Australasian College
for Emergency Medicine

Position Statement

Statement on Parenting in Emergency Medicine

It is entirely achievable for ACEM members and trainees to have a rewarding career in emergency medicine as a parent. As such, ACEM recommends that this statement is part of a much wider dialogue on how we treat parents and other caregivers in our workforce. The aim of this statement is to promote wellbeing and career sustainability for ACEM members and trainees with parenting and caring responsibilities.

- ACEM recognises that parenting responsibilities extend beyond the formative years of a child's life. Employers should support all ACEM members and trainees to fulfil their parental responsibilities across the lifespan of the child
- All ACEM members and trainees should have equal opportunity for advancement in their emergency medicine careers
- Women experience disproportionate responsibility for child-bearing and child-raising. ACEM supports efforts by employers to lead structural and cultural changes that anticipates non-birthing partners and fathers to take up parenting responsibilities
- All ACEM members and trainees should be supported by their employer as much as reasonably practicable to have a healthy and sustainable work-life balance

January 2023

1. Acknowledgement Of Country

The Australasian College for Emergency Medicine (ACEM) acknowledges the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the lands upon which our office is located. We pay our respects to ancestors and Elders, past, present and future, for they hold the memories, traditions, culture and hopes of Aboriginal and Torres Strait Islander peoples of Australia. In recognition that we are a bi-national College, ACEM acknowledges Māori as tangata whenua and Treaty of Waitangi partners in Aotearoa New Zealand.

2. Purpose and scope

This document is a statement of the Australasian College for Emergency Medicine (ACEM; the College). The aim of this statement is to promote wellbeing and career sustainability for ACEM members and trainees with parenting and caring responsibilities.

This statement applies to all ACEM members and trainees working in hospital emergency departments (EDs) and other settings where care is provided by emergency medicine clinicians in Australia and Aotearoa New Zealand. Also in scope are hospital executives and administrators.

2.1 Disclaimer

ACEM expects that all members and trainees workplaces follow and act according to relevant state and federal/national legislation. If members and trainees experiences are outside the legislation, they should contact their relevant medical association, or their state or federal/national workplace ombudsman.

2.2 Health New Zealand

On 1 July 2022, Aotearoa New Zealand moved to a new national health system. Health New Zealand has taken over the planning and commissioning of services and the functions of the existing 20 District Health Boards (DHBs).[1] This document refers to DHBs to align with current contracts and Aotearoa New Zealand policies.

3. Terminology

3.1 ACEM members and trainees

ACEM has a range of membership categories, the requirements of which are set out in the College Constitution and associated regulations.[2] For the purposes of this document, *ACEM members and trainees* refers to Fellows, trainees, PHRM, Diplomates, Advanced Diplomates, and Certificants.

3.2 Parent

Family structures in Australia and Aotearoa New Zealand are varied and diverse. For the purposes of this document, *parent* refers to one or more persons who assume the role of primary or secondary carer of a child or children. This includes the following:

- the child's biological or gestational parent
- the spouse of the child's parent
- the de facto partner of the child's parent
- any person with parental responsibility of the child (i.e., adoptive, foster, guardianship court order)

4. Background

For many Fellows of ACEM and trainees, becoming a parent for the first time, or increasing the size of their family, is an event that many will experience at one or more times during their professional career. Being pregnant or in a caring role for children may leave individuals in particularly vulnerable situations within the workplace.

Having children is a normal part of life, and there are many issues that should not need to be negotiated by new parents or caregivers. Doctors working in EDs, coping with the demands of shift work, are no exception. There are a multitude of issues affecting people of all genders in a caring role.

In many instances, workplaces and colleagues do offer a great deal of support for those in a parenting role. This may be in the form of changing shift work patterns to accommodate fatigue levels or having frank discussions about options for the return to work.

