The NZMA guide for combining parenting and a medical career
## Contents

- **Introduction** ........................................................................................................................................ 3
- **Who are New Zealand parents?** ........................................................................................................ 4
- **Parental leave** ..................................................................................................................................... 5
  - Your legal entitlements ........................................................................................................................... 5
  - Partner’s/paternity leave ......................................................................................................................... 5
  - Parental leave for junior doctors ......................................................................................................... 6
- **Employment contracts** ....................................................................................................................... 7
  - DHB MECA / Senior Medical and Dental Officers Collective Agreement (20 December 2011 – 28 February 2013) ...................................................................................................................... 7
  - RDA MECA / Resident Medical Officer Collective Agreement (01 April 2012 – 30 September 2013) ........................................................................................................................................ 8
  - International comparisons for parental leave 
    - United Kingdom .................................................................................................................................. 10
    - Australia ............................................................................................................................................ 10
- **Childcare in New Zealand** ................................................................................................................ 12
  - Nannies .................................................................................................................................................. 12
  - Daycare .................................................................................................................................................. 12
  - Kindergarten ......................................................................................................................................... 12
  - Home-based care (e.g. PORSE) ............................................................................................................. 12
  - Childcare – pros and cons ..................................................................................................................... 13
  - Childcare subsidies – who is eligible? ................................................................................................... 13
  - How much are you entitled to? ............................................................................................................ 14
  - What is paid for? ................................................................................................................................... 14
  - What types of subsidy are available? 
    - Childcare subsidy ........................................................................................................................... 14
    - OSCAR Subsidy ................................................................................................................................. 14
    - Early Childhood Education (20 Hours ECE) ..................................................................................... 14
  - How to apply for a subsidy .................................................................................................................... 15
- **Providing medical care to your dependants** ..................................................................................... 16
- **Information on fertility** ...................................................................................................................... 17
  - Fertility ................................................................................................................................................... 17
  - Chromosomal abnormalities .................................................................................................................. 18
- **Profiles** .............................................................................................................................................. 19
  - Melissa Gilbert ....................................................................................................................................... 19
  - Alexander Lyudin and Nicki Pointing ................................................................................................. 21
  - Vincent Wong ....................................................................................................................................... 23
  - Michael Buckley ..................................................................................................................................... 24
  - Gina O’Grady ......................................................................................................................................... 26
  - Gina Kaye ............................................................................................................................................. 28
  - Rosalynd Pochin .................................................................................................................................... 30
  - John Langham ....................................................................................................................................... 31
  - Maria and Chris Poynter ...................................................................................................................... 33
- **Tips to make it easier** .......................................................................................................................... 36
- **Disclaimer** .......................................................................................................................................... 37
Introduction

Many a person has concluded, “There is no good time to have children.” The reasoning is understandable, with myriad explanations: too young, not enough money, too many other things to accomplish (and experience), too busy, or too old.

For doctors, those pressures seem to intensify. Student debt is typically large so becoming financially secure can take a long time. The additional pressure of vocational training – long days, shift work, postgraduate exams, a requirement to move city (and country) frequently, and the constant need to ‘prove’ yourself worthy of future consultant status, is tough to mix with family life. And on the ‘other side,’ vocationally registered doctors still have many of those work pressures.

And yet we still have children… some of us must have found a workable solution!

The NZMA guide for combining parenting and a medical career provides information, resources and personal experiences to make the process easier for doctors having children. We want to motivate people to make medicine and parenthood compatible, and we show you how others have achieved this.

It won’t be a walk in the park, but the doctors portrayed in this guide go a long way towards showing you that any time is a good time to have children – but you should plan for a busy time.

Dr Maria Poynter
Doctor, and mother to three children
Who are New Zealand parents?

According to Statistics New Zealand, fertility rates throughout New Zealand and the world at large are dropping. There are 2.1 births on average (per woman) required to sustain theoretical replacement levels and, in 2002, 64 countries already experienced rates well below this. Similar trends are projected to continue.

In the 1996 New Zealand Census, there were 1.2 million women aged 15 years and over, who specified that they had had children. Asian and European women have much lower fertility than Maori and Pacific women, but that gap is showing signs of decreasing.

There are also an increasing number of women who do not have children, which is one consequence of declining fertility. Increased life expectancy has tended to lead to women choosing to have children later in life, which in turn has a depressive effect on the total number of children a woman may be expected to give birth to.

This can also be explained by the rise in the number of women deciding to delay having children – this delay may reach the point when it is biologically too late or too dangerous to have children. Forty years ago, the proportion of child free women was low – at just nine percent – and the ideal family was seen as three children.

The table below outlines the average number of children born per woman, by both age group and ethnicity.

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Ethnicity(^1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>European</td>
</tr>
<tr>
<td>15 - 19</td>
<td>0.03</td>
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<tr>
<td>20 - 24</td>
<td>0.27</td>
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<td>25 - 29</td>
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<td>30 - 34</td>
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<td>35 - 39</td>
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<td>3.11</td>
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<tr>
<td>65 and over</td>
<td>2.79</td>
</tr>
<tr>
<td>Total</td>
<td>1.89</td>
</tr>
</tbody>
</table>


\(^1\) People may have more than one ethnicity and may be counted in more than one category.

\(^*\) Please note that Statistics New Zealand considers that quality fertility data can only be produced for census years, so some data is not available up to date.
Parental leave

The Parental Leave and Employment Protection Act 1987 provides paid and unpaid leave, and employment protection, for qualifying employees who are having a baby or adopting a child under the age of five.

Your legal entitlements

To qualify for the full range of parental leave provisions an employee must, at the expected date of delivery or assumption of care, have been in employment with the same employer for at least 12 continuous months, and for an average of at least 10 hours per week. The 10-hour average must include at least one hour in each week, or at least 40 hours in every month.

The full range means you are entitled to 52 weeks unpaid extended leave, which includes 14 weeks of paid parental leave.

To qualify for some periods of parental leave, an employee needs to have been in continuous employment with the same employer for at least six months, at the expected date of delivery or assumption of care, with the same 10 working hours requirement detailed above.

Maternity leave may start up to six weeks before the expected date of birth or adoption. In certain cases maternity leave can start earlier. Your doctor or midwife can direct you to start your leave earlier if they believe it is necessary for the health of you or your baby. Your employer can also direct you to start maternity leave early if you cannot continue to do your job safely or cannot perform your job adequately.

If you plan to take maternity leave, you must write to your employer at least three months before your expected date of birth.

Employees with between six and 12 months’ service are entitled to 13 weeks of paid parental leave or one week of partner’s/paternity leave, as appropriate. Special leave of up to 10 days can be taken by a mother before maternity leave for reasons connected with pregnancy (e.g. antenatal checks).

On your return to work the same, or a similar position, must be available to you.

We recommend you visit the Department of Labour website to find out more about leave and payments you are entitled to. Go to: www.dol.govt.nz/er/holidaysandleave/parentalleave/summary.asp.

Partner’s/paternity leave

Partner’s/paternity leave provides up to two weeks for the spouse/partner or father on the birth or intended adoption of a child, dependent on whether they meet the hours test for the previous six or 12 months of service. Where you meet:

- the six month eligibility criteria – you will be entitled to up to one week of partner’s/paternity leave on the birth or intended adoption of a child
- the 12 month eligibility criteria – you will be entitled to up to two weeks of partner’s/paternity leave on the birth or intended adoption of a child.

