

Female Physicians: Balancing Career and Family

Glese Verlander, M.D., J.D.

Finding an acceptable balance between career and family is a difficult challenge for many physicians. Medicine is a profession in which dedication to the wellbeing of others is of paramount importance. Careers in medicine historically demanded a selfless emphasis on caring for one's patients, sometimes at the expense of one's marriage, children, and personal life. Such a skewed focus worked more easily in the past when the vast majority of physicians were men. When male physicians spent long hours at work or traveling to meetings, their wives were home to run the household and care for the children. As women entered the medical field in increasing numbers, however, the tensions between career and family became more prominent. In trying to balance personal and professional responsibilities, female physicians face a difficult task in striving to "have it all." As a physician and single mother of four children, I know that it can be done successfully, but there are many challenges that female physicians must confront in balancing their multiple roles as physician, mother, and spouse.

The number of females pursuing careers in medicine is steadily increasing. In 1997, women constituted 43% of medical students in the United States and 22% of practicing physicians (1). In 2001, those numbers reached 45.8% for female medical students and 28% for female academic medical faculty (2). Women are expected to comprise 30% of practicing doctors by the year 2010 (3), and 50% by the year 2040 (4). Despite the dramatic surge in the number of female physicians, hospitals and medical centers have moved slowly to provide support for women who pursue medical careers while managing families and raising children (5-7).

The difficulties of balancing family and medicine affect women's choices of specialty (8), advancement in academic medicine (9), health (4, 10), and decisions regarding whether to have children. Professional women in many families remain responsible for the

majority of domestic and child-related duties (11-13), which makes it difficult to devote the necessary hours at work to obtain promotions and tenure. Most medical institutions furthermore remain oriented toward traditional families of the past, rather than today's dual-career parents, with rare availability of onsite daycare and little opportunity for creative scheduling or job-sharing.

CHOICE OF SPECIALTY

Women, far more than men, consider the balancing of family, parental, and occupational roles when making career decisions (8, 14). When specialty choices are examined, women are proportionately overrepresented in the primary care fields and psychiatry. They are underrepresented in most surgical fields (5), with the exception of obstetrics and gynecology, where women now comprise the majority of practicing physicians (2). This skewed specialty choice may be related in part to the female physician's awareness of the competing demands that will be made on her time by career, marriage, and children. Factors other than a balanced lifestyle clearly are at play, however, as evidenced by the high percentage of women in obstetrics and gynecology, despite the intensive and unpredictable character of that field.

PREGNANCY

The timing for starting a family is a critical decision for women in medicine. The most opportune time biologically for a woman to have children coincides with the phase of life when career demands are most intense, making the balancing of career and family

Dr. Verlander is a former Child Psychiatry Fellow at the University of Colorado Health Sciences Center (UCHSC, Denver, Colorado. Address correspondence to Dr. Verlander, General Delivery, Silverthorne, CO 80498; gleseann@yahoo.com (E-mail).

Copyright © 2004 Academic Psychiatry.

particularly difficult for women during their 20s and 30s (15). This period in a woman's life coincides with medical school, residency, and fellowship training, when work demands are high and finances are strained, with little money available to hire support personnel. Many important issues must be weighed in the balance when deciding to have a child. When is a good time to get pregnant and begin a family? If postponed until a woman's mid-30s or later, the risks of infertility and congenital anomalies increase. How will colleagues and supervisors handle the woman's pregnancy and its impact on them? Will working long hours impact negatively on the pregnant doctor or her fetus? How long can, or should, the new mother stay home with her infant before returning to work? How will pregnancy and parenting affect the mother's career?

The general consensus in one study was that internship is the most difficult time for a female doctor to be pregnant, and the third year of medical school runs a close second (8). Residency is the most common period for female physicians to give birth to their first child (8). When asked retrospectively, most doctors in one study indicated that they recommended postponing pregnancy until after the completion of training (16); another study surveyed pediatricians who gave birth to their first child during residency, with the majority indicating that residency was a good time to begin having children (17).

The issue of pregnancy outcomes for female physicians has been explored in a number of studies, with most studies concluding that women who are full-time residents or practicing physicians do not experience an increased risk of adverse pregnancy outcomes or complications (16, 18, 19). Although those studies found that female resident physicians experienced more pre-eclampsia and pre-term labor than other women, their incidence of premature births increased only when they worked more than 100 hours per week.

