'We'd like to have a family' - young women doctors' opinions of maternity leave and part-time training

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Summary

Maternity leave and part-time training should facilitate the integration of the family and professional lives of young women doctors - whom the NHS cannot afford to lose as their numbers rise to half the number of the graduates of UK medical schools. Women doctors' planned professional activity is high, but to what extent do the maternity leave and part-time training arrangements assist them in fulfilling their plans?

One hundred and forty-five young women doctors reported their experiences of and views on maternity leave and part-time training. Most had children between 6 and 10 years after qualification, to fit with career development. Seventy-one per cent of the confinements had qualified for maternity leave and pay, but there were complaints about the working of the regulations, particularly in relation to junior hospital doctors' short contracts. When asked to comment about part-time training, most (77%) expressed themselves as broadly in favour - only three actively opposing it. It was perceived as difficult to organize by 20% of respondents, as difficult to undertake by 29%, and as being of low status by 15%.

This study concludes that the arrangements for maternity leave need to be improved and that the availability and status of part-time training need enhancing - especially to encourage women doctors to enter careers in hospital medicine.

Introduction

Nurturing a medical career and a family is difficult[1]. Both sexes feel the strain of being a junior house officer[2], but extra stress is felt by women doctors as they consider starting a family. This is when role strain or 'fragmentation' may become significant, as 'a product of conflict and bargaining between occupational and traditional gender roles'[3].

The statutory availability in the UK - for employees - of maternity leave with pay[4] and of the possibility of part-time training[5] ought to minimize stress for British women doctors. This study, which was part of a larger investigation into women doctors' commitment to medicine[6], aimed to determine whether such provision aids them through their children's early years. This is important for individual families and the NHS because the childbearing years are also those of higher training for a hospital specialty or establishment as a principal in general practice.

Women now comprise 46% of the intake of medical schools[7] and are over-represented amongst those training for general practice[6]. Many wish to have children, and their potentially slower paced careers have clear significance for national manpower planning.

Method

A random sample of 150 women graduates of British medical schools was drawn from the fortnightly lists of those admitted to the Provisional Medical Register of the General Medical Council for 1976, 1980 and 1984. They were exhaustively traced[6]. Each subject was telephoned in Spring 1987 by the same woman doctor (VJW). They were asked to outline their experience of and thoughts about maternity leave and part-time training.

Subjects with addresses outside Europe were sent an explanatory letter with a printed questionnaire and an International Reply Paid Coupon. If the questionnaire was not returned, attempts were made to telephone them. The responses were then coded and analysed using SPSS-X.

Results

Answers were obtained from 145 of the 150 doctors in the sample, a response rate of 96.7%. One of the remaining five was dead; the name of the second had been erased from the Register for failure to pay her annual retention fee to the GMC, and she emphatically refused to participate in the study. Three had always been expected to return home to Africa and Asia.

Eighty-one respondents (56%) lived with their husbands and 14 with their fiance or boyfriend (total 66%). No one was asked whether she had previously been married. Four more (3%) were single parents. Fifty-six (39%) were mothers and one was a step-mother. No elderly relatives lived in a younger family's home. Table 1 shows family size in relation to year of graduation.

Current work status is shown in Table 2, and specialty in Table 3. Ninety-nine (68%) had a higher qualification, the highest frequency being amongst

Table 1. Family size by year of graduation

	Year of graduation		
	1976	*1980*	*1984*
Years qualified at time of study	10.5	6.5	2.5
Number with:			
baby	—	12	2
1 child	5	5	1
2 children	20	3	—
3 children	4	1	—
4 children	3	—	—
stepchildren	—	1 (n=3)	—
Total number of children	69	29	3

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Table 2. Current work status

	n	%
Full-time plus one-in-three/four rota	53	35
Less than the above, more than 40 h/week	60	40
Less than the above, five sessions/week or more	14	9
Four or fewer sessions/week	10	7
Looking after family only, planning to return to medicine	7	5
Lost to medicine (2), non-respondents (3), missing data (1)	6	4
Total	150	100

Table 3. Area of work outside the home

	n	%
General practice	77	51
Hospital medicine	42	28
Community health/family planning/ National Blood Transfusion Service	6	4
Community medicine, industry, academe, Armed Forces	9	6
Time split between different jobs	3	2
Not working outside home (but plan to return to medicine)	7	5
Lost to medicine (due to death, illness or erasure from the Medical Register); outside medicine; non-respondents	6	4
Total	150	100

the 1980 graduates; 73% of the mothers held a higher qualification.

Maternity leave and pay

Eligibility Forty-one of the 56 mothers had taken formal maternity leave for every pregnancy[4,8,9]. Thirteen had not been eligible for formal maternity leave for any of their 16 pregnancies; two had been eligible for one of their two pregnancies.