Partner’s/paternity leave can be taken in the period between 21 days before the expected date of delivery (or date you assume the care of a child with a view to adoption) and 21 days after the actual date of birth or the date you have assumed the care of a child with a view to adoption. If you and your employer agree, you can start partner’s/paternity leave at any other time.
Parental leave for junior doctors

If you are a junior doctor working for a District Health Board (DHB) you are required to rotate between different DHBs as part of your compulsory training. Your length of service with each employing DHB will be added together for the purposes of determining whether you meet the six or 12 month criteria for leave and payments. You will still need to meet the hours of work test.

More information can be found on the Department of Labour website at: www.dol.govt.nz/er/holidaysandleave/parentalleave/index.asp.

Your exact entitlements regarding parental leave may vary depending on your employment status. It is important to note that your employment agreement cannot change your eligibility for the government parental leave payments and you can receive additional payments through your employment agreement.

Following are excerpts from the DHB MECA/Senior Medical and Dental Officers Collective Agreement (20 December 2011 – 28 February 2013) and the Resident Doctors Association MECA/Resident Medical Officer Collective Agreement (28 May 2011 – 31 March 2012), which cover an employee’s entitlement to parental leave. You’ll see that under the DHB MECA below you will be paid for a period of up to six weeks, in addition to the government’s paid parental leave.

Please note that if you are not party to a MECA agreement and have an Individual Employment Agreement, then you may have different clauses in your contract.
Employment contracts

DHB MECA / Senior Medical and Dental Officers Collective Agreement
(20 December 2011 – 28 February 2013)

28.1 General Entitlement

(a) Employees are entitled to up to twelve months’ parental leave without pay for births and adoptions in accordance with the Parental Leave and Employment Act 1987.

(b) Parental leave of up to six months is to be granted to employees with less than one year’s service at the time of commencing leave.

(c) Employees intending to take parental leave are required to give not less than three months’ notice in writing and the application is to be accompanied by a certificate signed by a registered medical practitioner certifying the expected date of delivery. The provision is waived in the case of adoption or circumstances outside the control of the employee.

(d) Employees are required to give at least one month’s notice of return to work.

(e) The maximum period of parental leave may be taken by either the employee exclusively or may be shared by the employee and their partner concurrently or consecutively. This applies whether or not one or both partners are employed by the employer.

28.2 Paid Parental Leave

(a) Where an employee is granted leave in terms of Clause 28.1 above and assumes the primary care of the child(ren), he/she shall be paid for a period of up to six weeks, beginning at the start of the leave period. Where both partners choose to share the primary care, the payment shall be split (irrespective of whether or not both are employed by the employer) in accordance with those employees’ wishes.

(b) The partner of the primary caregiver shall be granted paid leave to up to two weeks. Such leave shall be continuous and shall be taken within a period commencing three weeks prior to the expected date of delivery (or adoption) and ending three weeks after the actual date of delivery (or adoption). Variations to this period may be agreed between the employee and the employer in order to meet the special needs of the child such as premature birth or placement prior to adoption. An employee availing him or herself of this entitlement shall not be eligible for paid parental leave pursuant to sub-clause (a) above.

(c) Payments in sub-clauses (a-b) above shall be calculated at the rate applying for the six weeks immediately preceding the cessation of duty. Employees who resign from their employment with the employer without returning to work will be required to refund the paid leave that they received.

(d) Where, for reasons pertaining to the pregnancy, an employee, on medical advice and with the consent of the employer, elects to work reduced hours at any time prior to the taking of the leave, then the calculation of payment for the first six weeks of leave shall be based on the proportion of full-time employment immediately prior to any such enforced reduction in hours.

(e) Where an employee is absent on parental leave for less than six weeks, he/she shall be paid as calculated in sub-clause (c) above for the period of leave taken.
An employee returning from parental leave may request the employer to vary the proportion of full-time employment from that which applied before the leave was taken. The granting of such a request shall be at the discretion of the employer.

RDA MECA / Resident Medical Officer Collective Agreement
(01 April 2012 – 30 September 2013)

23.0 Parental Leave

23.1 Parental leave shall be granted to an employee as leave without pay and not as sick leave on pay.

Providing an application for leave of absence under this heading is received at least one month before it is intended to commence parental leave and is supported by a certificate signed by a registered medical practitioner, parental leave shall be granted as follows:

23.1.1 Leave of up to 12 months is to be granted to employees with at least one year’s service at the time of commencing leave.

23.1.2 Parental leave of up to six months is to be granted to employees with less than one year’s service.

Provided that the length of service for the purpose of this clause means the aggregate period of service, whether continuous or intermittent, in the employment of a Hospital and Health Service, District Health Board, Crown Health Enterprise or an Area Health Board.

23.2 Employees shall continue to be awarded their normal salary increments when their incremental date falls during absence on parental leave.

23.3 Subject to 23.5 below, an employee returning from parental leave is entitled to resume work in the same position or in a similar position as s/he occupied at the time to commencing parental leave. For the purpose of this provision a similar position means a position of equivalent salary and grading in the same locality or within a reasonable commuting distance and involving responsibilities broadly comparable with those of the position previously occupied.

23.4 Where, for reasons pertaining to the pregnancy, an employee, on medical advice and with the consent of the employer, elects to work reduced hours at any time prior to confinement, then the guaranteed proportion of full-time employment after parental leave shall be the same as that immediately prior to any such enforced reduction in hours.

23.5 Where the employer is not able to hold the same position open or to fill it temporarily until an employee returns from parental leave and, at the time the employee returns to work, a similar position is not available, the employer may approve:

23.5.1 An extension of parental leave for up to a further 12 months until the employee’s previous position or a similar position becomes available; or

23.5.2 An offer to the employee of a similar position in another location (if one is available) with normal transfer expenses applying. If the offer is refused, s/he continues on extended parental leave as in 23.5.1 above for up to 12 months; or

23.5.3 The appointment of the employee to a different position in the same location. If the appointment is not acceptable to the employee, s/he continues on extended parental leave in terms of 23.5.1 above for up to 12 months; or
23.5.4 Where extended parental leave in terms of 23.5.1 above expires and no position is available for the employee, s/he continues on leave without pay and the employer may terminate employment with three months’ notice; providing that an employee whose services are terminated under this provision shall be entitled to be paid the ex gratia payment calculated in terms of 23.8 below.

23.6 If the employee declines an offer in terms of 23.3 above, parental leave shall cease.

23.7 An employee granted parental leave in terms of 23.1 above shall notify the employer in writing of his/her intention to return to work or to resign at least one month prior to parental leave expiring, and if returning to work report for duty not later than the expiry date of such leave.

23.8 Where an employee who is granted leave in terms of 23.1 above returns to duty at or before the expiration of leave or extended leave and completes a further six calendar months’ service, s/he shall receive a payment equivalent to six weeks’ leave on pay calculated at the rate applying for the six weeks immediately following cessation of duty. If employment prior to confinement was part-time, however, payment shall be based on the proportion that the part-time hours worked a week bears to 40.

Where, for reasons pertaining to the pregnancy, an employee on medical advice and with the consent of the employer elects to work reduced hours at any time prior to confinement, then the calculation of the lump sum payment shall be based on the proportion of full-time employment immediately prior to any such enforced reduction in hours. Where an employee is absent on parental leave for less than six weeks, s/he shall receive that proportion of payment that the absence represents in relation to six weeks.