A problem occasionally encountered by physician-mothers is the resentment of their colleagues. Other residents or practicing physicians may object to any increased work that they must shoulder when female doctors reduce their work hours or take time off due to pregnancy or the birth of a child (16, 20, 21). They also may resent what may be perceived as "special treatment" afforded to pregnant physicians or physician-mothers. Some colleagues may view a

female doctor's pregnancy and family commitments as evidence of a diminished dedication to medicine and career. The impact of pregnancy and childbirth is somewhat lessened in large residency programs or physician practices, and can be minimized by notifying colleagues well in advance of the impending birth and the mother's plans for maternity leave.

MATERNITY LEAVE

The American College of Physicians recommends maternity leave beginning at least 2 weeks prior to an expectant mother's due date and advises that one parent should be the infant's primary caregiver for at least 4 months (22). Many physicians, nevertheless, work until the baby's birth (15). Canadian physicians (including residents) receive 20 weeks of paid maternity leave (23); in most of the industrialized world, employers provide the mother with a minimum of 12 weeks of paid leave (1). Interestingly, many American physicians do not take the entire 6 weeks of maternity leave to which they are entitled (5, 13). This may be partly attributable to concern about colleagues' attitudes toward their staying home with their infant, as well as their own feelings of guilt about being away from their patients and work.

For women who plan to have children, policies on maternity and parental leave are important factors in selecting a residency program or a position as a practicing physician. Although the American Medical Association in 1984 enacted its first maternity leave guidelines (14), policies continue to differ widely among hospitals and health care institutions (8, 24, 25). Many institutions and residency programs do not have specific written policies, but prefer to handle maternity leave on an individual basis (26). Both the American Medical Association and the American Academy of Pediatrics recommend clearly delineated *written* leave policies (25, 27) which can decrease the expectant mother's anxiety about her pregnancy, reduce any resentment during her absence, and preclude inconsistencies in leave time. Besides the length of maternity leave provided by a program, other important issues include whether maternity leave is paid or unpaid, the amount and duration of insurance benefits available for the mother and child, the impact of leave time on completion of training or consideration for tenure, sched-

ule flexibility, the availability of leave for adoption of a child, and provisions for paternity leave.

The federal Family and Medical Leave Act of 1993 (FMLA) applies to residents as well as practicing physicians. It provides for an optional 12 weeks of unpaid family leave for pregnancy, childbirth, adoption, foster care, or care of a sick child or relative, in addition to any paid maternity or family leave. The Act further provides for retention of health insurance benefits during the leave and requires the employer to provide the same job, or an equivalent position, to the employee upon his or her return to work. The Federal Pregnancy Discrimination Act of 1978 forbids an employer from discriminating against pregnant women and states that maternity leave cannot be less than the amount of sick leave provided.

CHILDCARE

As maternity or family leave draws to an end, the physician-mother must confront new challenges in balancing her career and family. One of the most crucial jobs in preparing for the mother's return to work is the search for consistent and competent childcare. It is essential for the physician-parent to have a high degree of confidence in the quality of the childcare, so anxiety regarding the child's safety and wellbeing does not distract the physician from focusing on patients and other work-related activities while away from home. A high degree of confidence and trust in the child's caregivers can dramatically reduce the stress of balancing parenthood and career.

Options for childcare are varied and include: 1) a live-in nanny, which is expensive and reduces family privacy but provides a high degree of flexibility and eliminates transportation time; 2) a paid childcare provider who comes to the home, which also is expensive and requires a backup plan in the event of the provider's absence or tardy arrival; 3) paid or unpaid childcare provided by extended family; 4) informal childcare in a provider's home which again requires a backup plan in the event of unavailability of the provider but costs less and gives the parent more control over timeliness; 5) a formal, licensed daycare which is the most highly regulated and least expensive alternative but lacks flexibility in hours, often makes no provision for ill children, and can result in an increased incidence of childhood illnesses. Few hospitals or medical schools provide on-

site daycare, but that option is ideal for the physician-parent, particularly when the daycare program offers round-the-clock care and provides a setting for mildly ill children.