In the ACEM 2017 survey on Discrimination, Bullying and Sexual Harassment (DBSH)[3], one of the major issues highlighted was 'parenting discrimination'. Specific concerns which may contribute to this include:

- reluctance to hire female doctors
- unwanted nightshift rostering during the third trimester of pregnancy
- questioning of the validity of medical certificates issued in pregnancy
- pressure to return to work earlier than desired after becoming a new parent
- failure to pay parental leave
- having employment terminated rather than being paid parental leave
- being denied a new contract because of pregnancy
- refusal to roster part-time work at set times, restricting access to childcare options

5. Key themes and strategic actions

The following subsections identify key themes that contribute to the challenges faced by ACEM members and trainees. Legislation related to this section can be found in Section 6. ACEM has developed a series of recommended strategic actions that can support ACEM members and trainees to have a rewarding work-life balance:

5.1 Discriminatory practices

ACEM members and trainees who are pregnant or parents can face discrimination in the workplace. In Australia and Aotearoa New Zealand it is against the law for an employer, or potential employer, to discriminate on the basis of:

- pregnancy or potential pregnancy
- breastfeeding
- parental or carer status, marital status, disability or sex

This applies to all stages of employment including recruitment, pay and other conditions while in a job, when looking to return to work, and to any treatment that relates to termination of employment. Discrimination may be direct or indirect, and may also consist of an unreasonable failure by an employer to accommodate parental or carer responsibilities, or particular requirements related to pregnancy (for example, to attend doctor's appointments, or carry out any instruction provided by a doctor).

Direct discrimination occurs where an employer treats, or proposes to treat, a person unfavourably because of pregnancy or carer/parental status. For example, it is against the law to dismiss or demote an employee because of pregnancy. Direct discrimination can occur in the workplace when an employer makes unfair assumptions about what a person can or cannot do because of pregnancy or parental status.

Indirect discrimination occurs where an employer imposes, or proposes to impose, a condition, requirement, or practice that appears to treat everyone equally, but which has the potential to disadvantage a pregnant person or parent/carer. To be discrimination, the condition, requirement or practice imposed must be unreasonable in the circumstances.

Strategic actions

- That ACEM members and trainees are aware of their rights and responsibilities in relation to workplace discrimination
- That ACEM members and trainees have access to due process and mechanisms for investigation and redress if they believe they have been discriminated against
- That ACEM provides ongoing support for ACEM members and trainees who have experienced discrimination

5.2 Recruitment practices

During recruitment, employers should not seek information unless it is reasonably required for a purpose that does not involve unlawful discrimination. An employer may ask a person if they are pregnant or a parent/carer for non-discriminatory reasons, such as ensuring safety or to determine if special services and facilities might be necessary. This is not against the law.

Examples of potentially discriminatory questions may include:

- Are you planning on starting a family?
- Are you pregnant?
- Have you had a termination of pregnancy or would you consider one?
- Do you have a pregnancy related medical condition?

Strategic actions

- In line with legislation, potential employees who are pregnant, have the potential for future pregnancy, and/or parents/carers should be considered for the same roles as all other applicants, free from recruitment discrimination

5.3 Pregnancy at work

Some ACEM members and trainees who have worked in EDs during pregnancy have registered concerns around their experiences. These can be aggregated under the following themes: physical limitations, safety concerns, shift work and acceptance of personal leave.

In many cases, appropriate rostering for pregnant doctors relies solely on the goodwill of rostering personnel, rather than policy driven by safe practice. Better support for parents through this phase will enhance workplace performance, job satisfaction, engagement and loyalty of staff.

Physical limitations and safety concerns

While some doctors feel well in all trimesters and should have the right to continue to work as normal, others may experience physical limitations related to pregnancy. This may be associated with, but is not limited to: nausea and vomiting, back pain, ligament pain, reflux, fatigue, reduced sleep, frequent urination, immune-compromise and increased stress.

ACEM members and trainees working on the floor may experience physical limitations of pregnancy which can affect the ability to perform procedures such as intubation, line insertion, or chest compressions during CPR.

Pregnant doctors' safety also needs to be considered in the avoidance of radiation and infectious disease exposure in the workplace. Safety concerns should also extend to potentially aggressive and intoxicated patients. EDs should routinely offer roles to pregnant doctors which reduce the chance of exposure to radiation, infectious disease, and occupational violence.

