

## The Case of the Post-Paternity Blues

Case by Dr. Eve Purdy

### Case

Dr. Eve Purdy

### Objectives / Questions:

Dr. Teresa Chan

### Expert Commentaries

Dr. Carolyn Snider

Dr. Brent Thoma

### Curated Community

#### Commentary

Dr. Eve Purdy

### MEdIC Project Lead

Dr. Tamara McColl

Dr. Teresa Chan

### ALiEM Editor-in-Chief

Dr. Michelle Lin

Jake bundled up his baby preparing to leave his house for the local coffee shop. He laughed thinking about how much leaving the house with a baby is like preparing for a medical procedure: prepare the necessary equipment, plan for complications, call for help when needed. After six months of paternity leave, and many mishaps, he felt competent to perform this task. His heart sank a bit, remembering that he would be headed back to his clinical and academic roles in just over two weeks.

As he pushed the stroller down the familiar route that he and his new son have walked countless times during their awesome months of bonding, he found himself worrying about what it would be like to go back. "Will I function as efficiently in the department as I did before I left? Will I still have the same procedural skills? Will I be able to get back on the academic bandwagon? I don't want to look stupid, maybe I should have been studying in the last few weeks. Will I regret taking the time off?" He enters the coffee shop, orders, and finds a table with his son, all the time still worrying.

"Hi, Jake! My goodness, look at your little guy! He is so big," said familiar voice from behind him. Jake turned and noticed Dr. Jane Murphy headed his way. Dr. Murphy was one of the senior female faculty in his department. After exchanging pleasantries, Dr. Murphy asked when he would be headed back to work.

"In about two weeks," he said hesitantly.

"And how do you feel about that," Dr. Murphy probed.

Jake considered for a moment whether or not to be vulnerable and disclose his concerns. He hadn't shared his apprehension with anyone yet; moreover, he and Dr. Murphy were not especially close. Most of his mentors were male faculty, and none of them have taken paternity leave. He wasn't sure that any of them would fully understand his anxiety about the looming "first day back".

He recalled, however, that Dr. Murphy had four kids, took maternity leaves throughout her career, and was still (in his opinion) a total boss. He decided that this may be a good opportunity to get some advice.

Jake opens up about his concerns about returning to work, and Dr. Murphy nodded knowingly.

"How did you do it so well?" Jake asked desperately.

## Usage

This document is licensed for use under the creative commons selected license: Attribution-NonCommercial-NoDerivs 3.0 Unported.



## Questions for Discussion

1. If you were in Dr. Murphy's shoes, what advice would you give Jake about returning to work?
2. What would have happened if Jake didn't happen to run into Dr. Murphy? How can physicians returning to work after a prolonged leave seek assistance about their return?
3. What department supports should be available for physicians post-sabbatical, prolonged sick leave, or parental leave?

## Competencies

ACGME	CanMEDS
Professional Values (PROF1)	Professional Collaborator

## Intended Objectives of Case

1. Discuss the role of mentors in helping junior faculty members with work life integration.
2. Describe an approach to enlist additional help when you are unsure of how you might proceed with a personal matter within your physician group.
3. List specific ways that a physician group or residency program might assist physicians who are absent from work for a period of time due to personal or professional circumstances.

## Returning to Clinical Work: Embrace the Apprehension!

by Carolyn Snider MD, MPH, FRCPC

“The case of the post-paternity leave blues” highlights common concerns from physicians returning from parental leave, sabbatical, or leave of absence. I felt the apprehension associated with returning to work in the emergency department both as a new mom returning from a 6-month maternity leave (who also moved to a new city to start a new job as part of this return) and more recently, returning from a year-long research sabbatical.

It is normal, healthy, and responsible to feel apprehensive when returning after an extended leave. We all feel a little rusty after a few weeks away from clinical medicine, so it is normal to feel especially vulnerable returning from an extended leave; and frankly, who wants to be taken care of by a doctor who isn't a bit apprehensive given the responsibilities associated with our jobs? A study of female pediatric trainees returning from maternity leave in the UK demonstrated a general sense of apprehension over a perceived loss of competence by peers, resuming clinical work at the same level as prior to their leave, logistical worries on taking on the new role of physician-parent, and being more emotional on the job - especially when treating sick children.<sup>1</sup>

### Update your knowledge and improve your confidence

Prior to both returns to work, I attended conferences which helped to get rid of the cobwebs and ensure that I felt up to date on any changes that may have taken place while on leave. In the weeks leading up to my return, I also got back into listening to emergency medicine podcasts. Aside from being a great way to review key topics, it's also a great way to help your kid fall asleep in the car!