Where an RMO taking Parental Leave receives the parental leave payments provided for in the Parental Leave and Employment Protection Act, at the employee’s nomination instead of the lump sum payment provided for above, the DHB will pay the equivalent total (i.e. up to six weeks’ salary as at the date of taking parental leave) in equal installments as a partial salary top up while the RMO is in receipt of the statutory payment. Each equal installment shall be calculated based on the ratio of 6 weeks to 14 weeks and shall only be made in respect of the period for which the RMO is on parental leave and in receipt of the statutory payment if this is less than 14 weeks. If the total value of this top up is less than the value of the 6 week lump sum entitlement referred to above, then the balance shall be paid as a lump sum on the return of the RMO to work at a DHB.

23.9 An employee returning from parental leave may request the employer to vary the proportion of whole-time employment from that which applied before the leave was taken. The granting of such a request shall be at the discretion of the CEO. The calculation of the ex gratia payment in these circumstances shall be based on the proportion of whole-time employment which applied before taking the leave but excluding any temporary reduction in hours immediately prior to confinement.

23.10.1 Leave on adoption. The provisions of this clause shall apply in full to parents legally adopting a child under the age of 12 months, subject to the requirement of one month’s notice and the provision of a medical certificate being replaced by the provisions of 23.10.2 below.

23.10.2 The intention to legally adopt a child shall be notified to the employer immediately following advice from the Department of Social Welfare to the adoptive applicants that they are considered suitable adoptive parents. Subsequent evidence of approved adoption placement shall be provided to the satisfaction of the employer.

23.11.1 Limits on Hours for Pregnant employees. Employees shall be able to reduce hours of work as follows:

(a) From 28 weeks of pregnancy (or earlier if considered medically appropriate by the employee’s lead maternity carer), no night shifts shall be worked.
From 32 weeks of pregnancy (or earlier if considered medically appropriate by the employee’s lead maternity carer), no long days in excess of 10 hours shall be worked.

From 36 weeks of pregnancy (or earlier if considered medically appropriate by the employee’s lead maternity carer), no acute clinical workload shall be allocated.

23.11.2 Employees reducing hours as provided for in clause 23.11.1 above shall have their salary reduced in a manner agreed between the parties on a case by case basis.

International comparisons for parental leave

Maternity leave entitlements differ from country to country, so it is best to check your entitlements with your employer – these should be outlined in your contract. Employers may have their own maternity leave scheme, which could be more generous than the statutory scheme. Some information on basic international entitlements is outlined in this section.

United Kingdom

Check your employment contract or staff handbook for details or ask your employer – your employer can’t offer you less than your statutory rights.

As an employee you have the right to 26 weeks of paid Ordinary Maternity Leave and 26 weeks of Additional Maternity Leave making one year in total. The combined 52 weeks is known as Statutory Maternity Leave.

To qualify for Statutory Maternity Leave you must be an employee. If you are an employee and you give your employer the correct notice, you can take Statutory Maternity Leave no matter:
- how long you have been with your employer
- how many hours you work
- how much you are paid.

Not qualifying for Statutory Maternity Leave

If you don’t qualify for Statutory Maternity Leave, speak to your employer. They may offer enhanced maternity rights that you are entitled to.

If you are a worker, your employer may allow you to take unpaid leave. Alternatively, you could consider taking paid holiday, unpaid leave or parental leave. You may still be entitled to Statutory Maternity Pay.

For more information, visit the website of the UK Government: www.direct.gov.uk/en/index.htm.

Australia

Under the National Employment Standards in the Fair Work Act 2009, if you have been employed by your employer for 12 months or more prior to the birth or adoption of your child, you may be entitled to access up to 12 months unpaid parental leave associated with the birth or adoption of your child. You can also request an additional 12 months unpaid leave on top of this.
In January 2011, Australia’s Family Assistance Office introduced changes to the maternity entitlements afforded to parents. There are two types of paid assistance that you may be eligible for. These are:

- Parental Leave Pay
- Baby Bonus Scheme.

Parental Leave Pay and Baby Bonus cannot be paid for the same child. If you meet the eligibility requirements for both payments, you can choose which payment is the best financial decision for your family.

Parental Leave Pay

The Paid Parental Leave scheme is a new entitlement for working parents of children born or adopted from 1 January 2011. Parental Leave Pay is available to working parents who meet the eligibility criteria. Eligible working parents can get 18 weeks of government funded Parental Leave Pay at the rate of the National Minimum Wage.

You may be eligible for Parental Leave Pay if you:

- are the primary carer of a newborn or recently adopted child, usually the mother
- are an Australian resident
- have met the Paid Parental Leave work test before the birth or adoption occurs
- have received an individual adjusted taxable income of $150,000 or less in the financial year prior to the date of birth, adoption or date of claim, whichever is earlier, and
- are on leave or not working from the time you become the child's primary carer until the end of your Paid Parental Leave period.

If your employer currently provides paid maternity or parental leave through an industrial agreement, they cannot withdraw the entitlement for the life of that agreement.

Baby Bonus scheme

The Baby Bonus scheme is 13 fortnightly non-taxable payments. The maximum amount paid is less than the maximum amount of paid parental leave payments. Eligibility is based on your family income.

To be eligible for Baby Bonus you must:

- be the primary carer of a dependent child or the partner of the primary carer
- have the care of the child within 26 weeks of the child’s birth and be likely to continue for at least 26 weeks
- in the case of adoption, have the child come into your primary care as part of the adoption process before the child is 16 years of age
- not have received or be receiving Parental Leave Pay for the child
- have a family adjusted taxable income of less than or equal to $75,000 for the period in the six months following the child's entry into your primary care
- meet Australian residency requirements for family assistance purposes.

Childcare in New Zealand

One of the great challenges of being a parent is deciding when to return to work, whether to work full time or part time and then deciding on the best childcare to suit the needs of your family and child. The following section outlines the various childcare options available.

Nannies

Care options include hiring a nanny through an agency. Private nannies tend to be a popular choice but can be more expensive than other options such as daycare or in-home care. There are a few things to consider i.e. is childcare to be their only task, or do you want a nanny to also do light housework, grocery shopping etc? The International Nanny Association (INA) recommends that you interview any prospective nanny at least twice and that you conduct a criminal background check, which is usually undertaken by placement agencies. For more information on the process of hiring a nanny, visit The Nanny Company website: www.thenannycompany.co.nz/looking-for-a-nanny/. While this is a commercial website, it contains a lot of useful information about what you need to consider when selecting and employing a nanny.

Daycare

The term ‘daycare’ typically refers to a childcare facility that parents take their children to during the day for care, supervision and learning. This can be while a parent or parents return to work, or for those that have other commitments during the day where they are unable to provide care for their children. Daycare centres specialise in care of infants through to pre-schoolers, although some daycare facilities also offer before and after school care for school-aged children.

Kindergarten

Kindergartens provide early childhood education for children aged between two and five years. Many have a waiting list so you may want to contact the kindergarten and put your child’s name on the waiting list as soon as possible. They do not charge fees but ask for a donation, usually about $1 to $2.50 per day (this may vary based on the area in which you live). Help with fundraising activities is often also expected. Most kindergartens run two sessions, one in the morning and another in the afternoon, although increasingly more kindergartens offer an option of all day care. Sessions are informal and focus on developing social skills and learning through play, supervised by qualified and registered teachers.