COVID-19 has amplified concerns around the risk of infection and severe illness. RANZCOG advises that pregnant healthcare workers are vulnerable clinicians and should not be placed in areas with a higher risk of COVID-19 exposure.[4]

Strategic actions

- Ensuring the radiation safety of pregnant doctors working in the ED
- Ensuring that infectious disease exposure (including COVD-19) is minimized for pregnant doctors working in the ED
- Whilst the following should apply to all doctors, it is essential that pregnant doctors are not exposed to potentially violent situations without adequate assistance

Shift work and long hours

A study in the American Journal of Obstetrics and Gynaecology reviewed 62 studies with nearly 200,000 women engaged in shift work during pregnancy and found that pregnant women working rotating shifts, night shifts or longer hours are at higher risk of adverse pregnancy outcomes.[5]

Adverse pregnancy outcomes included pre-term delivery, low birthweight, small for gestational age, miscarriage, gestational hypertension, pre-eclampsia, intrauterine growth restriction, stillbirth and gestational diabetes. Additionally, dose-response analysis found that pregnant persons working more than 55.5 hours per week were 10 per cent more likely to have preterm delivery compared to those working 40 hours per week.[5]

The first 2000 days of life (conception to five years) is a window of opportunity in early life to establish and support healthy behaviours among parents and their children to reduce the likelihood of poor health outcomes and associated economic impacts in the short and long term.[6] Doctors who are parents need support during this time to set their children up for life as investing in interventions that support health during this period incurs benefits for the individual, communities, the health system, the economy, and society.[6]

Strategic actions

- Minimising the shift work of pregnant ACEM members and trainees.
- ACEM members and trainees in their third trimester should be offered access to a roster without night shifts, without serial late shifts (more than two in a row) and without long stretches of shifts (>40 hours in a seven-day period).
    - Some pregnant doctors may choose not to take on these provisions and this should also be supported.
    - New Zealand the District Health Boards Multi Employer Collective Agreement (17 May 2021 to 31 March 2024) allows junior doctors to opt out of rostered night shifts after 28 weeks.[7]

Personal leave

Pregnant doctors and partners should be able to access personal leave without prejudice or discrimination. This includes urgent pregnancy related presentations (for example bleeding, high blood pressure, gestational diabetes, and loss of foetal movements) and routine medical care.

Strategic actions

- Personal leave is supported as required during pregnancy for pregnant doctors
- Personal leave is supported as required during pregnancy for partners in their caring capacity

Pregnancy loss and miscarriage

Miscarriage is defined as the spontaneous loss of pregnancy before the foetus reaches viability. The term therefore includes all pregnancy losses from the time of conception until 24 weeks of gestation. Studies show that up to one in five pregnancies will result in miscarriage before 20 weeks. The majority of these will happen in the first 12 weeks.[8]

Pregnancy loss can be an extremely distressing situation, and doctors may not have disclosed their pregnancy to work colleagues. Personal leave and appropriate support should be accessible to deal with the medical and psychological sequelae of pregnancy loss.

Threatened miscarriages occur when the pregnancy is showing signs of miscarry such as vaginal bleeding or lower abdominal pain, which may last for days or weeks. Threatened miscarriages require sensitivity, support and access to unscheduled medical care/personal leave.

Additionally, some doctors may choose to terminate their pregnancy. A termination of pregnancy or the reason why a pregnancy was terminated does not need to be disclosed. As with other early pregnancy loss, personal leave and appropriate support should be accessible.

Strategic actions

- Personal leave and appropriate support is accessible as required in circumstances of pregnancy loss or threatened pregnancy loss including miscarriage, threatened miscarriage or termination of pregnancy
- Personal leave and appropriate support is accessible for partners as required in circumstances of pregnancy loss or threatened pregnancy loss, including miscarriage, threatened miscarriage or termination of pregnancy.
- In Australia, 12 months unpaid parental leave is accessible if a baby is stillborn or a child dies in the first 24 months of life.[9]
- In Aotearoa New Zealand, three days of bereavement leave is accessible after a miscarriage for both the pregnant person and their partner.[10] In Australia, this is two days for both the pregnant person and their partner.[11]

5.4 Parental Leave

Doctors working in emergency medicine should be allowed to choose when they start parental leave based on their needs, their health and the needs of their family. This should not be influenced by existing roster constraints. Doctors should be supported by their employer to access parental pay as entitled by their relevant contract or workplace agreement.

The traditional model for parental leave whereby a parent's leave entitlements are determined by their identification as either the 'primary carer' or a 'secondary carer' are grossly inadequate, and is identified as one of the most prominent structural barriers that exacerbates gender gaps and inequities in opportunity and career progression.[12]

12 months continuous service is required for eligibility to access parental leave from organisations across Australia and six or 12 months in Aotearoa New Zealand.