Simulation is also very helpful. Prior to returning from maternity leave, I re-took my ATLS certification. I didn't actually need the certification but I knew the simulation practice would be helpful. It confirmed my hope that my procedural dexterities would return quickly, much like riding a bike - the muscle memory is still there! Throughout my research leave, I engaged in visualization of various procedures.<sup>2</sup> I had adopted this practice more recently in my career, both personally and as part of my teaching. Having a list of key procedures that I rotated through in the months prior to my return strengthened my confidence when I returned to clinical practice - and indeed it felt like riding a bike when the time came to perform them on shift.

### Acknowledge our vulnerability

I also believe that we need to be more open and humble about our vulnerability throughout our career. I will never forget when a very senior staff asked for my advice on a complex and very sick patient late in my residency. Initially I assumed I was being tested, but he quickly clarified that he knew I was actively studying for my boards and may have some suggestions on how to approach the case. While I was initially surprised, I was honored. Role modeling our vulnerability to junior staff is an incredibly important role as a staff physician. A few months later, I was his colleague and it was clear that I could run hard cases by him without him perceiving me as weak in knowledge. Medicine has become more and more complex over the past 20 years. We must acknowledge our imperfections and be able to count on our colleagues to continue to learn on the job. Being open about your vulnerability when you start back reminds your colleagues to be open and available to your questions.

### We need improved system supports

Ideally, return to work preparation would not be driven by individuals. In the UK, employers are encouraged to offer 10 “keeping in touch days” to all employees on parental leave.<sup>3</sup> These are paid days where the employee can come in to work alongside another employee - in emergency medicine it would likely be a buddy shift - but not compulsory (for either employer or employee). At the London School of Paediatrics, regularly scheduled courses are offered for women returning from maternity leave that cover hot topics in pediatrics, simulation, and networking.<sup>1</sup> Offering a return to work update program a few times a year for emergency medicine residents and staff returning from an extended leave would be a great way to help improve the confidence of our returning colleagues and would also serve as a wonderful physician wellness initiative.

When I started in a new hospital after 6 months away from emergency medicine for maternity leave, I was paired for my first 5 shifts with a final year emergency medicine resident. He was able to advise me on the site-specific protocols, but also was competent enough to handle most major resuscitations. I knew I had backup for the tough cases. Vocalizing my apprehension and appreciation for him being there was an important role modeling for a soon-to-be staff. I was also happy to be able to teach a lot during those shifts, a great strategy to reaffirm my knowledge. Coming from a different centre and having completed so much

# Expert Response

CME in the weeks and months prior to returning to work meant that I had a lot to give back in return.

The new role as physician-parent

No matter how much you think you can go back to being the same MD, you are a changed person coming back after parental leave. You are a parent, likely sleep deprived, potentially still breastfeeding, and have increased responsibilities at home. While none of these are weaknesses, they definitely need to be managed.

## Getting enough sleep to ensure you are competent at work

Ensuring you get enough sleep is such an important role as an emergency physician and it was initially a very big struggle for me. Early on, my daughter was up at least twice a night to feed and was an extremely early riser. This was especially hard when coming home from a late evening shift. It was almost impossible to fit in the hours of sleep I needed to recover post evenings and nights. It was like my kid could smell me from another room and I couldn't ignore the cries from the next room despite my sleep deprivation. Once we got our child placed into a daycare outside the home, we all seemed to benefit. I could now create a sleep schedule that worked around my shifts while she was at daycare. I was better rested and was able to be a better parent, partner, and physician as a result. When she hit toddler age, I decided to involve her in my pre-night shift routine. Instead of me putting her to bed and making sure she was asleep, she put me to bed (by reading me her favorite memorized board book, singing me a song, tucking me in, and turning out the light). She then took great ownership in making sure the house was quiet so that I could sleep.

## Pumping at work

Many mothers try to pump while at work but it can be hard to do. I found myself dropping the number of feeds within weeks of returning to work, however, other colleagues have found private spaces and many use that time to chart on their most recent patients or eat a quick bite at the same time. Finding a private space is often the biggest challenge and really needs to be

acknowledged by departments as an important priority for mothers returning work.

