British Orthopaedic Association

Supporting Trainees through Pregnancy, Maternity, Shared Parental or Adoption Leave and Returning to Work

A BOA Guide for Education Supervisors and Trainers

Contents

Introduction

Time spent in pregnancy and on maternity, shared parental or adoption leave makes up a relatively small proportion of a surgeon's working life but having the right support in place makes a significant difference to their experience and contributes to retention within the surgical workforce. With over 50% of the medical workforce being female it is vital to ensure that Trauma and Orthopaedic Surgery (T&O) is an attractive and supportive specialty and one where time out for raising a family is not seen as a barrier to progression.

Each trainee (and each pregnancy) is different and it is important to not only have the right processes and procedures in place but also to have an open dialogue between trainer and trainee to ensure that any necessary adjustments can be made. Positive and proactive discussions focused on an individualised plan for each trainee are strongly recommended.

The following guide aims to support educational supervisors and trainers in understanding the overarching requirements, any adjustments that may be necessary, and how they can be achieved. This should be considered in conjunction with official guidance and documentation provided by your trust. There is also wider information and support available for expectant surgeons on the BOA website.

It is unlawful to discriminate against someone in the workplace on the grounds of pregnancy or maternity. Adaptations should ideally be offered without the trainee asking, but only implemented after discussion of their needs. Adjustments for those who are undergoing fertility treatment or having recurrent miscarriages should also be addressed proactively.

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1. Notification of Pregnancy

1.1. It is the responsibility of the trainee to notify the Lead Employer HR Department,TPD, clinical supervising consultant and Medical Staffing at the host organisation as soon as is reasonably practical and no later than the end of the 15th week before the expected week of childbirth (EWC) or the intended start date of Maternity Leave[1].

1.2. Earlier notification can help with identifying and managing any risks within the workplace. A supportive environment within a training programme should encourage trainees to have an open dialogue about their pregnancy, but it must be recognised the decision to notify is personal to the trainee.

2. Time off for appointments

2.1. Prior to the birth, pregnant trainees are entitled to paid time off to attend antenatal care when these cannot be arranged outside normal working hours[1]. Trainees must provide evidence for their supervising consultant, manager, or Medical Staffing at the host organisation that they are attending appointments.

2.2. There is also a legal requirement for the father or partner to be able to attend two appointments[1], and requests to attend additional appointments should normally be accepted.

3. Risk Assessment

3.1. All trusts should have a designated person with appropriate clinical experience to undertake a risk assessment and your trust should have documentation to facilitate and record the assessment.

3.2. A Risk assessment should be performed as soon as practically possible after being informed a trainee is pregnant and no later than 3 weeks after the information has been received.

3.3. It is essential to consider all the risks and identify mitigating actions. There are risks which will be applicable to all staff but some which are especially relevant to T&O and these need to be considered appropriately.

3.4. During risk assessment specific consideration should be given to:

- Physical demands (moving and handling, on call shifts and long durations of standing)
- Specific hazards (radiation, cement, iodine, high risk cases such a blood borne infections)
- General conditions (lone operating, OOH operating/on calls, adequate rest)
- Mental demands of the job

3.5. If the risk cannot be removed, then the department must either:

a) Adjust working conditions or hours

b) Offer suitable alternative work (on same pay)

c) Provide paid leave

3.6. A copy of the formal risk assessment must be returned to the Lead Employer HR Department and any potential or significant changes to working practices highlighted.

3.7. If the trainee changes host trust during pregnancy then a further risk assessment is required based on the new position, premises etc.

3.8. If a pregnant trainee is unwell the normal provisions apply up to the commencement of maternity leave. If a trainee becomes ill with a pregnancy-related illness during the last four weeks before the EWC then maternity leave will normally commence early[1].

4. Risk Exposure

4.1. There is no legal obligation to use radiation in pregnancy. Should a trainee wish to continue using radiation the IRMER radiation officer for the host trust should be contacted.

4.2. A radiation dosimeter should be provided and monitored with a maximum dose exposure of 1mSv. The radiation badge should be worn at the foetal level inside the lead gown. Double lead gowns (0.5mm lead) should be worn and trainees should stand 2m away from the radiation source [2-7].