Accessing timely parental leave should extend to partners regardless of gender, and include adoptive and foster parents. The traditional model of parental leave serves as a disincentive for non-birthing parents to access parental leave. Birthing parents will continue to be disadvantaged by disproportionate expectations to be responsible for child-raising and care unless there is a cultural and structural shift that supports non-birthing parents to fulfil their parental responsibilities.

- In Australia, doctors can access 18 weeks paid parental leave from the Australian Government if they have worked: 10 of the 13 months before the birth or adoption of the child and a minimum of 330 hours, around one day a week, in that 10-month period.[13] This will be extended by two weeks each year until reaching 26 weeks by 2026. This is paid at the Federal minimum wage.
- In Aotearoa New Zealand, doctors can access 26 weeks access paid parental leave from the New Zealand Government if they have worked: an average of at least 10 hours a week for any 26 weeks of the 52 weeks (can be across multiple employers).[14]
- In Aotearoa New Zealand junior doctors working rotating between different DHBs as part of compulsory training, employment with each employing DHB treated as one employer for the purposes of determining whether you meet either the six or 12 month criteria for parental leave.[14]

Strategic actions

- Employers must support a parent's decision on when to commence parental leave
- Employers must support access of parental pay entitlements
- Employers should consider providing parental leave entitlements that support and encourage the non-birthing parent to take leave beyond the legislated minimum requirements

5.5 Return to work

Parents should be able to choose when they return to work based on their individual needs and the needs of their family. Returning to work after a period of extended leave can be both daunting and stressful. Challenging parental experiences can include (but are not limited to): separation anxiety; repeat viral illnesses upon commencement of childcare; lack of sleep for all family members; postpartum mental health challenges; physical complications following pregnancy/delivery; problems associated with breastfeeding; family dynamics; and financial constraints. Clinicians may not feel they are able to raise these issues with their colleagues. Employers and departments should therefore be inherently sensitive to such concerns.

Doctors returning to work from parental leave should have the right to access flexible working arrangements to facilitate return to work as stipulated by legislation (see Section 6). Employers should recognise that flexible work arrangements are for a limited period of time, after which point these doctors will be well placed to support others with special requirements.

Many employers have dedicated guidelines for returning to work, but most refrain from stipulating mandatory 'return to work programs' on the basis that the needs of each individual is different.

Returning to safe clinical practice

There is no strong evidence on how duration of leave relates to a diminution of clinical skills and knowledge.[15] Therefore, each clinician should be supported by their employer with a return-to-work plan that is assessed on a case-by-case basis. Multiple factors may influence a plan for return to work including duration of leave, ability to maintain CPD whilst on leave, career length and experience, familiarity with the department and how long the clinician has been in their role.

Six-month CPD exemptions can be granted to clinicians on parental leave. ACEM has also created Skills and Updates for Parents in Emergency (SUPER) courses for employees returning from parental leave, which systematically address core topics and updates within emergency medicine and include practical skills stations. Not only can these courses help reassure returning clinicians of their prior knowledge and skills, but they can also offer added support and collegiality from the emergency medicine community and from ACEM.

Strategic actions

- 'Keeping in touch' days and supernumerary shifts should be supported by employers
    - In Australia this is 10 days before parental leave is affected
    - In Aotearoa New Zealand this is 64 hours before parental leave is affected
- Hybrid departmental meetings that allow working parents to attend virtually from home, can help keep parents on parental leave engaged and in touch
- Professional development days, for example refresher courses, participating in mandatory hospital training, and online hospital training modules should be supported and encouraged for parents wishing to join whilst on parental leave

Flexible working arrangements

Doctors returning to work from parental leave have a right to access flexible working arrangements as stipulated by legislation (see Section 6). Employers should recognise that flexible work arrangements are for a limited period of time, after which point these doctors will be well placed to support others with special requirements.

While ED lends itself to flexible work conditions, it is not uncommon that parents are offered part-time work without access to a fixed or semi-fixed weekday roster. This also extends to on-call requirements, which may be covered by both FACEMs and senior registrars. This practice restricts access to childcare options, as many formal childcare centres insist on a regular attendance pattern. Evening shifts and on-call duties may require additional caring expenses in the form of a nanny or other carer. For a single-parent family (particularly for trainees), these expenses can be considerable.