Home-based care (e.g. PORSE)

Play Observe Relate Support Extend (PORSE) is a New Zealand in-home childcare programme. A PORSE home offers you an alternative to putting your child into a kindergarten or daycare centre. There are other options for home-based care, of which PORSE is just one.

Generally speaking PORSE, and similar programmes, are in-home childcare programmes – you choose an educator from the company of your choosing, which you feel fits your child’s situation best. Your child then goes into the educator’s home to be looked after for the day, and is usually with a couple of other children.

A variety of activities for children and their educators to participate in are organised by the company, which can include weekly play dates with other educators and their children, music groups, and outings. These activities are aimed at promoting fun, role modelling, observation, and confidence.
Childcare – pros and cons

The issue of pre-school childcare is often contentious with varying and strongly held views about what is best for the child.

There have been many studies over the years to evaluate the impact of daycare centres on children with both negative and positive aspects reported. Often however the media tend to focus on the negative, not providing a balanced interpretation of the studies.

A long-running United States National Institutes of Health study showed children in high-quality childcare scored slightly higher on measures of academic and cognitive achievement in their teenage years. A common negative aspect of daycare that is reported in studies is that children in daycare have elevated levels of the stress hormone cortisol, largely attributed to situations where the children's care providers were intrusive or over controlling, and where the balance between structured and free play was unbalanced. Children under stress could show signs of anxiety, anger or aggression.

Overall, studies have found that the impact of daycare on children depends on a number of factors including the quality of daycare, with quality measured by how much time the provider spends interacting with children, as well as warmth, support and cognitive stimulation. The closeness of the relationship between the child and its parents is also reported to be a key factor.

The best solution for each family will differ greatly – and your own values and emotional needs will also come into play. We encourage you to research the options available to make the best choice for your family situation, as there are many issues to consider.

- Are you anxious about leaving your child with a number of carers, or would you prefer one-on-one care?
- Will you need childcare out of hours i.e. early in the morning, and/or late at night?
- Would you prefer a learning or play-based programme?

For assistance with choosing the best childcare facility for your family, a list of questions and considerations can be found on the Childcare Online website: www.childcareonline.co.nz/How-to-Choose-a-Childcare-Facility.html.

Childcare subsidies – who is eligible?

You may be eligible for a Childcare Subsidy if you are:

- the main carer of a dependent child
- a New Zealand citizen or permanent resident.

You should also normally live in New Zealand and intend to stay here. It also depends on how much you and your spouse or partner earn.

The child must be:

- under five years old (or under six years if you get a Child Disability Allowance for them)
- attending an early childhood programme for three or more hours a week.

A Childcare Subsidy is normally paid for up to nine hours of childcare a week. In some situations you may be able to get up to 50 hours a week. This information is a guide only. To find out what assistance you may qualify for, please contact Work and Income New Zealand: www.workandincome.govt.nz/.
How much are you entitled to?

How much you are entitled to will depend on the size of your family, your income, and how many hours a week your child goes to the service provider. The subsidies are paid directly to the service provider.

You can calculate an estimate of the amount of Childcare Assistance or Accommodation Supplement you are entitled to by using the online calculator on the Working for Families website: www.workingforfamilies.govt.nz/. This calculator is for working families not currently receiving a main benefit or New Zealand Superannuation from Work and Income.

Current maximum rates are also available on the Working for Families website.

What is paid for?

From 27 September 2010 there are two income cut-off points (thresholds) that apply to the Childcare Subsidy. The different thresholds apply to:

- clients who had not received assistance in the 12 months prior to 27 September 2010
- clients who had received assistance in the 12 months prior to 27 September 2010 - these clients qualify for grandparented thresholds.

For full charts refer to the Work and Income New Zealand website: www.workandincome.govt.nz/.

What types of subsidy are available?

Childcare Subsidy

The Childcare Subsidy is for pre-school children aged under five years and attending an early childhood programme for three or more hours a week (or under six years if you receive the Child Disability Allowance for them).

You could get help with up to nine hours of childcare a week and in some cases up to 50 hours a week if you are:

- working, studying or on an approved training course or
- involved in an activity that WINZ have asked you to do or
- a shift worker who works nights or
- seriously ill or disabled or
- caring for a child in hospital or a child you receive the Child Disability Allowance for.

The early childhood programme must be licensed and/or chartered – this includes home-based care schemes, chartered under the Education Act 1989 and Te Kohanga Reo.

You can’t get the Childcare Subsidy for more than nine hours a week if the child’s other caregiver can care for them (unless you get the Child Disability Allowance for that child). If you are ill or disabled because of an accident, you need to talk with ACC first.

OSCAR Subsidy

The OSCAR Subsidy (Out of School Care and Recreation Subsidy) is for children aged five-13 years (or up to 18 years if they receive the Child Disability Allowance). It helps towards the costs of before and after school care of up to 20 hours a week, and school holiday programmes of up to 50 hours a week.
You could get this subsidy if you are:

- working, doing a work related activity or studying or
- seriously ill or disabled or
- paid the Child Disability Allowance for any of your children or
- caring for a child that is in hospital.

The service that provides the care must be approved by the Ministry of Social Development.

You can’t get the OSCAR Subsidy if the child’s other caregiver can take care of the child unless you get the Child Disability Allowance for that child.

To qualify for either subsidy you must also meet these conditions.

- You must be the main caregiver of the child.
- Your family must be on a low or middle income (this could be income support).
- You must be a New Zealand citizen or permanent resident.
- Your child must have at least three hours of care a week.

If you don’t know how many hours of care you’ll need each week (because you are a casual or on-call worker for instance), Work and Income will talk with you about your options when you apply for a subsidy.

**Early Childhood Education (20 Hours ECE)**

The Government funds up to 20 hours a week of ECE for children aged three to five years attending an Early Childhood Education (ECE) service.

You can choose between receiving 20 Hours ECE, the Childcare Subsidy or a combination of both payments. Families cannot receive 20 Hours ECE and the Childcare Subsidy for the same hours.

If you would like more information about how 20 Hours ECE and the Childcare Subsidy work together, call Work and Income New Zealand on 0800 559 009. If you have specific questions about 20 Hours ECE, talk to your local Work and Income office or go to the Ministry of Education website: www.minedu.govt.nz/Parents/EarlyYears/.

**How to apply for a subsidy**

You can apply for childcare assistance via the online application form on the Work and Income New Zealand website: www.workandincome.govt.nz/online-services/apply/index.html, or phone 0800 559 009 and they will send you a form to fill in.
Providing medical care to your dependants

It can be difficult to manage being “just a parent” rather than trying to doctor your child(ren) when health problems occur. The Medical Council of New Zealand (MCNZ) has published guidelines around providing care of those close to you, enabling you to make informed decisions about the health care of your dependants.

**Good medical practice**

“Wherever possible, avoid providing medical care to anyone with whom you have a close personal relationship. The Council recognises that in some cases providing care to those close to you is unavoidable. However, in most cases, providing care to friends, those you work with and family members is inappropriate because of the lack of objectivity and possible discontinuity of care.”


The Medical Council recognises that there are some situations where treatment of those close to you may occur, but maintains that this should only occur when overall management of patient care is being monitored by an independent practitioner.

**Providing care to yourself and those close to you**

“A lack of objectivity can also be a problem when providing care to family members, those you work with and close friends. Those with whom you have close emotional ties should have a general practitioner who can provide appropriate care after an objective medical assessment.

The Council acknowledges that there are some exceptions where providing care to yourself or those close to you may be appropriate: When doctors prescribe for themselves and those close to them for a continuing condition and their general practitioner will monitor the treatment at regular agreed intervals.”

