CAEP Position Statement on Pregnancy and Parental Leave – Executive Summary

INTRODUCTION

A career in Emergency Medicine can be very rewarding but comes with a unique set of challenges related to shift work and the need to function in an unpredictable high-stress environment. These environmental considerations can be particularly impactful around the time of pregnancy and infant care, and it is imperative that departments have policies in place to protect and support physicians who become pregnant or take parental leave. The following policy statement is intended to provide a template for individual emergency departments in Canada to develop, adopt, update, or modify pregnancy and parental leave policies. The goal of these policies is to support physicians by optimizing physical and mental health throughout their pre-pregnancy, pregnancy, parental leave, and return-to-work journeys. An additional benefit is that policies with clear expectations can help departments and leadership navigate their human resource management, including recruitment and retention, recognizing that there will be differences based on geographic location and size of department. A previous position statement from the Canadian Association of Emergency Physicians (CAEP) has identified a need to have parental leave and chestfeeding policies in place that are reviewed and updated by a gender balanced committee at regular intervals.[1] This policy statement will help provide guidance and evidence for departments to achieve that goal.

LIST OF RECOMMENDATIONS

Pregnancy

1. *The pregnant physician should be provided with the option to stop night work as early in the pregnancy as possible, and no later than 28 weeks gestational age.*

Several consensus statements,[2,3] emergency departments,[4] and residency associations[5] specifically recommend no call or night shifts after a gestational age ranging from 24-28 weeks. Some of these also support stopping shifts that end after midnight over this time period.[4] Numerous studies across the global landscape[6,7,8,9] and several systematic reviews and meta-analyses,[10,11,12] reflect moderate evidence of increased risk of preterm birth in association with night shifts or irregular shift hours.

2. *It is expected that a physician in the third trimester may require accommodations in shift type, timing, and structure to reduce the physical demands.*

The literature reflects a modest increased risk of preterm birth in association with higher work hours.[7,8,10,11] Many factors associated with working in an Emergency Department (long periods of standing, heavy lifting, a high physical workload) may be associated with increased risks of preterm birth,[9,10] small for gestational age infants,[9,13,14,15] and gestational hypertension[9]. To mitigate this risk and allow pregnant physicians to keep working safely, departments should consider a variety of options where possible, such as ensuring the pregnant physician has double coverage, the option to stop resuscitation or acute care shifts, and the ability to reduce the number of shifts worked.. To avoid last-minute shift coverage concerns, some physicians may choose to stop working several weeks prior to delivery.[4] Should the physician choose to do so, the department should support this option as well as the option to pick-up last-minute shifts in lieu of pre-scheduled shifts. In addition to the specific suggestions above, physicians may require further accommodations on the advice of their treating health care provider, regardless of stage of pregnancy.

3. *Physicians should not be required to make up missed shifts before and/or after a pregnancy or parental leave in order to accommodate the leave*.

Requiring increased shift loads to compensate for shifts not worked during pregnancy and parental leave counteracts the support provided by the leave. Further, several studies reflect a

correlation between shift work or long work hours in the first trimester and increased risk of preterm birth.[7,8]

4. *Where possible, it is ideal to have another, non-pregnant physician see the very sick febrile patient, patients with undifferentiated rashes, chemical or radioactive exposures, and patients who are agitated or violent. If this is not possible, adequate PPE and security support should be provided.*

There are inherent risks to personnel working in an Emergency Department. Minimizing risk of harm to the growing fetus from specific infectious scenarios, chemical and radioactive exposures, and trauma is a reasonable expectation. If double coverage is available for pregnant physicians, then this should be feasible. Emergency departments should engage in proper screening and isolation of patients in addition to provision of PPE.[16] A pregnant physician may ask a colleague to assist with procedures that may become more challenging in the third trimester due to physical constraints (such as intubation and central line insertion).[4] Violence in the ED is a recognized issue in Canada, with woman physicians being more likely to experience physical assault than their colleagues.[17,18] Measures should be taken to ensure security protection is available.[17,18]