Many employers have done remarkable work in supporting clinicians returning from leave. Other employers have placed a 'price' on part-time or flexible work and disproportionately roster clinicians to shifts outside business hours. It is important that parents and carers have a voice in how shift work obligations can work best for their families and their employers. All staff will potentially benefit from this flexible and consultative approach to rostering.

Supporting clinicians with fixed working days during an initial period is entirely reasonable and applies to all ACEM members and trainees. Alternatively, having fixed rostered days off may be another option for employers. All out of hours shifts – weekends and late shifts – should be offered *pro rata* for workers on less than 1.0 FTE.

ACEM's Quality Standards[16] under item 2.5 – *Workplace Safety* provides insight into the importance of a healthy workplan for the ED as a whole and individuals. This standard includes access to all leave types, including parental, and stresses the importance of psychosocial health of all working withing the ED. This support may include the processes listed or others as required by the clinicians and discussed with workplace management.

Strategic actions

- Flexible work arrangements must be supported in line with local legislation
- Employers should as reasonably practicable have fixed rostered days off

Breastfeeding

Many doctors may be breastfeeding upon return to work. There are legislative requirements for designated spaces in the workplace to breastfeed or express breastmilk.[17-18] Laws also stipulate that allocated time off the floor to breastfeed or pump is a right for breastfeeding parents, and should be supported by colleagues.

While many hospital employees already have access to breastfeeding spaces, these may be a significant distance from the ED, and hamper utilization.

A suitable space requires a lockable door, a power point and privacy from public view. This area should be well known to staff and be in the vicinity of the ED to avoid long periods away from the floor. Access to private refrigeration for storage of pumped breastmilk is also essential.

In the advent of online examinations, meetings and courses, doctors who are breastfeeding require additional consideration to ensure their privacy and support.

ACEM will align ACEM events to adhere to our quality standards[16] – particularly standard 2.1 *Built Environment* – and ensure that all ACEM events include areas for breastfeeding.

Strategic actions

- Employers must offer adequate time and suitable space for breastfeeding to be supported
- Employers have knowledge of, and comply with local laws regarding breastfeeding

5.6 Part-time work

Many emergency physicians and trainees with caring responsibilities may opt to apply for part-time employment. This is not a unique situation and is standard practice for many industries and organisations outside of medicine.

Positions should always be offered to the best candidate for a role, irrespective of any expressed need for part-time work or set days. Increasingly, families are co-parenting across one or two households and should not experience limited employment opportunities due to these commitments.

Not uncommonly, part-time rosters can involve more than *pro rata* out of hours shifts. For many parents working in emergency medicine, this can be challenging, particularly when childcare centres close and alternative 'after-hours' caring arrangements are required during evenings.

Flexible rostering can support all staff, not just parents. From a wellness point of view, for parents and non-parents alike, ED staff must be able to plan their lives and commit with certainty to non-work engagements and activities. This can be achieved through fair negotiation of rosters.

Strategic actions

- *Pro rata* out of hours shifts should be offered for fractionally employed staff
- Part time employment should be supported, and employers should work to facilitate availability of part time ED and non-ED rotations

5.7 Trainees and new consultants

ACEM recognises that all of the aforementioned issues can be even more acutely experienced by trainees and new consultants. Some may not have the length of parental leave they need, and may return to work while recovering from birth, establishing breastfeeding or while lacking sleep.

Trainees who are parents must balance study, examinations and other ACEM program requirements, with the demands of raising children. The ability to attend conferences, examination preparation courses and other professional development events may be restricted by lack of work flexibility and financial concerns.

Consultants may be on zero-hour contracts which leaves them financially vulnerable and vulnerable to termination of employment. Zero-hour contracts should only be used to fill short-term contingency rostering needs.

There is a significant power imbalance between the trainee and their Director of Emergency Medicine Training (DEMT) and other FACEMs involved in their rostering and supervision. New consultants may also feel these vulnerabilities of power imbalances and both trainees and new consultants may feel vulnerable when questioning their rostering or flexible work arrangements. Awareness of rights and responsibilities and associated actions, as well awareness of and formal escalation pathway can help to prevent such discrimination.

