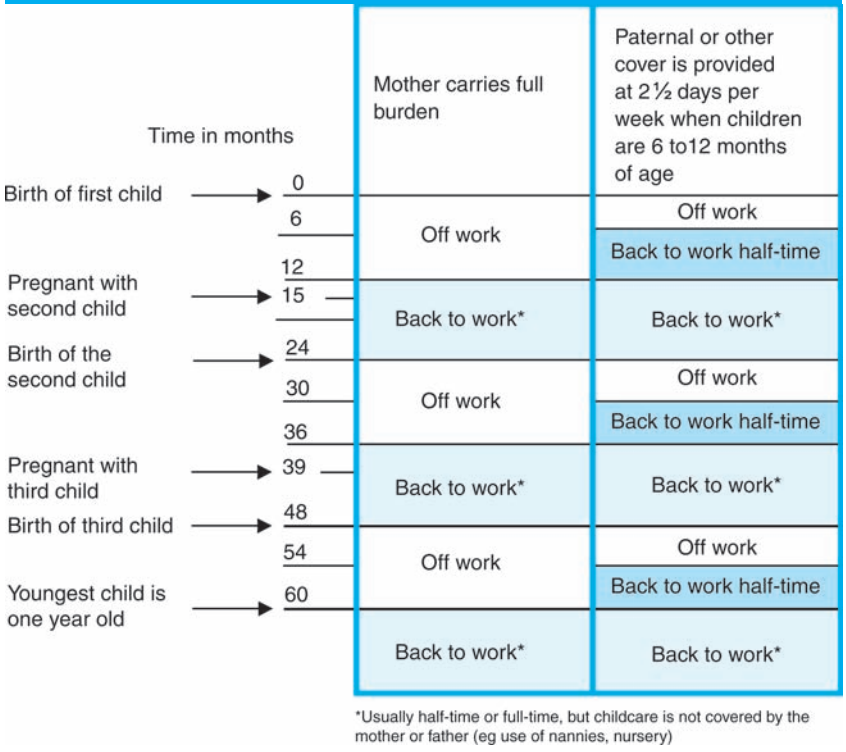
Increasing the period of parental care to two or three years greatly increases the parental burden. It is interesting that the European Working Time Directive (EWTD), substantially reducing the number of hours worked by trainees, could be a timely and valuable development in this area. Already, some trainees are working a four-day week to comply with current reductions in working hours. Out-of-hours work in combination with an overall reduction in hours is likely to enable the combined workload of the mother and father to be much greater than one full-time post and, if worked sequentially, can potentially make an important contribution to parental care of the children while both careers progress. It also reduces the net loss of medical manpower attributable to parental care, which should provide an incentive to administrators to embrace this concept. A move to parental, rather than maternal, leave, the EWTD and a small change in the attitude of fathers could make a major difference to childcare and the careers of women doctors.

There is little difference between committing to two or three years of parental care, as the third year of the first child or children will usually overlap with the first year of the following child. Should a couple decide to care for their children until they are two or three years old, and the mother bears the full burden of childcare, the effect on her career is catastrophic. She is out of the workforce completely for six or seven years with three children, and four or five years with two children. She loses her training number, requires retraining before re-entering the workforce, and is likely to find it difficult to resume training in her chosen specialty. This is what my wife and I chose to do more than 30 years ago, but it is not an acceptable solution in these times.

