Appendix 1: Authors’ suggested guideline for accommodating pregnancy and parental leave for the emergency physician

**1. Shift scheduling during pregnancy**

Each pregnant physician has the ability to seek her own arrangements to suit her pregnancy in consultation with the department’s administration. There are occasions where medical complications and the advice of the pregnant physician’s health care provider override the following recommendations. Here is a general guide of considerations:

*A. Notifying the scheduler*

As schedules are generated in advance, the pregnant physician should confidentially notify the head of the department and schedulers as early as she feels comfortable doing so. In general, requests for accommodations should be made prior to the request deadline established by the scheduler. If accommodations are needed after the request deadline has past, schedulers should attempt to assist the pregnant physician in shift change requests.

*B. First and second trimester*

The physician who requires special health-related considerations during the first and second trimester should discuss her specific accommodations with the Head of the Department.

*C. Volume of shifts after second trimester*

Many women find that emergency clinical work becomes more challenging after 24 weeks. The pregnant physician may choose, with adequate notice, to reduce the volume of her shifts by 25% after 24 weeks.

*D. Night/late evening shifts after second trimester*

There is a trend towards increased risk of preterm labour with night shifts. The pregnant physician can consider requesting no night shifts and/or shifts that end after midnight after 24 weeks. This is in line with the recommendation of the British Columbia Physician Health Program consensus statement of 2010 and ACEP position statement of 2019.

*E. Resuscitation shifts after 28 weeks*

Physical constraints in pregnancy may make managing resuscitation cases increasingly difficult. The pregnant physician can consider requesting no resuscitation shifts at 24-28 weeks or seeking access to a back-up physician from another area for specific procedures (eg. endotracheal intubation, central line insertion).

*F. Stop working before due date*

While this is open to personal preference, our group’s collective experience suggested stopping work at 35 weeks, with the option to pick up extra shifts after if desired. This would avoid having to cover shifts at the last minute.

**2. Shift scheduling for non-birth parent**

The non-birth parent could consider requesting days off prior to and after the estimated date of delivery, as a strategy to avoid last-minute shift cancellations.

**3. Working conditions**

Emergency Medicine comes with attendant risks of exposure to infectious agents which 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. Where 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.

**4. Parental leave**

While laws governing federal financial employment insurance benefit do not apply to physicians who work as independent contractors, it is important that departments and physicians are aware of the new federal regulations and it is reasonable for physician birth parents and non-birth parents to request a duration of leave that is in keeping with these new laws.

5**. Returning to work after parental leave**

1. *Skills considerations*

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.

1. *Shift accommodations*

As 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 in the first few weeks
	+ A fixed schedule for a limited period to allow for childcare planning in advance
1. *Breastfeeding accommodations*
	* Physicians should have access to a private, locked room with an electrical outlet close to the emergency department for pumping breast milk.
	* The room should have a computer with Electronic Medical Record Access 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.

1. *Other accommodations post return*
* Departments may consider exempting physicians from productivity metrics/targets during shifts where they are pumping and in the first several weeks of return to work.
1. *Length of Accommodations*
* We recognize that each family has specific needs and efforts should be made to accommodate reasonable requests.
* The type and length of these accommodations should be discussed with the Head of the Department.