Traineeship break

ACEM provides a parental leave policy for trainees on the FACEM Training program. Parental leave falls under 'interruption to training'. If a trainee has taken 'interruption to training' of more than two years, including a period of parental leave, then the FACEM training completion date and the interruption to training allowance will be extended by the period of parental leave that has exceeded the two-year maximum period. The policy also supports return to work through providing for variations to training regulations.[19]

Trainees on the ACEM Emergency Medicine Certificate, Diploma and Advanced Diploma and Diploma of Pre-Hospital and Retrieval Medicine programs make allowances for parental leave in their respective training regulations by extending training due dates by any period of parental leave.

Examinations

ACEM provides pregnant and breastfeeding candidates special consideration for examinations. Special consideration may include timing of examinations and provision of facilities to enable breastfeeding and adequate access to bathrooms.[20]

Strategic actions

- Trainees and new consultants can be especially vulnerable to discrimination due to power imbalance.
    - Supporting trainees to fulfil College requirements, while pregnant or returning to work, is imperative
    - Opposing zero-hour contracts
- Breastfeeding trainees must be able to access examinations without additional cost or fear of privacy breaches.
- ACEM to continue to implement and deliver policies that ensure trainees who are or become parents are supported to complete their traineeship.

5.8 Parenting at functions, events and conferences

ACEM holds numerous online and in-person events that require consideration of accessibility for attendees who are parents and carers. ACEM headquarters has been registered as a breastfeeding friendly location with a suitable private space provided.

Many events are attended by ACEM members and trainees in their own time, and they may have accompanying children. ACEM welcomes the presence of accompanying children and will support parents as required. If preferred, videoconferencing access will be provided. ACEM will also ensure that access to childcare and a private breastfeeding space is provided at its large conferences.

Strategic actions

- Children of attendees will be accommodated at ACEM events as appropriate
- Videoconferencing for meetings and conferences will be available to enhance accessibility and flexibility
- Parents will be able to access childcare at ACEM Annual Scientific Meetings and Winter Symposiums
- Carers with children will be able to access all areas of a conference venue but are responsible for the wellbeing of their children

6. Legislation

Australian Federal Laws:

- Fair Work Act 2009 (Cth)
- Sex Discrimination Act 1984 (Cth)
- Disability Discrimination Act 1992 (Cth)
- Paid Parental Leave Act 2010 (Cth)

Australian State and Territory Laws:

- Discrimination Act 1991 (ACT)
- Anti-Discrimination Act 1977 (NSW)
- Anti-Discrimination Act 1992 (NT)
- Anti-Discrimination Act 1991 (Qld)
- Equal Opportunity Act 1984 (SA)
- Anti-Discrimination Act 1998 (TAS)
- Equal Opportunity Act 2010 (VIC)
- Equal Opportunity Act 1984 (WA)

Aotearoa New Zealand:

- Human Rights Act 2013
- New Zealand Bill of Rights Act 1990
- Parental Leave and Employment Protection Act 1987
- Employment Relations Act 2000

7. Other ACEM documents

- Trainee Handbook
- Supporting Trainees in Difficulty Policy (TA545)
- Progression in Training Program (TA544)
- Interruption to Training (TA822)
- Parental Leave Policy (TA683)
- Regulation A
- Regulation B
- Regulation D
- Regulation G
- Regulation F
- Exceptional Circumstances and Special Consideration Policy (TA79)
- Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services
- Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services – Toolkit

8. References

1. The Department of Prime Minister and Cabinet. Future of Health. [Internet]. 2022 [Accessed 2 Nov. 2022]. Available at: https://www.futureofhealth.govt.nz/

2. Australasian College for Emergency Medicine. Regulation A Governance; 2022. Available from: https://acem.org.au/getmedia/f28ee43b-6cd8-441c-a153-35c2754d3b36/Reg_A_Governance

3. Australasian College for Emergency Australasian College for Emergency Medicine. Discrimination, Bullying and Sexual Harassment Action Plan [Internet]. Melbourne; 2018. Available from: Australasian College for Emergency Medicine https://acem.org.au/getmedia/533f9238-b12f-44ca-aa2a-38582002591c/ACEM_DBSH_Action_Plan.aspx

4. RANZCOG. COVID-19 and pregnant health care workers and other at-risk workers [Internet]. Ranzcog.edu.au. 2022 [cited 30 May 2022]. Available from: https://ranzcog.edu.au/news/covid-19-and-pregnant-health-care-workers

5. Cai C, Vandermeer B, Khurana R, Nerenberg K, Featherstone R, Sebastianski M et al. The impact of occupational shift work and working hours during pregnancy on health outcomes: a systematic review and meta-analysis. American Journal of Obstetrics and Gynecology. 2019;221(6):563-576.

