Regular Commentary

Accommodating pregnancy and parental leave for the emergency physician: An update

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In recognition of the unique needs of pregnant physicians, a group of emergency physicians at The Ottawa Hospital developed a document to guide departmental decision-making, published in this journal in July 2014.[1] In view of the evidence associating shift work, particularly night shifts, with preterm births and small-for-gestational-age infants, these guidelines focused primarily on modifying shift load as the pregnancy progresses.[2,3] This year, we updated the document (see Appendix 1 for the authors' updated suggested guideline). What follows is a discussion of our methods and rationale to update this local policy.

To inform our update of the 2014 document, we performed a scoping review of the literature. While there are no studies directly examining pregnancy outcomes for emergency physicians, research on shift work and pregnancy suggests small but significant negative associations between shift work and pregnancy outcomes.[4,5] There is a trend towards increased risk of preterm labour with night shifts.[6] Additionally, new evidence has come to light associating two or more night shifts per week during the first half of pregnancy with an increased risk of spontaneous abortion.[7] In regards to breastfeeding, the World Health Organization (WHO) recommends exclusive breastfeeding for a child's first six months, followed by continued breastfeeding for up to two years and beyond.[8] The literature suggests a positive relationship between workplace lactation accommodations and the duration of breastfeeding.[9,10] Further, paternity leave has been shown to have beneficial effects on breastfeeding duration up to 6 months of age.[11] With respect to parental and paternity leave, research suggests taking parental leave and working fewer hours increases paternal familial involvement, and workplace policies can facilitate fathers' uptake of parental leave.[12]

In addition to the scoping review, to make our update most useful to those who might access it in the future, we consulted with the members of our local department through an online survey regarding their experiences with pregnancy, parental leave, and return to work considerations. Questions were developed by the authors and distributed using a Surveymonkey online questionnaire that was emailed to our local staff physicians (see Appendix 2 for our survey questions). Our survey results suggest that parents and expecting parents felt supported by the department but that there was room for improvement with respect to the approach to the non-birth parent and return to work accommodations (including scheduled shifts, meeting departmental quotas, and breast pumping accommodations).

The updated document now addresses work accommodations for the breastfeeding physician and length of leave for the birth parent ("maternity leave"). Given the increasingly recognized positive associations between "paternity leave" and outcomes for children and families, we included parental leave considerations

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for the non-birth parent (including, but not limited to, "paternity leave," leave for the adoptive parent, same-sex partners, etc.). This document is designed to be used as a guide for: physicians who are contemplating pregnancy or are currently pregnant; physicians who are returning to work after delivery; physicians whose partners have given birth or physicians who have adopted a child; and schedulers and department chairs to inform discussions around shift scheduling and appropriate accommodations. The following is a summary of the key elements of the updated document.

Shift scheduling during pregnancy

Each pregnant physician has the ability to seek her own arrangements to suit her pregnancy (in accordance with her own individual health, family, and financial concerns) in consultation with her department's administration. A pregnant physician is encouraged to notify the head of the department and schedulers as early as she feels comfortable doing so. If accommodations are needed after the shift request deadline has passed, schedulers in a supportive department should attempt to assist the pregnant physician in shift change requests.

Many women find that emergency clinical work becomes more challenging as pregnancy progresses. The pregnant physician may choose to reduce the volume of her shifts, especially as she approaches the third trimester. Further, physical constraints in pregnancy can make managing resuscitation cases increasingly difficult. The pregnant physician may consider requesting no resuscitation shifts at this same stage of pregnancy or arrange access to a back-up physician from another area for specific procedures (e.g., endotracheal intubation and central line insertion).

The pregnant physician may consider requesting no night shifts and/or shifts that end after midnight at 24 weeks, and possibly earlier. This is in line with the recommendation of the British Columbia Physician Health Program consensus statement of 2010[13] and ACEP best-practice recommendations.[14]

While the duration of work during pregnancy is a matter of personal preference, our group's collective experience suggests stopping work at 35 weeks, with the option to pick up extra shifts thereafter, if desired. This would reduce the chance of having to cover shifts at the last minute.

Shift scheduling for non-birth parent

The non-birth parent could consider requesting days off prior to and after the estimated date of delivery or request alternative back-up coverage as a strategy to avoid last-minute shift coverage issues.

Working conditions

Emergency medicine comes with attendant risks of exposure to infectious agents that may not be known at the time of patient presentation. The pregnant physician can request her serum titer of immunity to varicella and parvovirus B19 to assuage unforeseen post-exposure concerns. If possible, it would be ideal to have another physician evaluate the very ill febrile patient or the undifferentiated rash. Pandemic preparedness should also consider the accommodation of pregnant physicians.

Parental leave

In Ontario, the Employment Standards Act (ESA) entitles employees who are new parents to unpaid parental leave of up to 61 weeks, shared between two parents.[15] Canada's Employment Insurance Act provides eligible employees with financial benefits in relation to maternity and parental leave, up to a combined total of 76 weeks.[16]

Ontario's ESA does not apply to physicians practicing as independent contractors. Additionally, most physicians practicing as independent contractors will not be eligible for financial benefits under the federal Employment Insurance Act. However, it is important that departments and physicians are aware of the maternity and parental leave entitlements established under provincial and federal law. The authors believe requests for leave duration that are in keeping with these laws should be favourably received by emergency departments (ED).

Returning to work after maternity and/or parental leave

The returning physician might consider a skills update course prior to returning to work or during the first few months of return. Participation in simulation resuscitation scenarios, where the physician can practice crisis resource management and procedural skills, is highly encouraged, when available.

As the time to return for each physician varies, the physician could request accommodations that suit his or her family's needs. These could include one or more of the following shift modifications: no resuscitation or night shifts during the first few weeks, a reduced number of shifts for the first few months, and/or a fixed schedule, for a limited period, to allow for childcare planning.

With respect to physicians who are breastfeeding, there should be access to a private, locked room with an electrical outlet close to the ED for pumping breast milk. For any department that operates using an electronic medical record (EMR), the pumping room should have a computer with access to the EMR or be able to accommodate a workstation on wheels. The physician should advise a colleague that she will be out of the department and should remain available by phone, if possible.

Departments may consider exempting physicians from productivity metrics/targets during shifts during which they are pumping and during the first several weeks of return to work.

Regarding the extent of these accommodations, we recognize that each family has specific needs, and departmental efforts should be made to accommodate reasonable requests.

In conclusion, given the physiological, psychological, and emotional challenges that occur during pregnancy and after the birth of a child, we have designed a guide for pregnant physicians and physicians seeking parental leave. Future updates to this guidance will be informed by emerging research in this evolving area. A national survey is underway to explore the experiences of Canadian emergency physicians with respect to parental leave. The accommodation of physician parents and parents-to-be is an important issue for all departments and individual physicians. We recognize that this approach is informed by the experience of physicians at a large tertiary care centre, with a staff of nearly 90 doctors. Smaller centres will have different staffing challenges in the face of pregnancy and parental leave. At this time, we strongly believe that every ED should have a structure that provides physicians with appropriate accommodations to ensure their optimal health, clinical functioning, and overall wellness during this significant life event.

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