## Graduated return to work

Some colleagues find it easier to return with fewer shifts for the first few months after parental leave and to minimizing night shift initially. Group scheduling practices should allow for this flexibility as it allows a parent and their family to figure out how to balance their new responsibilities with the life of an emergency physician.

## College Responsibilities

It is important to contact the college prior to going on leave but also prior to your planned return. Various provincial colleges have differing requirements for time away - be aware of them to avoid any unfortunate surprises.<sup>4</sup> Additionally, some colleges provide a discount or even a fee waiver during the months you are off.

## References:

1. Brightwell A, Minson S, Ward A, Fertleman C. Returning to clinical training after maternity leave. *BMJ*. 2013;f5965.
2. EMCrit A, Lauria M, Crew T. EHPR Part 5: Using Mental Practice and Visualization Exercises by Mike Lauria [Internet]. EMCrit Project. 2018 [cited 6 April 2018]. Available from: <https://emcrit.org/racc/ehpr-part-5-using-mental-practice-visualization-exercises-mike-lauria/>
3. Employee rights when on leave [Internet]. Gov.uk. 2018 [cited 31 March 2018]. Available from: <https://www.gov.uk/employee-rights-when-on-leave>
4. Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice [Internet]. Cpsso.on.ca. 2018 [cited 31 March 2018]. Available from: <http://www.cpsso.on.ca/Policies-Publications/Policy/Ensuring-Competence>



## About the Expert

Dr. Carolyn Snider (@DrCarolynSnider) is an academic emergency physician and injury prevention researcher in Winnipeg, Manitoba. Her focus is on violent injuries and while she prefers to prevent trauma, 15 years into her career as an emergency physician she admits to the ongoing rush of adrenaline that comes with a tough trauma case. More importantly, Dr. Snider is a mom to a 7-year old daughter and wife to a sport historian. She is a singer, reader, weightlifter, cook, and obsessive adventure traveler.

## The Struggle is Real - Returning to Work After Parental Leave

by Brent Thoma MD, MA, FRCPC, MSc

As an academic emergency physician and the father of an adorable 9-month-old (pictured to the right), this case resonated with me.

I took 5.5 months off from emergency shifts after the birth of my son, although my academic work and quota of trauma call infringed upon a "true" parental leave. My wife, an emergency nurse, is still on maternity leave.

Despite keeping some of my "hats" on during this leave, reintegrating into full-time work was still a challenge. I struggle to see myself as any degree of expert in this topic because our family is still trying to figure it out. However, I know that the concept of male physicians taking parental leave is still relatively rare and I'm happy to share what I have learned thus far in my new role as a physician who is a new father.

### Home

Like the initial transition that occurred when we brought our munchkin home from the hospital, reintegrating into my day/night job was difficult. While I was regularly on trauma call and had set aside academic time to pump out some research papers throughout my parental leave, these activities could generally be done from home, making me much more available to my family. My increased presence in our home was incredibly important for our initial adjustment to having a new baby in the house, being able to share parental duties, sneaking in naps after a tough night, and being a regular support for my wife.

My advice to Jake would be to not underestimate the impact that returning to work will have on his spouse. Taking care of a baby is a ton of work! Despite the many warnings about this that I received during the pregnancy and the experience of my paternal leave, I still didn't fully appreciate how difficult the transition back to work would be. As Jake transitions, he should be sure to constantly communicate with his partner, reassess how they are doing, and adjust what they are doing to ensure that both partners' needs are being met.

Truly, I am not sure that there is a whole lot that can be done to soften this transition. For us, the biggest help was having family readily available to lend a helping hand. Both my wife's parents and mine live in the same city and are incredibly helpful in providing support while I was on shift, post night shift, or had academic commitments.



### Clinical Work

Naively, I didn't think that going back to regular clinical work after this leave would be a huge challenge. I only recently completed residency and knew that medicine wouldn't have changed much while I was gone. Unfortunately, the reintegration was not as easy as I expected. I was notably slower, found it more difficult to come to quick decisions on the 'grey' cases, and needed to discuss patients with my colleagues more frequently. Fortunately, I have an amazingly supportive group of colleagues who were happy to offer hallway consults without a second thought.

The other thing that changed was my shift preference. A productive night-owl, I used to frequently trade days for nights knowing that I'd be up anyways (and the night differential didn't hurt either!). However, since returning I've been finding the obligatory baby-induced early mornings to be a challenge following even a single night. I anticipate that I'll be retaining a more standard schedule moving forward.