Problems Eighteen respondents were dissatisfied with the system in relation to at least one of their pregnancies. Some of the difficulties would apply to any working mother: a GP employee had worked part-time for too short a time to qualify for maternity pay, and a registrar in anaesthetics had lost pay and job both times because she had moved house for her husband's job. A doctor who worked for a firm offering private health insurance had had difficulty when it decided to regard her as self employed, as did one who worked for the National Blood Transfusion Service and the Community Health department. Lastly, one hospital doctor, theoretically eligible for full maternity leave, was pressurized to return at three months in order to keep her post.

Fourteen had complaints which were a consequence of only doctors' work patterns. Eight had had their short, junior hospital doctors' contracts end during pregnancy, leaving them unemployed rather than eligible for maternity leave and pay; one complained of lack of sympathy towards the difficulties of doing a one in three rota in the third trimester; and one doctor was told she was not eligible because she was paid from a research grant.

A GP trainee had suffered pressure to resign as it was 'against the (unwritten) rules' to become pregnant during GP training. A FPC had refused maternity rights to a GP principal of less than a year's standing partly because of this and partly because she 'had too few patients to qualify'. Two others, who did not go into detail, complained that they had had to pay their own locums. Six principals described difficulties arising over interpretation of practice agreements (or their inadequacy or incompleteness) as to (a) the amount of time that might be taken off (in one case described as 'sick leave'), and (b) whatever amount of leave was permitted, whether any locums were expected to be paid by the individual (out of taxed income) or by the partnership.

Childless women Fifty-six of 89 childless women knew something of the statutory regulations[4], or the provision in their general practice partnership agreement. This awareness was usually because they planned to have children themselves at some point, but two GP principals, who did not, said that they had ensured adequate provision in their partnership agreements as a matter of principle. Two others volunteered accounts of interviews attended for GP principal vacancies: one regarded family plans as having taken up a quite disproportionate amount of the interview; the other reported disbelief that she intended to remain childless.

A number made observations about maternity leave. One was having difficulty discovering her entitlement as an Army officer. Two mentioned the desirability of paternity leave. One doctor, a consultant, looked on maternity leave with disfavour as she felt that the locums appointed were of low quality; A GP principal disapproved of pregnant women doctors 'leaving other staff in the lurch - people who play the system in their pregnancy make me cross'. A London teaching hospital research registrar described maternity leave and pay as 'fairly generous' - yet Britain has poor provision relative to the rest of the EEC[10].

Part-time training

The need for part-time training The possibility of part-time training is clearly important to women doctors: 112 (77%) made comments in favour of it. Three were against it in principle - two felt that the existence of part-time trainees was detrimental to the continuity of patient care and one felt that it should not be allowed as it 'hassles up the rota'. Only six held no views on the topic, the remainder making a variety of practical observations.

Thirteen of those in favour based their view on their own ($n=3$), or friends' ($n=10$), successful part-time training. Twenty considered it likely that they would train part-time in the future; 16 (11 in GP) felt that it would never be appropriate for them, and 15 were of the opinion that one should train full time, then have children. Conversely, 22 felt that part-time training was particularly appropriate for those with children. Three saw a need for it for childless women, and four said it should be available to men too. Four felt that the scheme should be better publicized.

Six GP principals commented that they would welcome a part-time trainee.

Difficulties The most frequent complaints, both made by 29 people or 20% of the sample, were of the difficulty of organizing part-time training and of its being disproportionately hard work. It was described by seven as 'a farce' to call it part-time. The extension of the time spent in the training grades was accepted as inevitable by 19.

Fifteen felt strongly that the status of part-time training needed to be improved, four emphasizing its potential to keep women in medicine. To achieve this aim, five saw merit in full-time training in the specialty before the switch to part-time, and two advocated a share in the 'on call' rota.

Discussion

Young British women medical graduates are highly committed both to medical careers and to family life[6] despite the difficulties that each presents to the other; indeed their hallmark is a determination to combine the two.

Maternity leave

Principals in general practice are self employed and controlled by their practice agreements and the 'Red Book'[9], but other women doctors are subject to the same regulations concerning maternity leave and pay as other employed women and so share the general hopes that the provision may be improved[10,11], rather than reduced as happened in the changes of April 1987. The study was then in progress. To qualify for maternity pay for the confinements reported here (six weeks at 90% of one's usual salary[4a]) and the right to return to work[10], one had to have been in the same employment for at least 16 hours a week for two years or more, or at least eight hours a week for five or more years. One had to work until one was 29 weeks pregnant; time on sick leave counted as employed time. The new regulations differ in detail but not in spirit from the old ones[4b,12]. Junior doctors were and are able to make out a special case, their short contracts being incompatible with such requirements.

It is a sad indictment of a 'caring profession' that its own members can be manipulated to resign rather than take sick leave, when the physical demands of an 80 hour working week become too much in the seventh month of pregnancy. It is also distressing that a woman doctor can suggest that 40 weeks leave is an inappropriately long time away from work 'for a young doctor who is establishing a career'[12].