<u>Parental Leave and Alternative Pathways to Parenthood</u>

1. *Both birthing parents (including surrogate parents) and non-birthing parents (including adoptive and foster parents) are entitled to and should be fully supported to take both pregnancy and/or parental leave in conjunction with provincial and federal laws.*

There is limited research on this topic in the Canadian medical setting; a single publication in the Canadian Medical Association Journal in 2000 emphasized that parental leave planning should be part of all physician human resource planning for the future.[19] A review of parental leave policies in Canadian residency education identified that all provincial residency organizations offer at least 35 weeks of total leave, with most offering some degree of supplemental income.[5] In Canada, provincial and federal labour laws guarantee an employee's right to take time off work to care for a new baby or adopted child.[20] The same should be offered to physicians. There are many reasons individuals may choose to pursue adoption, surrogacy, foster parenting or other alternative pathways to parenthood and these individuals have a right to the same accommodations.

<u>Return to Work</u>

1. *The returning Physician should be offered flexibility in shift structure, type, and duration on return-to-work.*

Many physicians may return to work after a parental leave shorter than the Canadian average or allowable duration.[19,21] At this stage many infants may not be sleeping through the night and childcare may be precarious. Accommodations for the returning Emergency Physician after parental leave proposed by Wilson et al.[4] suggest no resuscitation or night shifts for a set period of time, a shift reduction or gradual return to work over several months or a set schedule to accommodate childcare transitions. Additional accommodations may include part time return to work, no solo coverage shifts, job sharing, buddy shifts (whereby the returning MD works in parallel to a colleague), shorter/split shifts, or no supervision of learners.[4,22,23,24,25]

2. *The returning physician should have the opportunity to engage in continuing professional development and education prior to and/or during return-to-work.*

Clinicians taking leaves, particularly longer leaves, may express concerns over loss of skill and lack of confidence on return to work.[22,26] Multiple sources support the use of continuing education in conjunction with return to work.[4,21,22] These sessions may include simulation sessions, mentorship or procedural sessions.[4,21,22,27]

3. *The pregnant and/or returning parent should be considered equally for promotion, tenure and career advancement.*

Several studies cite the process of pregnancy/parental leave and return-to-work as having a negative impact on career opportunities and advancement.[22,24,28] Suggested inclusive support for professional involvement and advancement are family-supportive meeting schedules, virtual attendance options for meetings, mentorship, and stop-the-clock policies for promotion.[22,23,28,29]

4. *The returning physician should be provided with chestfeeding accommodations*.

Barriers to chestfeeding in the work environment contribute to parents not reaching their chestfeeding goals.[30,31,32,33,34] Departments should have clear chestfeeding policies.[1] The lactating parent should be provided with adequate breaks/time and space in close proximity to the ER to chestfeed or pump milk, including access to a private, locked room with a sink, sterilization capabilities (i.e. microwave), a fridge to store human milk, as well as a computer and phone access to continue administrative duties.[4,21,23,25,31,32,35] Furthermore, the lactating parent should be excluded from evaluation using departmental productivity metrics given the additional time required to feed/pump.[4,29]

<u>Fertility and Pregnancy Loss</u>

1. *Where possible, departments should offer accommodations if and when physicians with a history of pregnancy loss or infertility are attempting to conceive.*

Many women in medicine have delayed childbearing because of perceived threats to their careers.[36] These women often face resultant challenges with fertility and pregnancy loss, requiring fertility treatments and/or alternative pathways to parenthood at a higher rate than the average population. The infertility rate among female physicians is reported between 24-32%.[37] It has been demonstrated that in women undergoing fertility treatments for female infertility there is an inverse association between likelihood to conceive and perceived excessive workload, as well as an inverse association between likelihood to deliver and objective measures of workload (e.g. part vs full time).[38] There is a paucity of literature on how best to support physicians undergoing fertility treatment, however it is appropriate to provide accommodations to enable attendance at necessary medical appointments and abide by any recommendations from the treating reproductive specialist. These accommodations may vary based on geographic location and availability of treatment facilities.