My primary advice to Jake would be to lower his expectations for what he is going to be able to accomplish shortly after coming it back. By taking it one shift at a time I eventually got back to my 'comfort zone' and I'm sure that he will too. Some have recommended that clinicians transitioning back to work more in a slow and supported way<sup>1</sup>, but I think this would have just prolonged the reintegration for me. The more volume that I saw, the more comfortable I became. While not specifically directed at parental leave, Jake might find the guidance provided by the BMA<sup>2</sup> and NHS<sup>3</sup> on preparing to return to clinical work useful.

# Expert Response

I suspect that one difference between returning from parental leave as a male is the type of questions I received from the staff who I didn't know that I had just returned from a parental leave. Rather than the "How is your baby?", that I know my wife will be asked, I was more frequently asked "Where have you been?" This is not surprising given the substantially lower proportion of fathers who take parental leave<sup>4</sup>, numbers that are probably even lower among physicians who do not have explicit financial support to do so.

## Academic Work

Despite having continued much of my academic work throughout my parental leave, it was still a challenge to maintain momentum when I began my emergency shifts again. I had become quite used to being able to do academic work at my leisure without their intrusion. Whereas working shifts can be started and stopped quickly, it is much more difficult to turn "on and off" a research agenda.

In my case, a dedicated group of collaborators was incredibly helpful in keeping our research moving forward. This meant that, in some cases, my contribution shifted from a first or last author role to a middle author role. However, as I work to get my life back in balance I have been able to begin taking the lead on a smaller number of projects. One major change has been trying to adjust when I am doing this work because a small child makes maintaining my historical "night-owl" productivity extremely difficult.

## Conclusion

To finish off, I'd like to leave all our ALiEM MEDiC readers with a "Top 4 Tips" to transitioning back to clinical practice after a prolonged leave:

1. The support of friends and family is essential.
2. Constant communication with your partner is essential. A strong and happy relationship will help with the transition back to clinical work. Aim to share household and child rearing responsibilities.

3. Anticipate that you will be slower and less decisive when starting back on shift. Never feel ashamed to ask questions and double check your diagnostic/management strategies. The support of colleagues is key.
4. Lean on your academic colleagues and research collaborators to help with your academic load as you transition back to clinical shifts. Remember that caring for your child overnight will add to sleep deprivation and will limit academic productivity as you start your shiftwork again.

## References

1. Brightwell, A., et al. Returning to Clinical Training After Maternity Leave. *BMJ Careers*. 2013. [http://careers.bmj.com/careers/advice/Returning\\_to\\_clinical\\_training\\_after\\_maternity\\_leave](http://careers.bmj.com/careers/advice/Returning_to_clinical_training_after_maternity_leave).
2. British Medical Association. Returning to Clinical Practice - Preparing for Return to Work. 2013. <https://www.bma.org.uk/advice/career/applying-for-a-job/returning-to-clinical-practice-after-absence/preparing-for-a-return-to-work>.
3. Siddal, J. and Gosney, M. Preparation for Returning to Safe Clinical Practice. National Health Services - Health Education England. 2016. <http://www.oxforddeanery.nhs.uk/pdf/PreparationReturningSafeClinicalPractice12-04-16.pdf>
4. Hou, F, Margolis, R and Haan, M. Estimating Parental Leave in Canada Using Administrative Data. *Stats Canada*. 2017. <http://www.statcan.gc.ca/pub/11-633-x/11-633-x2017009-eng.htm>.



## About the Expert

Dr. Brent Thoma (@Brent\_Thoma) is an emergency physician and trauma team leader in Saskatoon, Saskatchewan. He also engages in educational scholarship with a focus on technological innovations that enhance learning with the goal of helping good people to provide exceptional healthcare. His work can be found online at CanadiEM.org, Debrief2Learn.org, and METRIQstudy.org

# Curated Community Commentary

By Eve Purdy MD, FRCPC (candidate)

This week's case asked our online ALiEM community to reflect on return to work post paternity leave. While there were some insightful comments, this case did not generate as much discussion as we have grown accustomed to and so does not represent a robust exploration of the issue - a reality that I will take time to explore a bit further at the end of this case summary. But before that reflection, I'll summarize what our online community had to say.

