

Motherhood and the working psychiatrist

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“For what is done or learned by one class of women becomes, by virtue of their common womanhood, the property of all women.”

– Elizabeth Blackwell

Raising a child is difficult. For working professional women, including doctors, that difficulty extends beyond bottles, bath time, and burping; it impacts day-to-day physiological function, time management, and emotional well-being.

The 1950s upheld a family model with traditional gender roles. By 1960, the family portrait of a breadwinner father and a stay-at-home mother with one or more children comprised 62% of American households.¹ Precipitous changes occurred over the next decades as the housing market soared, education costs increased, and divorce rates rose. The 1980s ushered the arrival of women’s power suits and the notion of women “having it all.”¹

Fast-forward to modern times. Medicine is changing, too. Women are slowly but surely starting to rise in this once male-led field. In 2017, for the first time more women than men enrolled in medical schools in the United States.² In a 2015 report, the Association of American Medical Colleges found that 57% of residents who were pursuing psychiatry were women.³ And the median age of women applying to medical school who enrolled in 2017 or 2018 was 23 years.⁴

Choosing to parent as a physician poses challenges for women and men alike. As the rates of women in medicine and psychiatry are increasing, this article focuses

on unique obstacles faced by mothers and aims to:

- explore the dueling duties of mothers who practice medicine
- consider the dilemma women face when returning to the workforce during the postpartum period
- discuss options for enhanced recognition and care of maternal and child well-being.

Duty: Being both parent and physician

The working psychiatrist mother has a duty to her patients and profession—not to mention a duty to her child. The demands are endless on both sides. No matter what stage of her professional career (medical school, residency, fellowship, or beyond) she chooses to begin motherhood, the responsibilities and expectations can be overwhelming. Doctor appointments, nausea and vomiting, fatigue, discomfort, and stress do not fit well within a schedule of intensive studying, working 24-hour shifts, navigating complex schedules, treating patients, and sorting out the financial heft of loan repayment, home ownership, contract negotiation, or relocation.⁵

Psychiatry carries a notable dichotomy of lecturing at length on the importance of maternal-infant attachment. John Bowlby

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Disclosures

The authors report no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.

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argued that a child's attachment to the mother is instinctual and primary, noting that early loss creates true mourning due to the primal ties of child to mother.⁶ Bowlby also asserted that personality development and psychopathology are rooted in the concept of attachment and the emotional security built through early childhood experiences.⁶

Dr. Donald Winnicott introduced the concept of a "good-enough" mother in 1953.⁷ Today, although Winnicott's teachings are explored in psychiatry training programs and practice, his concept does not resonate with many working mothers. Most physicians strive for perfection while struggling to balance their personal and professional lives.⁷

It's no wonder that tales abound of female physicians being praised for their ability to take on grueling shifts up to their due date, forego lunch to pump breast milk, or cover shifts beyond child daycare closing times. This raises an interesting dilemma: Is the primary goal the efficiency of promoting commerce, patient numbers, and the workings of the health care system? Or is it the wellness of expecting mothers and the development and attachment of an infant to the parent? Is the goal to slowly and carefully craft our next generation of young humans? Or is there a way to "have it all"?

Dilemma: Misperceptions after returning to work

As they regain control of their bodies, sleep, and overall health, women who return to work during the postpartum period battle a myriad of misperceptions along with the logistical hurdles of breast-feeding. In a study of surgical residencies, 61% of program directors reported that female trainees' work was negatively affected by becoming parents.⁸ But other evidence suggests there is a disparity between perception and reality. In a broader population of working mothers in the United States, studies showed that employed mothers were actually more engaged than fathers at work and had equal levels of commitment

and motivation.⁹ A lack of support from colleagues can produce a so-called "anti-mom" bias in the workplace.¹⁰