4.3. PMMA may be fetotoxic at levels >1000 parts per million (PPM), PMMA concentration of 50-100 ppm in the breathing zone of a surgeon has been reported. Use of modern methods including vacuum mixing, surgical helmet and local surgical field ventilation reduced this to an undetectable level [9,10]. The U.S. Environmental Protection Agency recommends exposure to a time-weighted average of no more than 100PPM of PMMA over an eight-hour workday [3,4].

4.4. Trainees should be offered the option to avoid exposure to PMMA cement.

4.5. If trainees are undertaking procedures with PMMA exposure vacuum mixing, personal protective equipment, Charnley hoods and lamina flow should be used to minimise the risk of exposure. It is unlikely that exposure would breach the recommended daily limit.

4.6. Iodine based antiseptic scrub solutions are not recommended for use during pregnancy. There is sufficient evidence that iodine may be absorbed to affect the fetal thyroid in the second and third trimester. It is also not recommended for regular or excessive use during breast-feeding [11,12].

4.7. Prolonged periods of standing should be avoided. There is good evidence to suggest that standing for periods in excess of three hours is associated with a

small increase in risk of pre-term birth and low birth weight[8].

4.8. Consideration should be given during the risk assessment to provisions in place to avoid lone operating due to risk of fainting, sickness etc.

4.9. Full personal protective equipment including facemasks should be worn for all surgical cases.

4.10. Pregnant trainees where possible should not undertake high-risk cases (i.e. blood borne infection) due to the risks associated with cross infection or prophylactic treatment if required. There is no post exposure prophylaxis available for Hepatitis C and antiretroviral prophylaxis for HIV exposure may have a risk of drug toxicity to the foetus [3,4].

5. Adjustments

5.1. Flexibility in job planning should exist to allow pregnant trainees to be reallocated to lower risk sessions. Such adjustments should not be detrimental to the education or training of other doctors within the department.

5.2. Trainees should be offered the option to come off the on-call rota and nights at 28 weeks (or earlier if there is a clinical indication). This should be offered by the supervisor at the initial risk assessment and with encouragement for the trainee to accept the offer.

5.3. In circumstances where a trainee wishes to come off the on-call rota before 28 weeks then it is expected that a GP note for modified duties would be provided. Trainees should still receive full pay, including banding[6].

5.4. With the agreement of the trainee, working hours should be limited to 40hrs/week. There is evidence of a small increase in pre-term birth, spontaneous miscarriage and moderate increase in intrauterine growth restriction when working long hours[4].

5.5. Should trainees wish to come off the on-call rota they should not be expected to swap or arrange cover for on calls.

5.6. Where possible trainees should be placed in rotations with limited exposure to radiation, long operation durations, high workload intensity and long geographical commutes[8].

6. Operating

6.1. Trainees must be given full opportunity to discuss and operate within their own boundaries (i.e., exposure to radiation and cement).

6.2. Lone operating needs to be recognised as a risk as sudden light headedness or vomiting are more common in pregnancy.

6.3. If a trainee is struggling to work in the operating theatre then possible strategies could include:

- Allocating an additional assistant so the trainee is supernumerary
- Swapping to a list with procedures which are less demanding but still offer good training opportunities

6.4. Trainees should be proactively offered the following adaptations:
- the opportunity to sit when feasible/ appropriate
- the use of flight socks and regularly walk or calf pumping (to prevent venous pooling)
- the opportunity to take water/ symptom relief from an assistant whilst scrubbed
- toilet breaks as required

6.5. Consider if a certain position or procedures might prove more difficult such as:
- Midline procedures
- Procedures involving bending (back pain or pelvis dysfunction)
- Pressurising cement in acetabular component
- Nailing procedures

6.6. Consider radiation exposure and limit where possible
- Allow the trainee to leave theatre or stand back from the table
- Procedures with increased exposure include
  - Spinal surgery
  - Nailing – especially free hand locking screws

6.7. Proactive discussions on advance planning should intermittent symptoms such as morning sickness become an issue during a case.