School-based childcare is usually available when children are older. That option has many advantages, including affordability and ease of use. The primary disadvantage is curtailment of children's extracurricular activities. One alternative is to hire a student to supervise the children at home after school, which allows the children to participate in extracurricular activities of their choice or to play with neighborhood friends. Having an adult in the home after school can provide additional support for the female physician, since the sitter can handle some errands with the children and take them for basic dental and medical appointments. Being freed from some of these duties allows the female doctor more time to relax in the evenings with her family.

BREASTFEEDING

Another issue faced by many new mothers is whether, and how, to continue breastfeeding when they return to work. Many work settings now allow time and provide quiet places for new mothers to pump milk for their infants. Modern electric breast pumps are efficient and effective. Another alternative is breastfeeding before and after work while at home and supplementing with formula during the new mother's work hours. Onsite daycare has the added benefit of allowing the mother to visit and breastfeed her infant during the workday.

ALTERNATIVE WORK SCHEDULES

Although the majority of men today report experiencing some role conflict, women more commonly report significant stress and conflict due to their multiple roles (28). A 1996 study concluded that women are more likely to alter their job responsibilities or make a career change to benefit their families and children, with the most common adjustment being a reduction in hours worked (27). The same retrospective study found that 85% of female physicians made career changes for the benefit of their children and family, while only 35% of male physicians made similar changes. Alternative work options are available in some healthcare and academic medical settings, in-

cluding part-time work, shared positions, alternating work and family time (such as alternating one year of work with a year spent home raising children), taking family leave, having summers off, or reducing travel.

A recent graduate medical education census indicated that the number of residents in part-time or shared positions actually declined from 1% in 1996–1997 to 0.8% in 2000–2001 (29). That survey was based on a 99.4% response rate from training programs nationwide; not surprisingly, 81% of the part-time residents were women. The number of part-time men and women were equal, however, in psychiatric training programs. Another study found that more men than women worked part-time in academic medicine, but that the majority of women who worked part-time did so for children, while most men did so to have more time for private medical practices (30).

ACADEMIC MEDICINE

The advancement of women in academic medicine and administrative psychiatry has not kept pace over the past three decades with the dramatic increases in the number of practicing female physicians. The percentage of female professors in academic settings has remained remarkably stable at 11%–12% (9). Female doctors frequently state that their interest in academic medicine is lessened due to concern about balancing their multiple roles (31). A 1998 study by Carr et al. concluded that decreased academic progress and success is related to childbearing (32), a finding which substantiates women's concerns about combining academic medicine and parenting. Male medical leaders additionally emphasize the importance of strong mentoring in their career development, while female academic physicians lament the fact that few female mentors are available to model the difficult balancing act required for a successful medical academician and mother.

Women who pursue careers in academic medicine sometimes are precluded from rising to leadership positions because of their family demands (33, 34). Many female academicians indicate that promotions and tenure are biased in favor of men due to the male-oriented career framework in medicine which emphasizes single-minded focus on research and career, with no flexibility in timing of promotion

and tenure for physicians with heightened family responsibilities (29). The American College of Physicians recently recommended increased flexibility in tenure timetables and promotion practices to encourage more women to pursue academic medical careers, and to accommodate doctors' family and parental duties (29). Parent-physicians need a variety of alternatives in their careers, with adjustments in promotion and tenure timelines, work schedules, and benefits. Efforts also should be made to decrease stigmatization of doctors who select part-time or slower progression tracks. To attract more female physicians to academic medicine, and retain them as academicians, women furthermore need stronger support from the medical community, including increased availability of childcare in academic settings, flexibility at work, strong mentors, and decreased "good old boy" cronyism.

HAVING IT ALL

Successful management of a demanding career and family responsibilities requires regular reassessment of priorities. It also requires a great deal of energy and flexibility and a level of comfort with a certain degree of chaos and unpredictability. It requires patience with one's own limits and with imperfection. In attempting to balance school and work in the legal and medical fields while single-parenting my four children, the guiding principle that allowed my family to do well was that my children came first (most of the time). This basic premise grounded me as I pursued intensive schooling, worked in the legal field, and trained in psychiatry. Whether making day-to-day decisions regarding time allotment or long-range decisions regarding career direction, the primary question I asked was what was good for my children and my own sense of self. Learning to regularly reflect and engage in that personal analysis took a great deal of trial and error and serious thought regarding my values and priorities. The right balance will vary for each woman and each family, of course, with the time allotment and emphasis likely changing during a woman's life course.