## Tension in Responsibilities

Tanner, a new dad, reflected on the tension he feels between going to work and wanting to be a supportive dad and husband. He wrote, "my first few shifts back was with a brain and heart split between duties." I have heard this sentiment, and resulting guilt, echoed in almost all conversations that I have had with new parents returning to work. I sense that this split, for many, lasts longer than simply a few shifts. Both Seth and Tanner discussed the importance of partnership in navigating the allocation of parenting responsibilities and planned return to work. The new challenge of reconciling the tension between the roles of parent and physician should not be underestimated.

## Practical Tips

Tanner, Seth, and the twitter community discussed some practical tips for this transition:

- Talk and coordinate A LOT with your partner about how this is going to work. (Seth, Tanner)
- Set your partner up for success. When returning to work do as much as you can in advance to help - food, house cleaning. (Tanner)
- Talk about your concerns with friends and colleagues. (Tanner, Lisa T., Shawn)
- Return to work gradually. Work buddy shifts, lower acuity shifts, engage in simulation/retraining, slow down. (Shawn, Lisa C., Tanner).
- Don't live in the USA - where parental leave is minimal (okay this is a somewhat editorialized tip that comes from reading between the lines! But many a true word is spoken in jest - the struggle is real for physician-parents in the United States.)
- Stay in touch - video baby monitors or pictures throughout the day might help. (Tanner)
- Put one foot in front of the other. (Lisa T.)
- Work with your department to understand if they have return to work policies. (Lisa C., Tanner)

## System Responses

There was limited discussion about the role that our departments and systems have in facilitating return to work. Both Tanner and Lisa C. felt that there should be some built-in systems approaches. Lisa Calder referenced a paper "Accommodating Pregnant Emergency Physicians," which is certainly worth the read.

## Contributors

*Thanks to the participants (in alphabetical order) for all of their input:*

"Josh"	Eric Wollorton
Alia Dh	Stella Yiu
Ed Kwok	
Nick Johnson	
Lauren Licatino	
Tamara McColl	
Terese Mead	
Shawn Mondoux	
Heather Murray	
John Neary	
Melody Ong	
Kari Sampsel	

## Reflections on the Case and Community Response

We were hoping that this case would be an opportunity for our online community to discuss their experiences returning to work after a prolonged absence - be it a sabbatical, sick leave, or parental leave. Particularly, we were hoping for female physicians - who are experts in returning to work after having children - to share their wisdom with male colleagues, who are now choosing to take paternity leave in increasing numbers. Unfortunately, we had limited engagement from female physicians in our online discussion. This significantly limits the validity of our community commentary.

When we have a low response from key stakeholders, our team takes the opportunity to reflect on why that might have been so. While there is always potential that people were busy this week and didn't have time to contribute, there is the very real possibility that the case was uninspiring, not discussion worthy, or worse - offensive. As such, we like to reflect on where we may have missed the mark. I have spent some time speaking with a few of our regular contributors, who didn't comment on this case, about why that may have been so. Some valid concerns were raised and even a few rants ensued.

The main issue seemed to be that the MEdIC community has never discussed return to work from maternity leave. Some community members were upset that we had not yet discussed return from maternity leave, a much more common issue, that comes with additional unique realities that do not affect male physicians returning to work (health related realities, breast feeding, societal expectations). Frustration was voiced because we jumped to addressing men's return to work, as "heroes for taking paternity leave" before recognizing and appreciating the very real challenges that all women who have children face.

# Curated Community Commentary

Minimizing the experiences of women returning to work was not the purpose of this case. The glorification of men taking paternity leave was similarly not the purpose of this case. We chose a male character, deliberately, with the intention of contributing to the normalization of men taking parental leave – something that we know is a good idea on many fronts. In doing so, we may have inadvertently limited the discussion and excluded issues that women were hoping to discuss and would have felt more comfortable doing had we had presented a case related to maternity leave. We are always looking for feedback for how to improve and if you have any additional suggestions, concerns, or thoughts please do let us know.

At the end of the day, it is clear that we have a long way to go when it comes to parental leave and return to work. Perhaps we should all just move to Finland!

Despite, and perhaps because of its limitations, we hope that the discussion continues well beyond this case!

## About

The Medical Education In Cases (MEiC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

## Did you use this MEiC resource?

We would love to hear how you did. Please email [MEiC@aliem.com](mailto:MEiC@aliem.com) or tweet us @Brent\_Thoma and @TChanMD to let us know.

## Purpose

The purpose of the MEiC series is to create resources that allow you to engage in “guerrilla” faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

## Usage

This document is licensed for use under the creative commons selected license:  
Attribution-NonCommercial-NoDerivs 3.0 Unported.