7. Clinic

7.1. Trainees should be offered adaptations such as the opportunity:
- to sit where possible
- to take water/ snacks to help control nausea between patients
- to take frequent toilet breaks
- to take a short rest period mid-clinic

8. Placement

8.1. Certain sub-specialties may be more suited to the pregnant trainee and this should be considered at a local level and include discussion with the trainee.

8.2. In general issues may arise with:
- High workload intensity
- Use of X-ray (trauma, spine)
- Cement (arthroplasty)

- Long procedure times (tumour and revision)
- Anatomical considerations (abdominal girth for spinal procedures)
- Length of commute

9. Miscarriage

9.1. The loss of a pregnancy is a bereavement for the parents regardless of the time since the positive pregnancy test.

9.2. Trainees are entitled to sick leave[1] and should take time to look after themselves and recover and not feel under pressure to return to work until they are ready.

10. Still birth

10.1. In the event where a trainee's baby is stillborn after the end of the 24th week of pregnancy, they will be entitled to the same amount of maternity leave and pay as if their baby was born alive[1].

11. Fertility Treatment

11.1. It is important to acknowledge and understand that fertility treatment can be a challenging time and involve a number of medical procedures. Trainees undergoing treatment will need flexibility as appointments can be scheduled with hours of notice for time sensitive procedures.

11.2. The trainee attempting to become pregnant under difficult circumstances may be very risk averse. They should be offered the chance to

- Come off the on-call rota
- Avoid exposure to radiation/ cement
- Reduce workload/ stress
- Avoid long periods of standing/ hard physical activity

11.3. Fertility treatment can make trainees feel unwell and the trainees are more at risk of

- Hyperstimulation syndrome
- Ectopic pregnancy

11.4. Each negative pregnancy test maybe felt as a bereavement to the trainee and it should be recognised that this could be an incredibly emotionally taxing time. For information regarding the processes involved in fertility treatment see HFEA website.

12. Maternity, Adoption and Shared Parental Leave

12.1. All new parents are entitled to leave with their child.

12.2. The mother or primary adopter must take a minimum of 2 weeks maternity or adoption leave straight after the birth or placement of the child. Thereafter it can be shared up to a total of 52 weeks leave. For more information see BMA website.

12.3. Maternity leave should not normally commence prior to the 11th week before theEWC (29 weeks pregnant) but can commence at any time up to the EWC [1].

12.4. The trainee must ensure that the relevant documentation such as the MATB1 form is passed to the Lead Employer HR Department to process no later than 28days before the start of the intended maternity leave[1].

13. Annual Leave

13.1. Trainees will continue to accrue annual leave during maternity leave including Bank Holidays. To avoid a negative impact on subsequent training this accrued annual leave will normally be taken prior to returning to work. All efforts should be made by trainees to take any outstanding holidays before they start their Maternity Leave.

13.2. Consideration should be given to a phased return to work; this can be achieved using accrued annual leave to allow return initially for fewer days per week.

14. Keeping In Touch days (KIT), or Shared Parental Leave in Touch (SPLiT) days

14.1. There should be no expectation on the trainee to do any form of work activity during maternity/adoption leave.

14.2. However, trainees are entitled to a maximum of ten Keeping in Touch (KIT days) during their leave or a maximum of twenty “shared parental leave in touch” (SPLiT) days [1].These are paid when they return to work at their basic hourly rate minus any maternity pay/allowance received.

14.3. If the trainee wishes to undertake KIT or SPLiT days or other work activities these should be supported. A proactive conversation around the use of KIT or SPLiT days provides a positive and encouraging workplace, acknowledges the trainees’ place within the team and aids readiness for return to work.

14.4. The arrangements (but not necessarily specific dates) should be made prior to Maternity/Adoption leave with an identified supervising consultant, host trust medical staffing and TPD.

14.5. If possible the KIT or SPLiT days should be allowed to take place in the department the trainee will be returning too. This may require the provision of honorary contracts if they are changing area.
14.6. They should not be used for service provision and ideally the trainee should be supernumerary on those days.
14.7. KIT or SPLiT days can be used for a number of purposes including attending courses or conferences then the trainee may apply for study funding for this purpose in line with local protocol.
14.8. Entitlement to study leave and expenses should continue while on maternity leave.