One of the hardest, but seemingly obvious, lessons that I learned over time is that I cannot be in more than one place at a time. It took some of my supervisors even longer than I to accept this simple fact of life. I tried for years, as many women do, to

meet everyone's needs both at work and at home. This allowed me to avoid feeling guilty for not living up to my own high standards and to avoid disappointing important people in various aspects of my life. Attempting to be a superwoman, however, can lead to enormous stress and personal sacrifice and, ultimately, is not good for the individual, the family, or for one's patients and work, as burnout can occur on all fronts. I eventually learned to weigh the costs and benefits of various demands and opportunities and to say "no" at times, while sometimes weathering my own resulting feelings, my children's or my own disappointment, and the reactions of my supervisors and/or colleagues.

When choosing a work setting or residency program, remember that job-related stress, career dissatisfaction, and psychological distress are greatest when high levels of demands are placed on the physician while providing little individual control over work and little autonomous decision-making power (9, 35, 36). With increased social support, greater job control, and increased flexibility at work, career satisfaction increases and psychological stress decreases. Supportive family and friends, understanding bosses and colleagues, and hired support personnel can greatly ease the stress associated with juggling multiple roles. Stress reduction can be further achieved by choosing to live in an area that provides geographic proximity to work, home, children's schools, and daycare (14). With less time spent traveling between various sites or stuck in traffic, more time is available for productive career and family activities. Living near extended family can be extraordinarily helpful, if grandparents and other family members are willing to assist with the children and errands. Grandparents and grandchildren also benefit when their lives are enriched through this special relationship.

Time allotment and priorities differ for working women when compared with mothers who stay home with their children. For most professional working women, housework, cooking, and gardening are not top priorities (37). Although the disapproval of others whose priorities center more heavily on domestic endeavors may be difficult for some women, children are unlikely to care whether the spaghetti sauce served for dinner came from fresh tomatoes and herbs grown in the garden or from a store-bought sauce with a quick pinch of added spice. They will recall, however, whether their parents read them bedtime stories, took them for walks, came to their school performances, and cheered at their sports events. Hiring others to clean house, care for the lawn and gardens, cook, and do household repairs can be invaluable in reducing the workload at home and allowing more time to interact with family or relax at home.

As women physicians struggle with the stresses associated with "having it all," they should be reassured by two studies which found that male and female physicians without children experience less job satisfaction than doctors with children (36, 38). In those studies, physicians with the largest families somewhat surprisingly reported the greatest job satisfaction. Although "having it all" is often demanding and sometimes exhausting, I cannot imagine my life without both my children and my career, and I feel satisfied with the balance that I have found. That, to me, is the ultimate goal for each woman: to find a personal balance that works well for herself and her family and leaves the physician-mother with a sense of fulfillment and contentment with the choices made. Having the support of important others at work and at home, and working in a more family-friendly medical environment, makes that goal infinitely easier to achieve.

References

1. Bickel J, Croft K, Marshall R: Women in U.S. academic medicine statistics 1997-1998. Washington, DC, Association of American Medical Colleges, 1998
2. Bickel J, Clark V, Lawson RM: Women in U.S. academic medicine statistics 2000-2001. Washington, DC, Association of American Medical Colleges, 2001
3. American Medical Association: Women in Medicine in America: In the Mainstream. Chicago, American Medical Association, 1995
4. Miller ME: Doctor-moms. *Hopkins Med News* Spring/Summer 2002
5. Bowman MA, Frank E, Allen DI: Women in Medicine: Career and Life Management. New York, Springer-Verlag, 2002
6. Bowman MA, Allen DI: Stress and Women Physicians. New York, Springer-Verlag, 1985
7. Warde C: Work-family balance. *Ann Intern Med* 2001; 134: 343
8. Bickel J: Women in Medicine: Getting in, Growing, and Advancing. Thousand Oaks, Calif, Sage Publications, 2000
9. Bickel J, Wara D, Atkinson BF, Cohen LS, Dunn M, Hostler S, Johnson TRB, Morahan P, Rubenstein AH, Sheldon GF,