2. *A physician experiencing pregnancy loss should be offered time off work as needed or requested to grieve and recover.*

There is very little research on pregnancy loss and the workplace. Experiencing a loss at any point in a pregnancy can be emotionally and physically stressful and may require varying degrees of medical intervention and recovery. Having a supportive work environment with flexibility for short-term leave to accommodate necessary medical procedures and grief were identified as important.[39]

SUMMARY TABLE OF RECOMMENDATIONS

Pregnancy	*The pregnant physician should be provided with the option to stop night work as early in the pregnancy as possible, and no later than 28 weeks gestational age.*
	It is expected that a physician in the third trimester may require accommodations in shift type, timing, and structure to reduce the physical demands.
	Physicians should not be required to make up shifts before and/or after a pregnancy or parental leave in order to accommodate the leave.
	Where possible, it is ideal to have another, non-pregnant physician see the very sick febrile patient, patients with undifferentiated rashes, chemical or radioactive exposures, and patients who are agitated or violent. If this is not possible, adequate PPE and security support should be provided.
Parental Leave and Alternative Pathways to Parenthood	*Both birthing parents (including surrogate parents) and non-birthing parents (including adoptive and foster parents) are entitled to and should be fully supported to take both pregnancy and/or parental leave in conjunction with provincial and federal laws.*
Return to Work	*The returning physician should be offered flexibility in shift structure, type, and duration on return-to-work.*
	The returning physician should have the opportunity to engage in continuing professional development and education prior to and/or during return-to-work.
	The pregnant and/or returning parent should be considered equally for promotion, tenure and career advancement.
	The returning physician should be provided with chestfeeding accommodations.
Fertility and Pregnancy Loss	*Where possible, departments should offer accommodations if and when physicians with a history of pregnancy loss or infertility are attempting to conceive.*
	A physician experiencing pregnancy loss should be offered time off work as needed or requested to grieve and recover.

NEXT STEPS

There have been advances in research and policies related to pregnancy and maternity leave in emergency medicine, but there remains work to be done in the areas of parental leave and in the experiences of physicians who are undergoing fertility treatment or experiencing pregnancy loss. Despite this lack of fulsome evidence, departments are encouraged to adopt flexible policies that address the recommendations in this statement while respecting everyone's unique needs. These policies should be reviewed regularly by gender balanced committees and incorporate new evidence as it arises.

CONCLUSION

There is increasing recognition and commitment to the importance of enabling physicians to fulfill important roles in both their professional and family lives. Meaningful work-life integration can help mitigate burnout and it is imperative that departments are able to recognize the unique challenges of physicians who are often balancing early career with starting a family. Recognizing that any leave from practice has the potential to impact human resources, departments should be proactive about operationalizing policies and procedures that enable staff to take the necessary leave and support re-integration, while being mindful of the fact that the requirements for each physician and leave will be unique.

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CAEP Position Statement on Pregnancy and Parental Leave – Full Document

INTRODUCTION

A career in Emergency Medicine can be very rewarding but comes with a unique set of challenges related to shift work and the need to function in a high-stress environment. These environmental considerations can be particularly impactful around the time of pregnancy and infant care, and it is imperative that departments have policies in place to protect and support physicians who become pregnant or take parental leave. The following position statement is intended to provide a template for individual emergency departments in Canada to develop, adopt, update, or modify a pregnancy and parental leave policy. The goal of these policies is to support physicians by optimizing physical and mental health throughout the pre-pregnancy, pregnancy, parental leave, and return-to-work journeys. It is important to recognize that each pregnancy and path to parenthood is unique, and the accommodations required or desired by individuals will vary and should be addressed on a case-by-case basis. Additionally, the resources available to support these recommendations will vary depending on geographic location and size of department.

A previous position statement on gender equity from the Canadian Association of Emergency Physicians (CAEP) has identified a need to have clear parental leave and chestfeeding policies in place that are reviewed and updated by a gender balanced committee at regular intervals.[1] This policy statement will help provide guidance and evidence for departments to achieve that goal.