Information on fertility

This section contains some eye-opening information on fertility, and other factors you should take into consideration when thinking about starting a family. There is a lot of information on the internet about fertility – we encourage you to do your own research. Fertility Associates has a raft of information available on their website: www.fertilityassociates.co.nz/.

Fertility

The average age of a woman’s first birth in New Zealand is 30 years of age. Even though we are living longer, fertility is hardwired into your DNA and the fertility window for women remains the same. Surveys have consistently shown that people over-estimate how long their fertility will last by about 10 years. In addition, there is widespread belief that fertility treatments such as IVF can overcome the effects of age.

For more information on fertility, please visit the Fertility Associates website: www.fertilityassociates.co.nz/.

<table>
<thead>
<tr>
<th>Your fertility</th>
<th>In your 40’s</th>
<th>In your 30’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chance of a baby per month (natural conception)</td>
<td>Woman aged: 40: 6% 43: 2% 46: &lt;1% 49: 0%</td>
<td>Woman aged: 30: 22% 33: 18% 36: 13% 39: 9%</td>
</tr>
<tr>
<td>Chance of a baby per IVF cycle</td>
<td>Woman aged: 40: 24% 43: 8% 46: 4% 49: 0%, would need an egg donor</td>
<td>Woman aged: 30: 48% 33: 44% 36: 38% 39: 28%</td>
</tr>
<tr>
<td>Impact of age</td>
<td>The quality of a woman’s eggs and her ovarian reserve decline with age. Most women go into menopause between 50 and 55, approximately 10 years after their fertility ceases. There is also an increased risk of genetic abnormalities as the woman ages. In regards to men, being aged over 50 is associated with a longer time to conceive, separately from the effect of his partner’s age. This doesn’t happen if using IVF as the number of sperm around the egg is greatly increased. There is also a moderate increased risk of genetic abnormalities as the man ages.</td>
<td></td>
</tr>
<tr>
<td>Impact of lifestyle – male and female</td>
<td>Poor lifestyle can reduce fertility, but a healthier lifestyle cannot compensate for the impact of age.</td>
<td></td>
</tr>
<tr>
<td>Publicly funded treatment</td>
<td>Unfortunately public funding does not cover the cost of treatment for women aged 40 years and over. You must have been assessed and if eligible, enrolled for a publicly funded consultation or treatment before you turn 40.</td>
<td>You are eligible to be assessed for a publicly funded consultation and/or treatment up until the female in the partnership turns 40 years old – as long as you meet the criteria as set by the Ministry of Health.</td>
</tr>
</tbody>
</table>
Chromosomal abnormalities

The risk of chromosomal abnormalities increases with maternal age. The table below shows how the risk of delivering a baby with a chromosomal abnormality increases with maternal age. (In the first trimester of pregnancy, the risk that the foetus has a chromosomal abnormality is higher than at birth, because many affected foetuses die naturally during the pregnancy).

<table>
<thead>
<tr>
<th>Maternal age (years)</th>
<th>Risk for Trisomy 21</th>
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<tbody>
<tr>
<td></td>
<td>At birth</td>
</tr>
<tr>
<td>20</td>
<td>1 in 1527</td>
</tr>
<tr>
<td>25</td>
<td>1 in 1352</td>
</tr>
<tr>
<td>30</td>
<td>1 in 895</td>
</tr>
<tr>
<td>32</td>
<td>1 in 659</td>
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<tr>
<td>34</td>
<td>1 in 446</td>
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<tr>
<td>36</td>
<td>1 in 280</td>
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<td>38</td>
<td>1 in 167</td>
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<tr>
<td>40</td>
<td>1 in 97</td>
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<tr>
<td>42</td>
<td>1 in 55</td>
</tr>
<tr>
<td>44</td>
<td>1 in 30</td>
</tr>
</tbody>
</table>
Profiles

The following section profiles parents who have ‘been there, done that’ in relation to managing a family and their medical training. We hope that by reading the experiences of others you will have the information and motivation you need to understand that doctors can, and do, manage to fit a family into the demands of medical training. Thank you to all of our participants for sharing their experiences.

Melissa Gilbert

Melissa’s specialty is general practice and palliative medicine (hospice). She has three daughters aged 15, 11, and five, and lives in Whangarei.

• How does general practice and palliative medicine fit in with your family?
  I can fit the job easily around family needs.

• You are seven years out of medical school – how have you fitted in training?
  My husband has worked from home, so could always fit his schedule around the children. Doing my RMO years, study and GP training has been much easier to achieve because of this. Our load is more evenly shared now that I can choose when I work.

• Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?
  If the other parent is not at home with the children I recommend a nanny if finances allow, it will take so much stress out of the picture not having to worry about daycare and ferrying to activities. Alternatively, or as well as, a housekeeper - it changed my life. Money well spent, it means I can spend what spare time I do have with my family.

• How has a medical career affected your family?
  I think I am a good role model for my daughters. A slightly better income means our standard of living is good and I also have job security given the current economic state. The long hours in the early years were tough but it’s totally worth it to be where we are now.

• What support do you get from your family?
  Very little but my mother-in-law has traditionally had our preschoolers one day per week. However trying to make it all fit around other people’s timetables makes it more of a hindrance than a help at times. It’s great if there is good family support but it’s also possible without it.

• How have you managed your training while bringing up a family?
  Constantly aiming for balance with regular fine tuning. There has to be sufficient time spent with family so that you feel like you’re making a valid contribution to your children’s lives. You also need time for yourself for exercise, creative outlets and relaxation. Trying really hard to not put your relationship at the bottom of the ‘needs’ list is important – a relationship needs feeding as well. Obsessive, insane study is for people who are single; 80% is still a pass.

• How did you find the support from your college?
  Very average. My placement requests were not taken into consideration and I had unreasonable driving times because of how far away one of the practices was. I was really disappointed especially since general practice prides itself on work/life balance.
• **What, if any, problems did you encounter when returning to training?**
  I’ve never really left training… I became a nurse then went to medical school, did my two RMO years including GP then did a post grad diploma in palliative medicine over a year, then PRIMEX last year…I had three children across the whole decade!

• **How did you/Did you maintain CME while on maternity leave?**
  I’ve always had related interests and so while I might not have gathered sufficient accredited points during the time I was off I still went to conferences and talks that I was interested in.

• **If you were just graduating from medical school again, what would you do differently?**
  I wouldn’t have stressed so much because it all works out in the end.
Alexander Lyudin and Nicki Pointing

Alexander and Nicki were both medical students when they had their son Christopher (now almost three years old). Alexander was starting his 5th year at medical school and Nicki was starting her 3rd year. Nicki is now in her final year of medical school as a TI and Alexander is starting his second year as a house officer. They live in Dunedin.

• How does working as an SHO, and being a TI fit in with your family?
  N: With Alexander working full time, and being in full time study at the hospital myself, it is very challenging. We support each other as much as we can and we really value the family time that we get because it is not as much as we would like!

• How have you fitted in training?
  A: We both went through medical school without taking any leave to not delay finishing. We were both graduates before starting medicine so were keen to start a family sooner rather than later.

• Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?
  It has been said that “there is never an easy time to have children” so start a family when it feels right and try to work everything else around a career. You don’t have to give up one for the other, but you will need support. You will find that a lot of things you will just have to work out as you go along!