- Stokes E: Increasing Women's Leadership in Academic Medicine: Report of the AAMC Project Implementation Committee. Washington, DC, Association of American Medical Colleges, 2002
10. Brisson C, Laflamme N, Moisan J, Milot A, Masse B, Vezina M: Effect of family responsibilities and job strain on ambulatory blood pressure among white-collar women. *Psychosom Med* 1999; 61:205-213
 11. Frank E, Boswell L, Dickstein LJ, Chapman DP: Characteristics of female psychiatrists. *Am J Psychiatry* 2001; 158:205-212
 12. Gabbard GO, Menninger RW: *Medical Marriages*. Washington, DC, American Psychiatric Press, 1988
 13. Menninger EW: The impact of the family on careers in psychiatry. *Bull Menninger Clin* 1994; 58:497-501
 14. Riska E, Wegar K: *Gender, Work and Medicine: Women and the Medical Division of Labour*. London, Sage Publications, 1993
 15. Carnes M: Balancing Family and Career: Advice from the Trenches. *Ann Intern Med* 1996; 125:618-620
 16. Sinal S, Weavil P, Camp MG: Survey of women physicians on issues relating to pregnancy during a medical career. *J Med Educ* 1988; 63:531-538
 17. Tinsley JA: Pregnancy of the Early-Career Psychiatrist. *Psychiatr Serv* 2000; 51:105-110
 18. Klebanoff MA, Shiono PH, Rhoads GG: Outcomes of pregnancy in a national sample of resident physicians. *N Engl J Med* 1990; 323:1040-1045
 19. Osborn LM, Harris DL, Reading JC, Prather MB: Outcomes of pregnancies experienced during residency. *J Fam Pract* 1990; 6:618-622
 20. Wiebe C: Parenthood and residency: the great balancing act. *Am Coll Phys Obs* 1997; 17:6-7
 21. Chow KH-Y: Maternal health and leave policies during medical training. *JAMA* 1997; 277:766-777
 22. American College of Physicians: Parental leave for residents. *Ann Intern Med* 1989; 111:1035-1038
 23. Sayres M, Wyshak G, Denterlein G: Pregnancy during residency. *N Engl J Med* 1986; 314:418-423
 24. Forman PD: Parental leave and medical careers. *J Am Med Womens Assoc* 1992; 267:741
 25. Bongiovi ME, Freedman J: Maternity leave experiences of resident physicians. *J Am Med Womens Assoc* 1993; 48:185-188
 26. American Academy of Pediatrics Policy Statement: Parental leave for residents and pediatric training programs. *Pediatrics* 1995; 96:972-973
 27. American Medical Association: H-420.976 Maternity leave policies
 28. Warde C, Allen W, Gelbert L: Physician role conflict and resulting career changes: gender and generational differences. *J Gen Intern Med* 1996; 11:729-735
 29. Graduate Medical Education Resident Census 2000-2001. Washington, DC, Office of Graduate and Undergraduate Education, 2002
 30. Levinson W, Kaufman K, Bickel J: Part-time faculty in academic medicine: present status and future challenges. *Ann Intern Med* 1993; 119:220-225
 31. Osborn EH, Ernster VL, Martin JB: Women's attitudes toward careers in academic medicine at the University of California, San Francisco. *Acad Med* 1992; 67:59-62
 32. Carr PL, Ash AS, Friedman RH, Scaramucci A, Barnett RC, Szalacha L, Palepu A, Moskowitz MA: Relation of family responsibilities and gender to the productivity and career satisfaction of medical faculty. *Ann Intern Med* 1998; 129:532-538
 33. Silver MA: Women in administrative psychiatry. *Psychiatr Ann* 1995; 25:509-511
 34. Krener P: Gender differences in career paths in psychiatry. *Acad Psychiatry* 1994; 18:1-21
 35. Phillips SP: Parenting, puppies and practice: juggling and gender in medicine. *Can Med Assoc J* 2000; 162:663-664
 36. Amick BC, Kawachi I, Coakley EH, Levine S, Colditz A: Relationship of job strain and iso-strain to health status in a cohort of women in the United States. *Scand J Work Environ Health* 1998; 24:54-61
 37. Frank E, Harvey L, Elon L: Family responsibilities and domestic activities of U.S. women physicians. *Arch Fam Med* 2000; 9:134-140
 38. Cujec B, Oancia T, Bohm C, Johnson D: Career and parenting satisfaction among medical students, residents, and physician teachers at a Canadian medical school. *Can Med Assoc J* 2000; 162:637-640