OVERVIEW OF CURRENT SITUATION

A report from the Canadian Medical Association in 2018 identified that 54% of physicians under age 40 are women, and projects that by 2030 the physician pool will have reached gender parity.[2] A recent scoping review on physician pregnancy identified that despite increasing prevalence of formal maternity leave policies, there is persistent stigmatization and discrimination related to pregnancy.[3] Authors propose that "reliable systems should be established to provide flexibility and appropriate clinical coverage in anticipation of physician pregnancy rather than approaching it with a 'crisis mentality.'"[3]

While the literature around maternity leave suggests modest gains, there is notably less published about leave for the non-birthing parent or for individuals who choose alternative pathways to parenthood like adoption, surrogacy, or fostering. There are also many practicalities to consider regarding return to work after leave and accommodating chestfeeding. Prior review articles have highlighted issues to consider around accommodations for pregnant emergency physicians and those returning from parental leave.[4,5]

There is ample literature regarding the increased risks of impaired fecundity and miscarriage for women in medicine,[6,7] for shift workers,[8,9,10,11,12] and specifically for emergency physicians.[13] It is important for departments to recognize this issue and support physicians who are trying to conceive or have experienced pregnancy loss.

RECOMMENDATIONS

PREGNANCY

Pregnant physicians are entitled to make their own decisions to suit their pregnancy and their own individual health, family, or financial needs. All the accommodations below should be made available to a pregnant physician. At the same time, it is important to recognize that most of

these accommodations have potential to impact the pregnant physician's income as well as the functioning of their department.

1. *The pregnant physician should be provided with the option to stop night work as early in the pregnancy as possible, and no later than 28 weeks gestational age.*

Several consensus statements,[14,15] specific emergency departments,[4] and most residency associations[16] specifically recommend no call or night shifts after a gestational age ranging from 24-28 weeks. Some of these also support stopping shifts that end after midnight over this time period as well.[4] Numerous studies across the global landscape,[12,17,18,19] and several systematic reviews and meta-analyses[8,20,21] reflect moderate evidence of increased risk of preterm birth in association with night shifts or irregular shift hours. In addition, multiple studies [8,22,23] note a further increased likelihood of gestational diabetes and hypertension or preeclampsia, felt to be related to sleep quality and circadian rhythm disruptions.[24,25] Physicians with twin/multiple pregnancies may require earlier accommodations, as there is evidence that working more than 28 hours per week, working at irregular hours, and high physical workload are all associated with a risk of preterm birth.[17]

2. *It is expected that a physician in the third trimester may require accommodations in shift type, timing, and structure to reduce the physical demands.*

The literature reflects an increased risk of preterm birth in association with higher work hours.[8,18,19,21] Further studies suggest that long working hours can increase the risk of hypertension and small for gestational age infants.[26] Many factors associated with working in an Emergency Department (long periods of standing, heavy lifting, a high physical workload) may be associated with increased risks of preterm birth,[12,21] small for gestational age infants,[10,12,27,29] and gestational hypertension.[12] To mitigate this risk and allow pregnant physicians to keep working safely, departments should consider a variety of options where possible, such as ensuring the pregnant physician has double coverage, the option to stop resuscitation or acute care shifts, and the ability to reduce the number of shifts worked. These modifications allow the pregnant physician to minimize the high physical workload component of their job. Further, some departments recommend stopping scheduled shifts at approximately 35 weeks[4] to avoid last-minute shift coverage concerns. Of course, this has the potential to impact the pregnant physician's income and cannot be a mandatory requirement. Should the physician choose to stop working prior to delivery, the department should support this option as well as the option to pick-up last-minute shifts in lieu of pre-scheduled shifts. Physicians experiencing pregnancy related complications may also require earlier accommodations at the direction of their treating healthcare provider.

3. *Physicians should not be required to make up missed shifts before and/or after a pregnancy or parental leave in order to accommodate the leave*.

