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Comment: pregnancy in the early career psychiatrist

Elsa Bernardi Director of Clinical Services and Medical Superintendent, Macquarie Hospital, Australia, and Senior Clinical Lecturer, University of Sydney, Sydney, NSW, Australia

Abstract

Objective: The aim of this paper is to provide an opinion on the issues surrounding the pregnant psychiatric trainee, from the perspective of a senior female colleague who has integrated professional life with motherhood.

Method: The basis for this opinion piece is the article by a psychiatric trainee who describes her response to pregnancy and this is supplemented by some additional articles from psychiatrists on the theme of early career pregnancy.

Results: A combination of published literature and personal experience were used to form an opinion on pregnancy and the early career psychiatrist.

Conclusion: Pregnancy while training provides challenges to the trainee, the employer and the training networks but it provides benefits to both the individual and patients, and the role of a supervisor is to facilitate this.

Keywords: colleagues' reactions, early career psychiatrist, patient care, pregnancy, early career psychiatrist, psychiatry training, system reactions

The medical workforce has become increasingly feminized over the past three decades, and from the early stages this trend has been reflected in the specialty of psychiatry. Nowadays, the once male-dominated specialities of obstetrics and gynecology boast having over 80% female trainees.[1] Not surprisingly, this leads to a number of issues, many of which have been addressed in Hamilton's paper.[2]

It is not uncommon for the expectant mothers to encounter challenges associated with the new role of motherhood and societal expectations of motherhood in a professional environment. There are additional tasks for the psychiatrist trainee who is to become a mother. She not only has to navigate motherhood and the post-partum period, but deal with training commitments and the return to work to complete her training, as well as the necessary juggling and changes in her relationship this will entail. She also has potential sources of conflict arising from the task of integrating a new maternal identity with a professional identity.

It is not surprising that these issues present a source of conflict for the trainee, her patients and her colleagues. The impact of pregnancy on the early career psychiatrist has been explored from a number of perspectives. Tinsley[3] divided the matter into three areas: patient care perspective; relationship with colleagues; and the response of the employing agency and the college training mechanism. More recently, Hamilton's paper[2] identified challenges facing the pregnant trainee and, in the spirit of self-reflection and inquiry, explored the literature covering pregnancy and the psychiatric trainee or early career trainee psychiatrist.

Patient care perspectives

There are common themes and case histories in the psychotherapy literature on patient care. When to disclose the pregnancy to patients, and the subsequent response of the patient (anger, fear and abandonment) are prominent issues.[2–5] These issues are relevant in general psychiatry and the literature makes some suggestions on how to handle such situations.[2–5]

Many patients naturally react by offering congratulations and share a basic human interest in the doctor who is pregnant. To the patient who is also a parent, there may be an increase in respect and a sense of increased rapport. For the trainee this may be quite challenging as it appears to be in conflict with notions of maintaining boundaries and may lead to discomfort. This represents an excellent opportunity for a supervisor to assist the trainee in managing tricky areas such as self-disclosure.

Correspondence:
Elsa Bernardi, Macquarie Hospital, North Ryde,
NSW 2113, Australia
Email: ElBernar@nsccahs.health.nsw.gov.au

When is self-disclosure permitted in the patient doctor relationship? When does it represent the slippery slope towards boundary violation? Pregnancy is an obvious statement to the patient that the doctor has another life beyond being a doctor. Being 'real' to the patient may be a challenge but our patients may be better able to deal with the reality rather than their fantasies. Leaving the patient to guess about a pregnancy, as is sometimes reported as occurring, is not wise. Timely disclosure accompanied by assurance as to the transfer of care or locum arrangements will assist the patient in feeling looked after.

Relationship with colleagues

Maternity leave is a significant factor in dealing with the workplace dynamics and workloads. It would be naïve not to acknowledge that some colleagues are quietly resentful of the extra workload resulting. There are tendencies to see part-time professionals as less committed to the profession. Similarly, when approaching relationships with colleagues, timely disclosure is advantageous as it allows for planning.