• How has a medical career affected your family?
  We are lucky to both understand the challenges of the job and the training, so can provide a lot of support to each other. There are a lot of times when one of us is on a long day or studying so only one parent is with our son, but we really make the time we have together as a family count. Being in the medical field is what we both want, and we don’t feel that we are better or worse parents because of this.
- **What support do you get from your family?**  
  N: We don’t have any other family in Dunedin so our son goes to full time daycare and we just manage between ourselves. Christopher has a supportive grandma that can fly down to help with any situations when needed, such as the chickenpox!

- **How have you managed your training while bringing up a family?**  
  A: We have learnt to become very organised and efficient. We have also learnt to make the most out of any learning opportunities because it is harder to come back and look something up later on.

- **What, if any, problems did you encounter when returning to training?**  
  N: Expressing breast milk, sleep deprivation and caring for a newborn can be exhausting! We felt that our level of functioning during the day was not as good, and we were less efficient with our studies at the time. But it gets easier!

- **If you were just graduating from medical school again, what would you do differently?**  
  We still question if not taking any maternity/paternity leave was the right thing to do, but now that we are almost both through medical school and have our adorable son we wouldn’t change anything. For future children, we would both like to take some leave to spend more time enjoying it, but what we did for our first ended up being right for us at the time.
Vincent Wong

Vincent is now a practising GP in Wellington, but had his two children when he was a house surgeon.

• How does general practice fit in with your family?
  Currently my wife has chosen to stay at home with the children. I found my years as a Registrar quite taxing as I was spending less time at home than I had hoped.

• How have you fitted in training since finishing medical school?
  I chose to delay training. After my wife returned to work after maternity leave with our oldest, I was able to stop working full time, instead becoming a general purpose hospital locum. My wife worked three days a week, and I worked the other two (and evenings, weekends and shifts as available). I was fortunate that I was happy to delay things - those who wish to pursue positions in more sought-after specialties would not have been able to do what I did.

• Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?
  Have a supportive spouse. Realise that there will always be some degree of compromise.

• How has a medical career affected your family?
  I still do the odd weekend and evening on-call shifts, so my oldest daughter probably thinks everyone has three jobs and gets called in to work on weekends. My wife is having to consider her work options – if we try to go back to working half time each, the family income will fall.

• What support do you get from your family?
  Very good support.

• How have you managed your training while bringing up a family?
  I became a bit of a hermit prior to exams, but otherwise it hasn’t been terrible. But normal GP hours are much nicer than hospital hours.

• How did you find the support from your college?
  Ok.

• What, if any, problems did you encounter when returning to training?
  It wasn’t so bad.

• If you were just graduating from medical school again, what would you do differently?
  I’d go get a non-medical job. Just kidding (sort of). Given the type of medical career I hope to have, I think things have worked out just about right.
Michael Buckley

Michael is a general practitioner living in Wellington. He has two children.

- **How does general practice fit in with your family?**
  Generally office hours with minimal afterhours or on call, very suitable for part time so probably the most flexible around arranging daycare.

- **How have you fitted in training since finishing medical school?**
  My undergrad and a lot of my initial postgrad training was done when I was single and without kids, and I trained in General Practice after the birth of my son.

- **Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?**
  Choose a really good partner, use effective contraception until you are absolutely sure you want to have kids with them.

- **How has a medical career affected your family?**
  Significantly.

- **What support do you get from your family?**
  Huge amounts, couldn’t do it without the help, support and frequent babysitting from family and friends.
• How have you managed your training while bringing up a family?
  By choosing the easiest training programme to participate in.

• How did you find the support from your college?
  I don’t really see that as their role and I never had to take so much time off that I needed to ask. The College of GPs takes into account care for dependants as useful to your experience as a GP and so you can claim 2/10th for it.

• How did you/Did you maintain CME while on maternity leave?
  Parental leave is CME for GPs – you learn so much that is relevant. My partner did a diploma whilst on parental leave and my mum came and helped me look after my three month old daughter whilst she was away at the block course for two weeks.

• If you were just graduating from medical school again, what would you do differently?
  What I would do differently is very specific to me and if I did change things, then I wouldn’t have my wonderful kids – so I would have to say that I wouldn’t change a thing.
How have you fitted in training since finishing medical school?
I finished my medical degree at the University of Auckland in 2003. My husband and I then spent our first two house surgeon-years working in Nelson. The broad range of experience and responsibility provided by a provisional experience gave us an excellent stepping stone into a registrar position. We moved to the Hawke’s Bay where I had an opportunity to gain excellent experience as a Paediatric Registrar. The following year saw my husband posted to Wellington as a surgical trainee. The difficulties of coordinating positions in the same centre then became apparent, as surgical placements were announced well after paediatric job applications closed. Fortunately I was able to secure a late position to continue my paediatric training in Wellington. In 2008 we chose to move to Auckland where my family is based. I worked as a Paediatric Registrar at Starship Children’s Hospital whilst my husband commenced his PhD. Greg’s foray into the world of research provided an opportunity to live in one city for several successive years and we chose this time to start a family. Our first son Liam was born in August 2008. I ended up taking 17 months of maternity leave because of difficulty arranging a Paediatric Neurology training position to return to. Such positions are very limited in New Zealand, and with fantastic support from the Starship Hospital Neurology Department I was able to secure a Starship Foundation Fellow position which allowed me to return to work 0.5 FTE in 2010. This position provided a wonderful opportunity to both continue my training and maintain family time. In Dec 2010 our second son Rory was born. Given I had ongoing funding from the Starship Foundation I chose to return to work 0.5 FTE when Rory was five months old. Balancing a clinical workload, poor sleep, and expressing was a challenge, but has enabled me to maintain a balance whilst continuing my training.
Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?
Complete clinical exams prior to starting a family if possible. I have seen several colleagues face the challenge of not being able to complete their exams because of pregnancy, and have the utmost respect for those who do manage family, work and exam study. We employed a nanny which I highly recommend – although the more expensive option, the flexibility and peace of mind it has provided has been invaluable. The presence of a stable caregiver, who both boys have loved, has ensured our boys have secure attachment relationships and are well adjusted to their parents’ comings and goings. I highly recommend medical couples considering having a family sit down and work out a training plan and also consider the financial burden as childcare costs can be considerable. We sat down together several years ago and wrote a three - five year plan of how we were each going to finish our training. This advanced planning has been incredibly helpful as arranging funding and fellowships required several months of preparation. Consider less conventional options, such as research positions, which can provide a greater degree of flexibility. Greg’s PhD, although a tremendous undertaking, has provided our family with many opportunities for increased family time.

How has a medical career affected your family?
Recently, my training has seen our family move from our settled life and own home in Auckland to Sydney. Having chosen a small specialty such as Paediatric Neurology I am not able to complete my training in New Zealand. The logistical challenge and financial burdens of moving family, even a short distance to Australia, are not to be underestimated. Having a medical husband means we are each continually struggling to meet our clinical commitments, but we do have an appreciation of each other’s stresses and challenges. Any free time is committed to family or training. But the joy of watching your own children grow and learn has far outweighed the loss of individual time.

What support do you get from your family?
We have been fortunate to have very supportive families, with one set of parents always living within an hour’s drive away. Balancing a career and family has frequently meant family have been called upon to look after the boys to cover additional meetings or work related trips.