Requiring increased shift loads to compensate for shifts not worked during pregnancy and parental leave counteracts the support provided by the leave. Further, several studies reflect a correlation between shift work or long work hours in the first trimester and increased risk of preterm birth.[18,19]

4. *Where possible, it is ideal to have another, non-pregnant physician see the very sick febrile patient, patients with undifferentiated rashes, chemical or radioactive exposures, and patients who are agitated or violent. If this is not possible, adequate PPE and security support should be provided.*

There are inherent risks to personnel working in an Emergency Department. Minimizing risk of harm to the growing fetus from specific infectious scenarios, chemical and radioactive

exposures, and trauma is a reasonable expectation. If double coverage is available for pregnant physicians, then this should be feasible. Emergency departments should engage in proper screening and isolation of patients in addition to provision of PPE.[30] A pregnant physician may ask a colleague to assist with procedures that may become more challenging in the third trimester due to physical constraints (such as intubation and central line insertion).[4] Violence in the ED is a recognized issue in Canada, with woman physicians being more likely to experience physical assault than their colleagues. Measures should be taken to ensure security protection is available.[31,32]

PARENTAL LEAVE AND ALTERNATIVE PATHWAYS TO PARENTHOOD

1. *Both birthing parents (including surrogate parents) and non-birthing parents (including adoptive and foster parents) are entitled to and should be fully supported to take both pregnancy and/or parental leave in conjunction with provincial and federal laws.*

Literature from Europe suggests that longer shared parental leave is associated with increased duration of chestfeeding,[33] and promotes bonding between children and fathers.[34] In the United States, a review of graduate medical education policies found that many programs do not have policies for paternity leave, and that policies for same gender partners were scarce. Additionally, they recognize the importance of time for bonding and attachment in families who adopt or foster children. Authors recommend providing time for parental leave for the non-birth parent.[35] A qualitative study of general surgery program directors in the United States identified themes related to poorly defined policies for paternal leave - a desire for more paternal leave, and significant stigma, perhaps greater than that faced by women taking maternity leave.[36] There is limited work in the Canadian medical setting, with a publication in the Canadian Medical Association Journal in 2000 emphasizing that parental leave planning should be part of all physician human resource planning for the future.[37] A review of parental leave policies in Canadian residency education identified that all provincial resident organizations offer at least 35 weeks of total leave, with most offering some degree of supplemental income.[16] In Canada, provincial and federal labour laws guarantee an employee's right to take time off work to care for a new baby or adopted child. Historically, maternity leave was introduced in Canada in 1971 with shared parental leave being added in 1990. The most recent expansion occurred in 2017 and currently provides 15 weeks for the birthing parent and up to 69 weeks extended leave which can be split between both parents.[38] The Quebec Parental Insurance Plan provides 18 weeks for the birthing parent and up to 32 weeks of shared parental benefits.[39] The challenge physicians face with federally and provincially funded programs is that the maximum weekly benefit often falls well below their usual income. As of 2023, most provincial medical associations provide expanded benefits ranging from 17-26 weeks duration.[40] It is important that departments have policies in place and can proactively work with expectant parents to help facilitate the desired leave. There are many reasons individuals may choose to pursue adoption, surrogacy, foster parenting or other alternative pathways to parenthood and these individuals have a right to the same accommodations.

RETURN TO WORK

Any significant life or work transition should be met with support and accommodation from the workplace. Returning from parental leave is no different. Parents returning from parental leave should be encouraged and supported to make decisions that support their physical and financial health as well as that of their families. This is particularly important as physicians often take shorter parental leaves than allowable in the Canadian context.[5,37] The need for return-to-work

accommodations may depend on the individual, duration of leave, stage of career, work environment and family situation (such as access to reliable childcare).

