CAREERS CLINIC

Working while pregnant: what should I consider?

Abi Rimmer asks about the risks and responsibilities among expectant doctors

“As a pregnant working doctor it’s important that you know your rights and responsibilities, and those of your employer.

“It’s the employer’s responsibility to carry out a risk assessment of an employee’s working conditions when she is pregnant, has recently given birth, or is breast feeding. Where an employee or her child would be at risk if she continued her normal duties, the employer should provide suitable alternative work at the employee’s usual pay rate.

“All pregnant employees are entitled to time off for antenatal care for both medical examinations and relaxation classes, as long as these are led by a registered practitioner. You should continue to receive your normal pay during your time off. You’re also entitled to ‘keep in touch’ days while on maternity leave.

“Keep a written record of everything you’ve agreed.”
Maddy Fogarty Hover, ST3 in paediatrics

“The main risks faced by pregnant surgeons occur because of long hours and fatigue, which are known to increase the risk of intrauterine growth restriction and fetal death.

“Transferring patients and heavy lifting should be avoided in pregnancy, owing to lax ligaments and an increased risk of miscarriage. We often hear concerns about using x rays, but a standard 0.5 mm lead apron will block 99% of radiation, and maternal tissues block a further 70%. It’s worth discussing your plans with the radiology department to reassure radiographers that it’s safe for them to use x rays in your presence.

“Surgeons come into contact with many potential teratogens, so it’s sensible to research any substances you use. Iodine scrub seems to be harmless, but lead and cytotoxic drugs can have teratogenic effects. Anaesthetic gases are thought to be teratogenic, but modern closed systems dramatically reduce the risk of inhaling these gases.

“Surgeons must each generate their own unique plan with occupational health, taking into account their specific job risks—but, with careful planning, there’s no reason why a surgeon should worry about pregnancy at work.”
Laura Hamilton, orthopaedic hand fellow at King’s College Hospital, London

“The demands on a gynaecologist are similar to those on a general surgeon, with the physical and psychological pressure of theatre and busy clinics.

“It’s very important that pregnant clinicians prioritise their wellbeing, not only for the benefit of their baby and themselves but also for their patients. Fainting while operating in a warm theatre, for example, is clearly a risk to patients.

“Pregnant women may feel more tired than usual, particularly in the first and last few weeks of pregnancy, so they should try to rest when possible and not overdo things. Commuting is also likely to become more challenging in the final trimester.

“If women are struggling to carry out their normal duties they should speak to their supervisor and employer’s occupational health department to identify where changes can be made. It will probably be helpful, for example, to limit prolonged operating and night shifts whenever these become too difficult.

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Maddy Fogarty Hover, ST3 in paediatrics

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David Sanders
Fascinated by zombies

What was your earliest ambition?
To be Spider-Man.

What was your best career move?
Leaving Glasgow, where my father was a well known and respected consultant physician: as much as I loved my dad, I needed to make my own way.

What was the worst mistake in your career?
I’ve made many mistakes and still do—just nothing catastrophic, fingers crossed.

How is your work-life balance?
It does indeed hang in the balance. Far too highly regulated, perhaps, with every minute accounted for.

How do you keep fit and healthy?
Running and low intensity gym, what with getting old and being injured too easily.

What single change would you like to see made to the NHS?
An end to pernicious and secretive privatisation.

Do doctors get paid enough?
Yes: I sincerely believe our job is a vocation and we’re privileged to serve patients.

To whom would you most like to apologise?
To my dad, for being a prodigal son. But I did get the chance to apologise.

What do you usually wear to work?
Theatre blues and trainers.

Which living doctor do you most admire, and why?
Chandu Bardhan (my mentor), who is essentially the Yoda of UK gastroenterology.

What is the worst job you have done?
I have a fascinating exposure to the world in theatre blues: often it’s quicker to push a trolley to endoscopy yourself than to wait for others, and people frequently think that I’m a porter. This gives me a unique perspective, as there’s an unsaid hierarchy that equates to not even recognising such people. It makes me sad.

What single change has made the most difference in your field?
Capsule endoscopy has revolutionised gastrointestinal medicine, and remote endoscopy is coming in our lifetime. I hope that you don’t mind me boasting and saying that my colleagues in Sheffield are leading the way.

What book should every doctor read?
Wonder, by R J Palacio. “When given the choice between being right or being kind, choose kind.”

What is your guiltiest pleasure?
A fascination with all things zombie.

Is the thought of retirement a dream or a nightmare?
Neither: it’s simply the next phase of this wonderful journey. Enjoy the ride.

If you weren’t in your present position what would you be doing instead?
I’ve recently watched many real life police programmes, and it struck me that there’s a gap in the market for a reasonably intelligent, methodical criminal. I’d like to test that hypothesis!

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David Sanders, 48, is professor of gastroenterology and a consultant at the Royal Hallamshire Hospital in Sheffield. His specialty is coeliac disease and the role of gluten. Born in Sri Lanka, Sanders came to Britain when his family fled the civil war in the 1970s, and he was brought up in Glasgow. His team’s pioneering use of the anaesthetic propofol in the endoscopy room was shortlisted for a BMJ Award in 2016.