6. Chung A, Hall A, Brown V, Kuswara K, Howse E, Stickney B, Rychetnik L. Why invest in prevention in the first 2000 days? from The Australian Prevention Partnership Centre and CERI. Sydney, Australia: The Australian Prevention Partnership Centre, 2022

7. New Zealand Resident Doctors' Association and District Health Boards. Multi-Employer Collective Agreement (17 May 2021 to 31 March 2024). NZRDA: Auckland, 2021.

8. The Royal Women's Hospital. Miscarriage. Melbourne; 2022. Available from: https://www.thewomens.org.au/health-information/pregnancy-and-birth/pregnancy-problems/early-pregnancy-problems/miscarriage

9. Fair Work Ombudsman. Parental leave for stillbirth, premature birth or infant death. Canberra; 2022. Available from: https://www.fairwork.gov.au/leave/maternity-and-parental-leave/parental-leave-for-stillbirth-premature-birth-or-infant-death

10. 10. Employment New Zealand. Bereavement leave to cover miscarriage, stillbirth [Internet]. Employment New Zealand. 2022 [cited 30 May 2022]. Available from: https://www.employment.govt.nz/about/news-and-updates/bereavement-leave-to-cover-miscarriage-stillbirth/

11. Australian Government. Circular 2021/08: Changes to the Fair Work Act 2009 to provide Compassionate Leave for Miscarriage [Internet]. 2021 [cited 30 May 2022]. Available from: https://www.apsc.gov.au/circulars-guidance-and-advice/circular-202108-changes-fair-work-act-2009-provide-compassionate-leave-miscarriage

12. Hoffman R, Mullan J, Nguyen M, Bonney A. Motherhood and medicine: systematic review of the experiences of mothers who are doctors. Medical Journal of Australia. 2020;213(7):329-334.

13. Employment New Zealand. Parental leave eligibility [Internet]. Employment New Zealand. 2022 [cited Services Australia. Parental Leave Pay [Internet]. 2022 [cited 30 May 2022]. Available from: https://www.servicesaustralia.gov.au/parental-leave-pay

14. 30 May 2022]. Available from: https://www.employment.govt.nz/leave-and-holidays/parental-leave/eligibility/#:~:text=You%20are%20entitled%20to%20take,can%20care%20for%20your%20child.

15. Oates, J. Skills fade: a review of the evidence that clinical and professional skills fade during time out of practice, and of how skills fade may be measured or remediated. General Medical Council: London, 2014.

16. Australasian College for Emergency Medicine. Quality Standards for Quality Standards for Emergency Departments and Hospital-Based Emergency Care Services. Melbourne (AU), ACEM, 2022.

17. Australian Breastfeeding Association. Breastfeeding in public – your legal rights [Internet]. Australian Breastfeeding Association. 2019 [cited 30 May 2022]. Available from: https://www.breastfeeding.asn.au/bf-info/breastfeeding-and-law/legalright

18. Employment New Zealand. Breastfeeding at work [Internet]. Employment New Zealand. 2022 [cited 30 May 2022]. Available from: https://www.employment.govt.nz/hours-and-wages/breaks/breastfeeding-at-work/

19. Australasian College for Emergency Medicine. TA683 parental leave policy. Melbourne (AU), ACEM, 2022

20. Australasian College for Emergency Medicine. TA657 Pregnant examination candidates and candidates nursing an infant. Melbourne (AU), ACEM, 2021

Document review

Timeframe for review:	Every three (3) years, or earlier if required.
Authoring group:	Advancing Women in Emergency (AWE) Network
Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Council of Advocacy, Practice and Partnerships
Document maintenance:	Department of Policy, Research and Partnerships

Revision history

Version	Date	Revisions
v1	Jan-2023	Approved by the Council of Advocacy, Practice and Partnerships

Copyright

Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au