1. *The returning Physician should be offered flexibility in shift structure, type, and duration on return-to-work.*

Many staff physicians may be returning to work after a parental leave shorter than the Canadian average or allowable duration.[5,37] At this stage many infants may not be sleeping through the night and access to childcare may be challenging especially given the nature of shift work. A qualitative study looking at anaesthetists returning to work after maternity leave demonstrated that they expressed concerns regarding "childcare, maintaining breastfeeding and the impact of sleep deprivation" on their return to work.[41] Accommodations for the returning Emergency Physician after parental leave proposed by Wilson et al.[4] suggest no resuscitation or night shifts for a set period of time, a shift reduction or gradual return to work or a set schedule to accommodate childcare transitions. Additional accommodations may include part time return to work, no single coverage shifts, job sharing, buddy shifts (whereby the returning MD works in parallel to a colleague), shorter/split shifts, or no supervision of learners.[4,41,42,43,44]

2. *The returning physician should have the opportunity to engage in continuing professional development and education prior to and/or during return-to-work.*

CAEP published consensus recommendations on navigating gaps in practice in 2023. These covered physicians away from clinical practice for any reason for periods less than two years. It was suggested that there be deliberate and department-facilitated re-entry strategies individualized to the physician's needs, ideally leveraging existing educational programs and infrastructure.[45] Multiple sources support the use of a "skills update" in conjunction with return to work to build confidence.[4,5,41] Some jurisdictions offer formal return to work programs for physicians returning to work after leave.[41,46] These sessions may include simulation sessions, mentorship or procedural sessions.[4,5,41,46]

3. *The pregnant and/or returning parent should be considered equally for promotion, tenure, and career advancement.*

Several studies cite the pregnancy, parental leave, and return-to-work process as having a negative impact on career opportunities and advancement.[41,44,47] Recommendations to support professional involvement and advancement include family supportive meeting schedules, virtual attendance options for meetings, mentorship, and stop-the-clock policies for promotion.[41,42,47,48]

4. *The returning Physician should be provided with chestfeeding accommodations*.

The World Health Organization recommends exclusive chestfeeding for the first 6 months of an infant's life.[49] Furthermore, chestfeeding provides numerous health benefits to both parent and child.[50,51] The literature supports that barriers to chestfeeding in the work environment contribute to parents not reaching their chestfeeding goals while robust workplace lactation programs lead to higher rates of continued chestfeeding.[50,51,52,53,54] Departments should have clear chestfeeding policies.[1] The lactating parent should be provided with adequate breaks/time (i.e. every 3-4 hours) and space in close proximity to the ER to chestfeed or pump milk, including access to a private, locked room with a sink, sterilization capabilities (i.e. microwave), a fridge to store milk, as well as a computer and phone access to continue administrative duties.[4,5,42,43,50,53,55] Furthermore, the lactating parent should be excluded from evaluation using departmental productivity metrics given the additional time required to feed/pump.[4,48] The above listed time and space accommodations need to be complimented by supportive leadership, peer support and flexible return to work schedules.[53]

FERTILITY AND PREGNANCY LOSS

1. *Where possible, departments should offer accommodations if and when physicians with a history of pregnancy loss or infertility are attempting to conceive.*

Many women in medicine have delayed childbearing because of perceived threats to their careers.[56] These women often face resultant challenges with fertility and pregnancy loss, requiring fertility treatments and/or alternative pathways to parenthood at a higher rate than the average population. The infertility rate among female physicians is reported between 24-32%.[3] It has been demonstrated that in women undergoing fertility treatments for female infertility there is an inverse association between likelihood to conceive and perceived excessive workload, as well as an inverse association between likelihood to deliver and objective measures of workload (e.g. part vs full time).[57] When comparing emergency physician fertility to that of the general population there is evidence that there is impaired fecundity over and above that expected by age alone.[13] In physicians there is an intertwined relationship between burnout and the development of reproductive disorders that warrants attention and further exploration.[58] There is a paucity of literature on how best to support physicians undergoing fertility treatment, however it is appropriate to provide accommodations to enable attendance at necessary medical appointments and abide by any recommendations from the treating reproductive specialist. These accommodations may vary based on type of treatment, geographic location, and accessibility of treatment facilities.