How have you managed your training while bringing up a family?
Prior to having children I had no appreciation of the amount of family time that would be needed. Although we wouldn’t swap this for anything, the opportunity to easily catch up on a few hours work or study in the evenings and weekends is long gone. Commitment to textbook based learning has been significantly reduced, whilst “on the job” learning has become a much greater priority. I do however feel that first hand experience with children has been immensely valuable to my paediatric practice. Parents do find it easier to relate to other parents, and I know how privileged I am to look after other parents’ most treasured possessions.

How did you find the support from your college?
I am grateful that the college has continued to sign off my prospective approval forms and accredit my training, slowly adding up the months.

What, if any, problems did you encounter when returning to training?
The biggest challenge is finding a position that fits around the demands of looking after young children, and I encourage others to look around for different options. I wanted to be able to work part time, however such positions are difficult to find. The Starship Foundation Fellowship has provided me with a fantastic opportunity to both continue my career and spend quality time with my family. I am also indebted to the support I have received from the Starship Paediatric Neurology Department.

How did you/Did you maintain CME while on maternity leave?
I found minimal opportunity to maintain CME whilst on maternity leave, considering it instead a time to devote myself entirely to family. Although I am certain I did lose considerable knowledge after my recently completed clinical exams, it does return quickly on re-entering the workforce.
Gina Kaye

Gina is a general practitioner, and was previously a palliative care registrar with five years working in hospice as a medical officer. She lives in Auckland with her four children, two boys and two girls aged 14, 11, eight, and five.

• How does general practice fit in with your family?
I think the reality is that it is hard to fit an ambitious medical career with a satisfactory family life. I have tried many different options including huge hours as a junior doctor in the UK (where I never saw my eldest child!), a job share which still involved 50hrs + a week, au-pairs looking after the children, and a part time job as a medical officer working approx 25 hrs a week over three days. At that time my husband and I shared the childcare. Now I work 9/10 as a GP and my husband is the full time carer for our children. Being a GP is good as there is little after hours work so weekends are family time and after 6pm I am able to know I can be at home.

• You are 13 years out of medical school – how have you fitted in training?
I initially trained as a physician and did MRCP in the UK. I fitted study into evenings mostly and had the occasional weekend away. I have had to be very disciplined to maximise any time I have available for study and I am quite proactive in getting things done quickly. I have done my GP training mostly on the job and it has, in comparison to MRCP, been extremely straight forward although very expensive. I do find CME in the evenings quite an intrusion on family time and try to balance this by spreading it throughout the year.

• Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?
Go for it! Believe in the motto “and all will be well.” The ongoing and enormous pleasure of children more than balances out the juggling required. I think guilt is over-rated – we do the best we can so be kind to yourself! Always tell them how much you love them and what the plans are for the day ahead – it helps kids stay happy if they know what to expect.
• How has a medical career affected your family?
Financially it has provided great stability and job security, and as I enjoy my job it makes for a happy mum!

• What support do you get from your family?
Huge – we are a team – we aim to support each other. I have 100% commitment to the family from my husband and now that he is the full time parent it means that the important dates are not missed. I pay for a cleaner twice a week, and my husband does all the cooking during the week except if I am home early.

• How have you managed your training while bringing up a family?
By learning that sleep is over-rated and not really needed! I also learned an efficient approach to revision/learning – do what you have to – not more than. I had my eldest child four months before my finals at med school so it is an approach that has worked for me. Being flexible is harder in hospital medicine than in General Practice. If I want to take the kids to school I can just make clinic start an hour later. Hospital medicine did not work like that but overall I don’t think medicine is that flexible. If you want to be a good doctor you need the time to listen and sometimes the one patient who needs the most time is the one at the end of the day!

• How did you find the support from your college?
Medical school was great – very supportive with making my attachments close to home. The College of Physicians was harsh in the UK and made no allowances. The hospital where I worked, however, enabled me to apply for my Senior House Officer training as a job share – we were the first in the country in the UK back in 1999. That really helped. In New Zealand the GP college has been uninvolved. They have taken my money for training, delivered a good one year programme at the beginning and then it’s been minimal since.

• What, if any, problems did you encounter when returning to training?
Have never really left it. I think medicine is such an evolving science we are constantly learning.

• How did you/Did you maintain CME while on maternity leave?
I have only taken maternity leave greater than six months with one of my four children – the last! Otherwise I took approximately three months and so I didn’t really find this a problem.

• If you were just graduating from medical school again, what would you do differently?
Realistically I would not switch the country I lived in half way through training – I had poor advice and having arrived here as a registrar was unable to join the Palliative Care training scheme without resitting FRACP (MRCP). This ultimately led to a switch in career which would not have happened if I had remained in the UK.
Rosalynd Pochin

Rosalynd is a general surgeon with a sub-specialty interest in breast and endocrine surgery. She lives in Nelson with her husband and two daughters aged 13 years and nine years. Rosalynd had her eldest daughter while she was a basic trainee, and her second daughter amid her advanced training.

- **How does your specialty fit in with your family?**
  I have a very supportive family and my kids have grown up knowing what being on call means and are unfortunately used to mummy being away a lot.

- **Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?**
  Be aware that it is not easy, don’t imagine that you can do it all or expect kids or your speciality college to fit around you. There will be sacrifices and you will miss some critical stuff. You cannot make excuses to your trainers because you have kids. It’s not fair on your colleagues to not do your job properly.

- **How has a medical career affected your family?**
  As I said, I have children who probably know too much about on call and have had to manage without mum at times. However they are happy independent kids and I don’t think they have been too scarred!

- **What support do you get from your family?**
  My parents are in the UK so I have been very reliant on my husband in terms of child minding.

- **How have you managed your training while bringing up a family?**
  There was no part time training when I came through and no potential for it, so I have really had to function as if I did not have kids. I had three months off for my first child, and six months off for my second. This has changed now and I am on the selection committee for general surgery. We now have many interruptions for maternity leave and part time training, so it has improved.

- **How did you find the support from your college?**
  There was none and when I got pregnant on the scheme I was told I would have to take a year off. However a friend was transferring to paediatric surgery so we managed to do half a year each.

- **What, if any, problems did you encounter when returning to training?**
  I returned full time as there was no part time training. I found it very hard to leave my daughters. I also found that it took a while to regain my confidence as I felt I had forgotten a lot.

- **How did you/Did you maintain CME while on maternity leave?**
  I had the maximum of six months and came into the weekly registrar teaching.

- **If you were just graduating from medical school again, what would you do differently?**
  I wouldn’t do anything differently as such, but if there was another speciality I liked I would pick that over surgery which is fairly unforgiving and inflexible. Unfortunately surgery is my love!
John Langham

John is a general practitioner and has just completed GPEP1. He was an ED trainee for four and a half years while raising twins. He lives in Wellington and now has three children – three and a half year old twins, and a two and a half year old.

• How does general practice fit in with your family?
  When the twins were born I was working as an ED medical officer in a provincial hospital. This meant regular shift work (basically an SMO roster) with no night shifts and regular evening commitments, rarely more than 40 hours a week. I had quite a lot of mornings at home, and never finished too late. Twins was a very tiring proposition aside from work, but the flexibility of a small town and an ED role worked reasonably well. General practice has worked much better in terms of family life. This has, in part, fitted in with the boys starting school and making family life more regular and weekends more precious. It has also been better due to the lack of evening shifts and nights, and so I’m less tired and more patient with family.