As a result, misperceptions can negatively affect maternity leave or lactation time. Women often rightfully fear they may be viewed as taking leisure time or making convenient excuses to shirk responsibility, rather than focusing on the necessities for recovery, care, and bonding. Such pressures can lead to burnout and resentment. The struggle with breast-feeding is pervasive across all medical specialties. In a 2018 survey of 347 women who had children during surgical residency, 39% of respondents strongly considered leaving their training, 95.6% indicated that breast-feeding was important to them, and 58.1% stopped breast-feeding earlier than desired due to challenges faced in the workplace, such as poor access to lactation facilities and difficulty leaving the operating room to express milk.¹¹

The American Academy of Pediatrics (AAP) recommends exclusive breast-feeding through 6 months of the postpartum period, and continued breast-feeding until the infant is at least 12 months old. Breast-feeding confers benefits to both the infant and mother, including positive impacts on the child's cognitive development and health into adulthood, as well as higher productivity and lower absenteeism for breast-feeding mothers.¹² By 2009, only 23 states had adopted laws to encourage breast-feeding in the workplace. In 2010, the United States government enacted the "reasonable break time" provision in Section 4207 of the Patient Protection and Affordable Care Act (ACA), which requires all employers to provide a period of time and private space other than a bathroom in which female employees can express milk for a child up to age 1.¹²

In 2016, a follow-up national survey of employed women explored workplace changes after the ACA, and noted that only 40% of women had access to both break time and a private space for lactation.¹³ If the goal is to give working women a true

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Is the primary goal the efficiency of the health care system? Or is it the wellness of mothers and their infants?



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Policies for faculty at the top 12 medical schools offer new mothers only approximately 2 months of paid leave

choice of whether to continue breast-feeding after returning to work, these mothers need to be provided with the proper social and structural supports in order to allow for that personal decision.¹⁴

Discussion: Barriers to change

Breast-feeding, it has been argued, is the most enduring investment in women's physical, cognitive, and social capacities, and provides protection for children against death, disease, and poverty.¹⁵ Research has shown that breast-feeding every child until age 1 would yield medical benefits, including fewer infections, increased intelligence in children, protection against breast cancer in mothers, and economic savings of \$300 billion for the United States.¹⁵

We are no longer in the 1950s, but modern times still present challenges for mothers who are working as physicians. Although the AAP recommends that new parents receive 12 weeks leave from work, policies for faculty at the 12 top medical schools in the United States offer new mothers only approximately 2 months of paid leave.¹⁶ There also are problems of inconsistency among approaches to parenthood in graduate medical education (GME) training, different specialty clinical requirements, and different residency training programs. These factors all contribute to negative attitudes towards parenthood.¹⁷

We know the barriers for women.¹⁸ With more women entering the medical profession, we need to continue finding creative and workable solutions as these problems become more pressing.¹⁹ In a 2018 *Time* article, Lily Rothman wrote, "you can't talk about breastfeeding in the United States without pointing out that every other wealthy country has found a way to accommodate breastfeeding mothers, and usually in the form of lengthy paid maternity leave."²⁰ However, maternity leave in the United States today dictates that mothers return to work while their children would still benefit from nursing.²¹

When it comes to GME and medical institutions, programs could look at barriers such as lack of accommodations for trainees who are pregnant or have young children. Addressing these barriers could include making private lactation rooms available and instituting flexible scheduling. It would be best if scheduling accommodations and policies were established by an institution's administration, rather than leaving coverage up to the students or residents. Going further, institutions could consider offering flexible maternity leave and work schedules, allowing breaks for those who are breast-feeding, and creating lactation facilities.²² This could take the form of a breast-feeding support program that fits available budget resources.²³

Psychiatrists frequently discuss Winnicott's "good-enough mother" concept, with the mother transitioning from focusing on her baby's needs to her own sense of personhood that is unable to respond to her baby's every wish.⁶ This concept was established well before the shifting demographics of the nuclear family, the short maternity leaves and early returns to work, early separation of one's infants to childcare settings, and experiences with pumped lactation milk that working mothers experience today. Is it any wonder childbearing female psychiatrists face a special kind of working-mother guilt?

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Scheduling accommodations should be established by institutions, rather than leaving coverage to students or residents