2. *A physician experiencing pregnancy loss should be offered time off work as needed or requested to grieve and recover.*

There is very little research on pregnancy loss and the workplace. Experiencing a loss at any point in a pregnancy can be emotionally and physically stressful and may require varying degrees of medical intervention and recovery. A qualitative study of Canadian women who experienced pregnancy loss while working full time identified complex interactions of shame, guilt, failure, and stigma.[59] There is tension between allowing for individual privacy and supporting the needs of the physician following pregnancy loss, as in many first-trimester losses the pregnancy may not have been disclosed. Overall, having a supportive work environment with flexibility for short-term leave to accommodate necessary medical procedures and grief were identified as important.[59]

SUMMARY TABLE OF RECOMMENDATIONS

Pregnancy	*The pregnant physician should be provided with the option to stop night work as early in the pregnancy as possible, and no later than 28 weeks gestational age.*
	It is expected that a physician in the third trimester may require accommodations in shift type, timing, and structure to reduce the physical demands.
	Physicians should not be required to make up shifts before and/or after a pregnancy or parental leave in order to accommodate the leave.
	Where possible, it is ideal to have another, non-pregnant physician see the very sick febrile patient, patients with undifferentiated rashes, chemical or radioactive exposures, and patients who are agitated or violent. If this is not possible, adequate PPE and security support should be provided.
Parental Leave and Alternative Pathways to Parenthood	*Both birthing parents (including surrogate parents) and non-birthing parents (including adoptive and foster parents) are entitled to and should be fully supported to take both pregnancy and/or parental leave in conjunction with provincial and federal laws.*
Return to Work	*The returning physician should be offered flexibility in shift structure, type, and duration on return-to-work.*
	The returning physician should have the opportunity to engage in continuing professional development and education prior to and/or during return-to-work.
	The pregnant and/or returning parent should be considered equally for promotion, tenure and career advancement.
	The returning physician should be provided with chestfeeding accommodations.
Fertility and Pregnancy Loss	*Where possible, departments should offer accommodations if and when physicians with a history of pregnancy loss or infertility are attempting to conceive.*
	A physician experiencing pregnancy loss should be offered time off work as needed or requested to grieve and recover.

NEXT STEPS

There have been advances in research and policies related to maternity leave in medicine, but there remains work to be done in the areas of parental leave and around physicians who are undergoing fertility treatment or experiencing pregnancy loss. Despite this lack of fulsome evidence, departments are encouraged to adopt flexible policies that address the recommendations in this statement while respecting everyone's unique needs. These policies should be reviewed regularly by gender balanced committees and incorporate new evidence as it arises.

CONCLUSION

There is increasing recognition and commitment to the importance of enabling physicians to fulfill important roles in both their professional and family lives. Meaningful work-life integration can help mitigate burnout and it is imperative that departments are able to recognize the unique challenges of physicians who are often balancing early career with starting a family. Recognizing that any leave from practice has the potential to impact human resources, departments should be proactive about operationalizing policies and procedures that enable staff to take the necessary leave and support re-integration, while being mindful of the fact that the requirements for each physician and leave will be unique.

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CAEP Pregnancy and Parental Leave Position Statement Authorship

Erin Brennan, MD, MMEd, FRCPC - Queen's University
Kyla Caners, MD, FRCPC, DRCPSC - Queen's University
Christopher Bennett Heyd, MD, FRCPC - University of British Columbia
Aimee Kernick, MD, CCFP-EM - University of British Columbia, Saanitchton, BC
Emma McIlveen-Brown, MD, CCFP-EM - Memorial University
Alim Pardhan, MD, MBA, FRCPC - McMaster University
Chau Pham, MD, FRCPC, MBA - University of Manitoba
Éliane Raymond-Dufresne, MD CM, FRCPC, PGDip, Université Laval
Gillian Sheppard, MD, CCFP-EM - Memorial University
Hannah Shoichet, MD, CCFP-EM – Northwest Territories Health and Social Services Authority
Kelly Van Diepen, MD, MScPT, FRCPC, ACBOM, McMaster University

Acknowledgement – Angelique Roy, Health Sciences Librarian, Queen's University