That these doctors had managed to qualify for formal maternity leave for 70 of 98 pregnancies despite these regulations demonstrates their determination to continue their medical career. That most of their children were born between 6.5 and 10.5 years after qualification implies that this was achieved by delaying having a family until they were settled, eg as GP principals. How many hoped thus to postpone their family and then found themselves to be infertile is unknown.

Part-time training

It may be that this willingness to delay pregnancies means that the possibility of part-time training is of little relevance to potential GPs whose post-registration training can be completed in four years. None of this sample had trained or were training part-time for general practice, and 11 (out of 77) in general practice or training for it said that training should be full-time, with children coming later. But 13 others complained about the difficulties surrounding the organization of part-time training, so it is possible that the willingness to defer a family may be a survivalist response to current practicalities.

Women doctors are not so likely to make their career in the hospital service, preferring general practice[6]. This may be due in some measure to their wish to be able to mother their children. Hospital medicine would be more attractive if there was feasible part-time training available, so it seems an odd omission that, given the increasing proportion of women doctors qualifying, the plan for action 'Hospital Medical Staffing: Achieving a Balance'[13] makes no mention of it.

Women may, in the future, have to consider hospital medicine more seriously. If they follow the pattern of the women in this study, their children will be born while they are registrars and senior registrars. Given that there is now no involuntary unemployment amongst British women medical graduates[6], although the total numbers of UK domiciled students entering British medical schools rose from 3056 in 1972 to 3800 in 1981[7], it may become necessary to provide part-time training for these women. Better to do that than cope with the alternative - unfilled posts and a pool of reluctant women doctors with small children, including those who have bowed to pressure to work full-time and those who are frustrated at home full-time.

Part-time training should be geographically widely available, ideally in an equally wide range of specialties, although women have shown their willingness to be flexible in this respect[6] if a part-time post is available within 30 miles or so of home[14], and so probably will continue to be willing to enter less popular specialties[15,16].

Probably more important is the image of part-time training and trainees. Davidson, O'Brien and Roberts[14] emphasized the need for the educational input to be clearly of high quality, so that credibility is high and trainees have self confidence when applying for career posts. Women in this study echoed this sentiment, and realized that the trainees themselves need to be respected in their specialty, and to be seen to pull their weight, in particular doing a fair but proportional share of 'on call' work. Nevertheless they expressed great annoyance that part-time posts could often take so many more hours than they were supposed to, leading to resentment from full-time junior staff if they tried to avoid this exploitation. Double standards among senior staff must be reconsidered: one (full-time) consultant anaesthetist drew a disparaging comparison between the commitment to NHS patients of some of her part-time colleagues - consultant male and senior registrar female - which did not favour her consultant colleagues.

Comparison with a contemporary DHSS-funded study

Our study was conducted in parallel with a major investigation into doctors and their careers, funded by the Department of Health and Social Security[17]. Allen reported on the careers of 326 female doctors who qualified in 1966, 1976 and 1981.

Participation in a medical career was similar, with 94% of our respondents so engaged and 94/95% of Allen's 1976 and 1981 female qualifiers[17]. Allen did

not find as high a proportion of women GPs as we did (44% and 37%[17]), compared to our 51%. She did not examine doctors' experience of maternity leave, specifically, but it looked in some depth at part-time training: experience of this, undertaken by only 2% of our respondents, was also limited among the relevant cohorts of Allen's study (8%; 2%[17]), but attitudes towards it were similarly positive - 93% of women thought that it was feasible, and 85% thought that there should be greater availability of part-time training posts[17]. Most felt that these posts should be organized on a job-sharing or split job basis.

As in our study, experience of part-time training was far more likely to have been in a hospital specialty than in training for general practice[17], although - perhaps a matter of concern - the later cohorts had undertaken part-time training to a far lesser extent than had the earlier, 1966, one. Allen concludes that '... the provision of part-time training opportunities had certainly enabled some women doctors to progress, particularly in hospital medicine'; and considered that part-time training posts were necessary for 'keeping women in hospital medicine' - sentiments supported by our findings.

The recommendations of Allen's study state that a review of part-time training should be given high priority and that part-time training should be encouraged. We agree most strongly.

Conclusion

British women doctors succeed in combining career and family, their 'coping strategy' for stress reduction being to change over time the priority they accord to the different calls on their time and energy - career, husband, children, wider family and friends, relaxation/hobbies and household management, the routine aspects of childcare and housework being delegated. Characteristically (and a minority follow different patterns), this means that they delay having children while they work demanding rotas in the years shortly after qualification, and then seek to work part-time while their children are small, resuming full time work as the youngest is established at school.

The results of this study show that British women doctors time the arrival of their children with reference to the development of their careers, using the regulations concerning maternity leave, and the influence of the existence of those regulations on general practice partnership agreements and paragraph 49 of the 'Red Book'[9], to ensure that it will be relatively simple for them to continue their career after each confinement. This timing is the concession that family life makes to career. That which many would wish career to make to family life is the realistic possibility of a few years part-time training.

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