The employers and training

In Australia and New Zealand, the employment landscape in which most registrars work is in the public sector. Maternity leave, long service leave, annual leave and other provisions are well protected in the various state industrial awards and in this respect the trainee has clear parameters.

However, the risks associated with pregnancy when working in acute psychiatric wards, the emergency department and forensic settings are less clear. Understandably, trainees may be concerned at the risk of assault during pregnancy or when pregnant makes them potentially more vulnerable. It is interesting to note that colleagues may become more protective. Furthermore, the literature reports long hours of work (100 hours per week) which poses as a risk factor to the fetus:[3] nevertheless, this does not consider the nature of the work environment.

It may be noted that the training site visits of the Royal Australian and New Zealand College of Psychiatry (RANZCP) are particularly sensitive to safety issues raised by registrars. However, the management of the pregnant psychiatry trainee's placement remains ad hoc and depends on the organization and allocations of the local training network.

Currently, anecdotal reports suggest that medical certificates from an obstetrician are being used to remove registrars from on-call duties. This has significant implications and may contribute to work load stress with remaining colleagues and may be a cause of resentment. Resentment by colleagues is also reported in the literature,[3] sometimes more often among male colleagues than female colleagues. This, too, appears to be changing as more male trainees request part-time work to fulfill personal, family and other requirements. Life balance arguments are now reshaping how the medical workforce views itself and it is not only women who are leading this change.

Being pregnant may be the first time the trainee has been on the receiving end of the hospital system in which she has worked. This may be a valuable experience in professional maturity and help her understand herself and her patients better. However, it may also be the first time she feels so vulnerable.

Our response

At a personal level, it is not uncommon for the female trainee to feel uncomfortable or guilty about pregnancy in the workforce. A sensitive supervisor can assist the trainee with these issues and an explicit and systematic approach by clinical directors in co-operation with directors of training is required. Trainees need to be appropriately placed to minimize risks, meet training requirements and to cover maternity leave due to gaps created in rosters. These organizational matters should be relatively simple to implement provided there is both financial and administrative support.

Pregnancy and maternity leave is predictable and can be planned for, and dedicated locums or relieving posts can largely resolve the workforce dilemma. Unfortunately, such posts are not always funded within psychiatry and are not accredited towards training. Similarly, part-time posts may be difficult to find, especially in mandatory experiences.

The RANZCP group of fellows has a high percentage of women, many of whom have combined pregnancy and family with professional life. It would be advisable for psychiatrists who are parents to provide insights for the trainee, thus allowing for the trainee to realize that pregnancy is both a challenging and rewarding experience which can assist in understanding the intergenerational issues that face our patients. Being a parent may be a great leveler.

The supervisor plays an important role in modeling how to achieve the balance between meeting parental and professional/training obligations. Helping and encouraging the trainee to complete their training is a useful mentoring and cross-generational experience. However, parenthood is not necessarily something that can be learnt directly from a manual. As supervisors who serve as role models, we can show that these inconsistencies can be tolerated. The supervisor and the director of training can assist in the process of managing the system and assisting the trainee in their return to work and training.

Whilst the pregnant trainee does encounter issues in patient, system and colleague relationships, it should be

noted that our trainees are a valuable resource and the experience of being a parent helps the trainee to become more empathetic. It is important to remember that whilst training may last a few years, motherhood is a lifelong career.

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References

1. Mackee N. Careers a new generation. *Med J Aust* 2012. Careers: A new generation: women dominate the training ranks in obstetrics and gynaecology. Med J Aust 2012; 197:c1-c2
2. Hamilton L. Baby on board: pregnancy as a source of conflict for the psychiatry registrar. Austral Psychiatry 2013; 21: 153–156.
3. Tinsley JA. Pregnancy of the early-career psychiatrist. *Psychiatric Serv* 2000; 51: 105–110.
4. Tinsley JA and Mellman LA. Patient reactions to a psychiatrist's pregnancy. *Am J Psychiatry* 2003; 160: 1–7.
5. Paluszny M and Poznanski E. Reactions of patients during pregnancy of the psychotherapist. *Child Psychiatry Hum Dev* 1971; 1: 266–274