15. ARCP

15.1. Maternity leave does not automatically mean that extra training time is required.
15.2. An ARCP held during maternity leave is permitted as the trainee isn't present, but the preparation by the trainee should be undertaken before the start of the leave rather than during the leave. Otherwise the ARCP should take place when the trainee returns to work.
15.3. The trainee should be assigned an educational supervisor for their maternity/adoption leave and ideally the same person should continue in this role for the first placement after return to work.

16. Return to Work

16.1. Trainees taking more than 3 months should have a formal risk assessment and return to work meeting with their TPD and Educational supervisor. This should consider:
- Trainee level
- Duration of absence
- Identify additional support
- Changes to CCT Guidance or change in practice since leave began
- Opportunity to discuss LTFT if the trainee wishes

16.2. The trainee should be offered a **voluntary** extension to their CCT date up to a maximum of 6 months.
16.3. For the initial return placement try to place the trainee in a hospital and speciality they are familiar with and close to home.
16.4. The trainee should be exempt from extra responsibilities, i.e., being rota master etc, during the initial period of settling back into work.

17. Supervision and settling in

17.1. A phased return can be achieved using accrued annual leave to allow return initially for fewer days per week.

17.2. It should be recognised that returning to work after maternity/adoption leave can be daunting and it may take a trainee time to regain their confidence in the workplace. Maintaining an open and honest narrative with the trainee will provide the most supportive environment and lead to better outcomes.

17.3. Adaptations should be offered to the trainee and a plan for return to work made with their education supervisor in advance of return. Other supportive measures can include:

- Pre-operative walk throughs
- Encourage trainee to seek advice from others in their position
- Encourage trainee to seek feedback or develop a routine of structured feedback after training events
- Focused helpful discussions should be had ahead of ARCP, rather than comments left on MSF etc

17.4. Trainees should have the option to be supervised during their return to work for 2 weeks if they have taken up to 6 months leave and 4 weeks for more than six months. This means the Consultant is available in clinic, they are not expected to operate alone – however, they can do so if they are happy and comfortable with the procedure.

17.5. Trainees should not start back on unsupervised on call shifts i.e., nights. A period of settling in before starting on call is sensible 2- 4 weeks if the trainee wishes.

18. Supported Return To Training: SuppoRTT Champions (England)

18.1. The trainee's first point of contact is their educational supervisor or training programme director throughout the return-to-work process. However, if additional guidance and support is required trainees, educators and other staff can contact their local SuppoRTT Champion and the SuppoRTT team.

18.2. A SuppoRTT Champion:

- Oversees the return-to-training process;
- Provides trainees and supervisors with guidance regarding the relevant policies and available resources.

18.3. Their role is to provide leadership within the Trust/School to ensure that the SuppoRTT strategy is fully implemented and results in a high-quality supported return to training for all concerned. Each regional HEE office offers a slightly different "menu" of support. More details are available here.

19. Breast feeding

19.1. A risk assessment must be carried out for any trainee who is breastfeeding and facilities must be provided[1] and they should be supported to find:

- Appropriate break times
- Adequate refrigerated storage (not shared facility with lunches)
- A private space (not a toilet, bathroom, relatives room, or located a significant distance from the ward)

19.2. A flexible approach to on call should be discussed in advance as part of planning the return to work.

19.3. To ensure compliance with Workplace (Health, Safety and Welfare) Regulations 1992 employers must provide suitable rest facilities for trainees who are pregnant or breastfeeding. Facilities should be suitably located and where necessary should provide appropriate facilities for the new to lie down.

20. Less Than Full-time Training (LTFT)

20.1. Throughout a surgical career, colleagues may wish to consider training or working less than full time (LTFT). LTFT must be proactively considered for male and female trainees with caring responsibilities and offered where practicable within local constraints.

20.2. There are eligibility requirements for trainees wishing to enter less than full-time training, and it is advisable to start the process of applying for, and arranging less than full-time training as early as is possible. Trainees should also bear in mind that it will take longer to complete training if they are not working full-time.

20.3. Less than full-time trainees can return to full-time training at any stage providing there is availability of a full time slot.

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