• You are eight years out of medical school – how have you fitted in training?
  We had the twins after two and a half years and then I commenced ED training. GP training has been over the past year. Part one exams were hard with children. Shift work as a registrar meant a lot more night and late evening/early morning shifts than a MOSS roster, and this took its toll on the family. For my wife this was the hardest thing about the training – the irregularity and the frequent evenings at work when you may not really see each other for most of a week. PRIMEX as an exam is also nothing like the demands of ED part one exams, in terms of a commitment to study either, and again it made for more availability for family.

• Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?
  If possible, get as many exams out of the way prior to kids as possible. I wouldn’t wait until the end of training though as I have really enjoyed having children while I am younger and still flexible in terms of career path. If you are expecting twins it’s definitely worth ensuring there is a lot of support prior to their arrival. We moved back to Wellington to be near family when the boys were 10 months old. A smaller hospital was a very supportive work environment to have children. They were much more willing to offer leave and work around my commitments.

• How has a medical career affected your family?
  Shift work and exams made it a stressful few years for the family, and with multiple children support from family was really important. Shifts/registrar rosters made it harder for my wife to commit to regular activities as my roster was always unpredictable.
• **What support do you get from your family?**
  We moved home to Wellington when the twins were 10 months old to get support from my extended family. This included baby sitting which enabled some last minute changes to rosters etc. I get a lot of support from my wife and children as well. My wife is a full time mum, which has made it a lot easier to work in both training programmes.

• **How have you managed your training while bringing up a family?**
  ED – splitting exams made it easier. Study is hard, and has meant that training and family are almost as much as I could do at one time.

• **How did you find the support from your college?**
  ACEM was good about splitting up exams so that part one exams could be sat one, two, three, or four at a time. I sat two at a time and this was much more manageable.

• **If you were just graduating from medical school again, what would you do differently?**
  Not a lot. If you could plan these things I might have sat part one exams prior to children.
Maria and Chris Poynter

Maria and Chris are from a double doctor family – Chris’s specialty is intensive care and anaesthesia (dual fellowship) and Maria is in Public Health Medicine. They live in Wellington and have three children aged eleven months, two years, and four years.

• How do your specialties fit in with your family?

C: Training years have been pretty demanding. I’ve been lucky that Maria has been full time at home to look after the kids. I’ve just finished my last night shift ever and the shift work would have been so much harder with two working parents. I feel like I’ve been a pretty good dad but at the expense of everything else – I have only had room for medicine and parenting during these training years.

M: Public health does have part time training (minimum 0.4 FTE) and of course the hours are great – no nights, and no shift work! I chose to spend a block of time (five years) at home having kids before returning, to avoid the to-ing and fro-ing of intermittent maternity leave. At the time I had my eldest child, there was no formal provision for maternity leave – I had to have ‘special leave’ approved, and then I ended up having to resign from the training scheme in order to have more than 12 months leave. I have been approved for re-entry into the scheme in 2012.
How have you fitted in training since finishing medical school?

C: I put my head down and got to the end of it – almost as fast as possible for a dual trainee. This meant no locums, and only one three month stint in Europe travelling. Once we decided to have kids, the pressure was on to finish because Maria was putting her career on hold until I had finished training.

M: I also chose my specialty early, and got onto the training scheme after PGY2. I finished my last MPH exam four days before our first child was born, and then completed my dissertation after she was born (which was tough with sleep deprivation and baby brain). Since I’ve been off work, I’ve tried to get to training days when possible, but this has been relatively hard.

Do you have any advice for doctors-in-training who are thinking about balancing a career and kids?

There is no perfect time, so figure out your priorities and go from there. To patients, you are one doctor, but to your family, you are the only mum/dad. Be prepared to compromise on everything but look towards finding a balance that you can live with. Have a plan and figure out what’s possible – make sure you are in touch with MCNZ and your college etc.

M: Lots of people have told me you can’t have five years out of medicine, and it is true that I’ll have extra supervision when I go back to work, but I was going to be supervised as a registrar anyway so that wasn’t a big issue for me.

How has a medical career affected your family?

C: Shift work and exams are both hard on families. Exam study means life is pretty much work, study and squeezing in some time with the kids. Shift work is hard when the kids have a grumpy, tired dad or a dad working weekends a lot. My demands from work have put a lot of added home demands on Maria and strained our relationship at times.

M: I think if I wasn’t a doctor I wouldn’t go back to work until the youngest was three or four years old, so I guess I have compromised on that somewhat. There are positive aspects though – it’s nice having secure job prospects.

What support do you get from your family?

C: We moved to Wellington to be near Maria’s parents. They see the kids a few times a week but we don’t have any formal child care arrangement.

M: It was really useful to have family around when Chris was studying and working weekends, because those are the loneliest times as a ‘solo’ parent. When we are both working, we will try to structure it so my mum is ‘back-up’ one day a week, in case of nanny illness.

How did you find the support from your college?

C: As a member of two colleges, I have felt that my trainee years have been more about meeting their demands rather than having their support. I have not sought any different treatment or deviation from the standard trainee model.

M: In the last few years the College has changed to have formal maternity leave (one year per child), and has also decreased the minimum requirement from 0.5 FTE to 0.4 FTE – both are really helpful and if they had been options for me then, I would probably have taken them rather than having a big block of time away from working.

What, if any, problems did you encounter when returning to training?

M: I kept the College informed of my (changing) plans, so rejoining the scheme was relatively straight forward. I have found finding referees for my CV difficult because basic public health training is academic so there wasn’t an employment relationship – something that an explanation can fix, but it does feel like I am making excuses. I am currently in the process of reapplying for my APC, which will have some conditions attached to it, and which takes a bit of paperwork.
• **How did you/Did you maintain CME while on maternity leave?**
  M: I joined the NZMA DiTC and subsequently Board because it was a good way for me to keep up with things like policy changes. I regularly read a couple of journals, plus other important articles that I become aware of, but I am sure there are gaps because I don’t have the employment relationships to hear about things (or time to spend reading). I have been to a few conferences/meeting days, and some informal study group meetings – all at personal expense. I belong to several different interest/professional groups so that I get email traffic relating to public health.

• **If you were just graduating from medical school again, what would you do differently?**
  M: I’m pretty happy with how we’ve done things – we have stayed true to our priorities. I look around lots of colleagues and see a lot who are ‘owned’ by their training scheme and who wonder if/when they will have the kids that they say they want to have.

  C: I’m happy with where we are now and looking back pleased that we have persisted with our plans and priorities as a family. There have been some dark years (particularly those postgrad exam years), and constant re-evaluation of what we are doing and where we want to go, but overall I am happy with the choices we have made.
Tips to make it easier

Our profiled doctors have provided tips to help out those who are thinking about having a family/may already have a family and are looking for advice.

- **Set up a coffee group in your area.** Having other medical parents to talk to, who understand what you’re going through, can be a huge help. Think about setting up a coffee group in your area where you can get together regularly for a chat. It also helps with the social side of things if you are feeling isolated.

- **Start looking at daycare early.** If you are planning to return to work within the first year of having children, it is a good idea to start looking at your daycare options as early as possible – many facilities have long waiting lists.

- **Have a day care plan B.** If you are planning to send your child to daycare, they get sick. All the time. So have a plan in place of how you are going to deal with this when it occurs.

- **Look into job sharing.** Many medical parents are interested in job sharing, however most jobs of this description require a job sharing agreement and it can be difficult to find someone else interested in sharing a position. Try looking at the Job-X website: http://www.jobx.co.nz/worktype/job-share-jobs/medical-practitioner-jobs/.
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