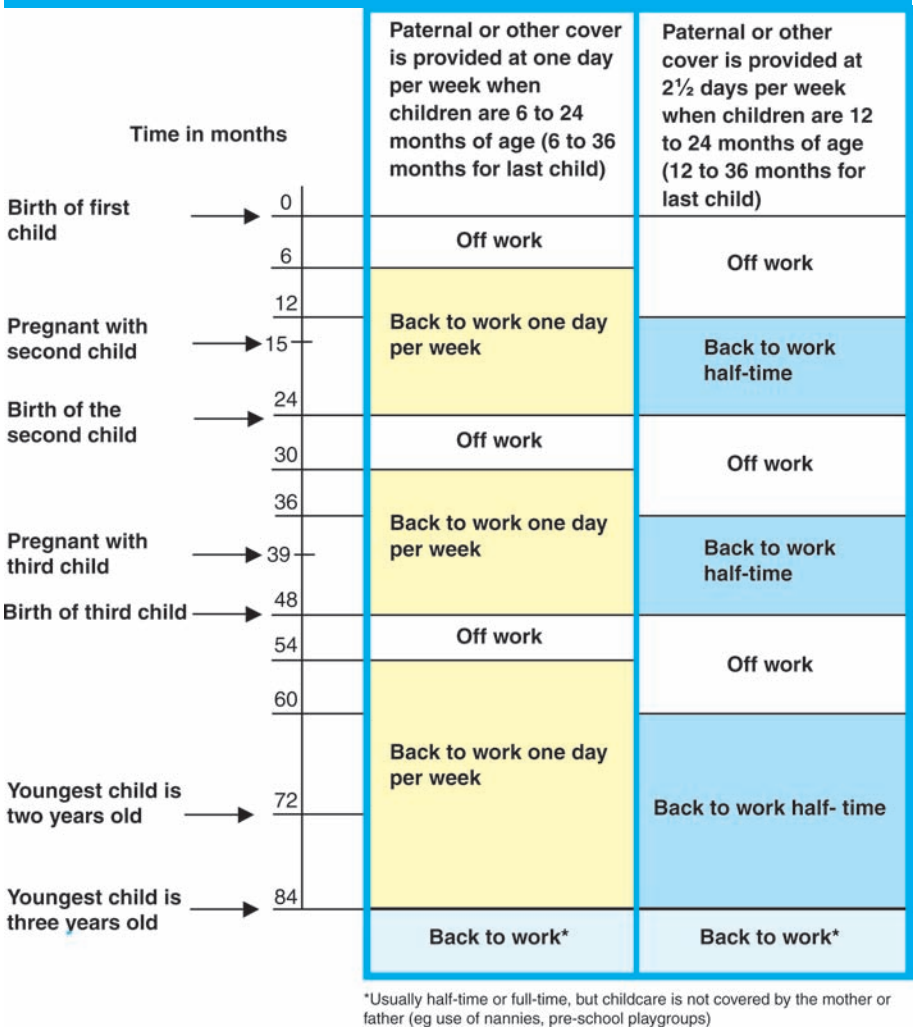
If the father is responsible for one day per week from the time the children are six months of age (Box 2, left column), the mother's career is barely sustainable. The one day per week enables her to maintain her clinical skills and professional relationships. However, under current rules, the mother loses her training number. Where this most minimal of options is the best that can be done, consideration should be given to retention of the mother's training number over this period, provided that the weekly contact with clinical work is strictly maintained. Clearly, however, more substantial periods of work are essential to maintain the mother's career momentum. The scenario where the mother goes back to work half-time after each child's first birthday (Box 2, right column) still represents a loss of five years over a seven-year period. Although babies cannot always be produced on schedule, reducing the time between pregnancies to 18 months reduces the period of childcare by one year if three children are planned. The father could take primary responsibility in the seventh year, by which time he is likely to be in a substantive post. Together, these factors reduce the mother's loss of work to three years over a six-year period. The loss of medical manpower is less if the parents together work more than one full-time equivalent, as discussed earlier.

Additional factors can make a difference, eg judicious use of part of the father's (and mother's) annual leave, and even small, short-term contributions from grandparents. A critical issue is that parental leave and part-time training should be available to every parent when pregnancy is confirmed. It is not acceptable that these matters be left to the discretion of local deaneries, hospital trusts or primary care trusts.

Box 1. Burden of childcare for the mother, when a woman has up to three children with a two-year gap between pregnancies, and one year of parental care for each child.



Box 2. Burden of childcare for the mother, when a woman has up to three children with a two year gap between pregnancies, and three years of parental care for each child. Note that, because of overlap, the only difference between two and three years of parental care is the seventh year.



*Usually half-time or full-time, but childcare is not covered by the mother or father (eg use of nannies, pre-school playgroups)

The period of intensive childcare is limited, and once complete both parents can proceed with their careers at full pace. Boxes 1 and 2 should be helpful for planning paternal support and for calculating work loss for both parents. The greater the father's contribution, the less motherhood will be perceived as a problem. In the meantime, the idea that a woman be denied a place at medical school on the grounds that she might become a mother should be treated with the derision it deserves.

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