

You Can!



You Can!

A guide for women emergency physicians

From the American Association of Women Emergency Physicians Section
American College of Emergency Physicians

Edited by Sandra M. Schneider, MD FACEP



our
inspiration



*To my daughters,
Kristin and Lauren,*



*who bring me joy,
make me proud,
and give me hope...*



CONTENTS

The History of Women in Medicine	7
Sandra M. Schneider, MD FACEP Professor and Chair, Department of Emergency Medicine University of Rochester	
The History of Women in Emergency Medicine	10
Diana Fite, MD FACEP Chair, American Association of Women Emergency Physicians Section University of Texas Medical School at Houston Brazos Emergency Physicians Association/ Southeast Emergency Physicians Association	
Louise B. Andrew, MD JD FACEP Past President, American Association of Women Emergency Physicians Past Speaker, American College of Emergency Physicians and President, Coalition and Center for Ethical Medical Testimony	
Single	14
Michelle Finkel, MD Instructor, Emergency Department Massachusetts General Hospital	
Married without Children	16
Jennifer Oman, MD FACEP FAAEM Assistant Clinical Professor, Residency Director, Emergency Medicine Residency Program UC Irvine College of Medicine UC Irvine Medical Center	
Pregnant During Medical School	19
Christine Houser, MD Clinical Assistant Professor, Department of Emergency Medicine UT-Houston Medical School	
Pregnant During Residency	24
Rita A. Manfredi-Shutler, MD FACEP Associate Clinical Professor, East Carolina University	
Rikki Lane, MD Assistant Professor, Department of Emergency Medicine Elmhurst Hospital Center Mount Sinai School of Medicine	
Beginning your Life after Residency Training	31
Colleen O. Davis, MD MPH Associate Professor, Department of Emergency Medicine University of Rochester	

ED Doc & Single Mom: Advice from a Survivor **36**

Lynne D. Richardson, MD FACEP
Vice Chair for Academic, Research & Community Programs
Department of Emergency Medicine
Mount Sinai School of Medicine

Adoption **41**

Linda Spillane, MD
Associate Professor,
Department of Emergency Medicine
University of Rochester

Child Care **44**

Katherine L. Heilpern, MD FACEP
Associate Professor and Vice Chair for Academic Affairs,
Department of Emergency Medicine;
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Tammie E. Quest, MD
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The History of Women in Medicine

Sandra M. Schneider, MD

Elizabeth Blackwell was the first woman physician; or was she? Women have served a healing role since primitive times. Many mythical gods of the ancient Greeks and Romans were women. One of the earliest medical schools established in Heliopolis, Egypt admitted both women and men. Medical practitioners in India and China were both men and women. The names of these early women physicians, Merit Ptah, Amyte, Agnodice, Lais, Elephantis, Olympias, Asparia, Fabiole, Philista, and Heloise are largely lost to modern history.

In the 1st and 2nd century only the Hebrews, occasionally the Greeks and the emerging Christians treated women as inferior. The inferior status of women grew stronger through the Middle Ages in Western society. In 581 the Church debated whether women were reasoning animals or mere brutes without a soul. Women could not hold a position within the Church, and a century later was forbidden to even speak in Church. However, women continued to study medicine in Egypt and throughout the Arab world on an equal footing with men.

Around the year 1000, the medical school at Salerno, Italy accepted both men and women. One of its most famous physicians was a woman, Trotula, who wrote several texts on gynecology and pediatrics. There is evidence that she performed Caesarian Sections and wrote of successful treatment of Bartholin abscesses. Copies of her texts together with those of Galen and Hippocrates formed the foundation of medicine for many centuries. Copies of her text are found today in the British Museum.

Among the great women physicians of this time was Hildegard of Binger (1098-1178) who authored of over 14 texts. In these she mixed the science of medicine with religion and a particular interest in mental illness and epilepsy.

By the 12th century women physicians were no longer educated in Europe except in Italy. By the 14th century there were 32 chartered universities in Europe including Oxford, Cambridge and Bologna but still the only medical schools to admit women were in Italy. There, women were permitted to practice but could only tend to women patients.

Little changed in Europe through the next several centuries. Italy, and a few scattered schools in Spain continued to educate women physicians. Elsewhere women midwives tended labor until the late 1700's when men took over this role with the invention of the forceps. In 1820 a professor of obstetrics at Harvard Medical School applauded this change and declared, "It was one of the first and happiest fruits of improved medical education in America that women were excluded from practice." Women were felt unfit to practice medicine because of their monthly 'instability'. An obstetrical text written in 1848 declared a woman's head was 'too small for intellect but just big enough for love'.

Women were barred from education and medical practice, yet some persevered. Women physicians continued to practice often clandestinely throughout Europe. Dr. James (Miranda) Berry rose to the rank of Inspector General of Hospitals for the British Army and was discovered to be a woman only after her death in 1865.

In the United States, the seeds of the women's rights movement grew in the early 1800's. A pioneer for women's rights, Elizabeth Blackwell decided to become a physician, largely due to her interest in women's equality. After applying and being rejected by many schools, she gained acceptance into Geneva Medical College. Her entry came about in an unusual manner. The dean, who did not want to make the final decision, left it to the student body to vote whether or not to accept Blackwell. Largely as a joke, they voted for her entry. She graduated two years later (schools lasted two years, five months each year). The following year, Harriot Hunt was accepted into Harvard Medical School by then dean Oliver Wendell Holmes, but student protests stopped her entry. (She later was awarded an honorary degree from Women's Medical College.) Twenty years later a distinguished Harvard professor warned that women who sought higher education would develop 'monstrous brains and puny bodies'. Interestingly this remark led to actual scientific studies attempting to prove his statement.

Dr. Blackwell's success in medical school, graduating high in her class, did not secure her a training spot, which was required for licensure. After training in Europe, she spent as much of her career fighting for equal rights for women as she did in the practice of medicine. Dr. Blackwell,

her sister and a European trained physician Maria Zakrzewska opened the first women's training hospital, the New York Infirmary for Women and Children in 1857.

In 1848 Dr. Samuel Gregory opened the first women's medical school, the Boston Female Medical School because of his belief that women should be obstetricians. The first Black woman physician, Rebecca Lee graduated from that school in 1864. Boston Female Medical School later joined with Boston University and became coeducational. By 1895 there were 19 medical schools exclusively for women. University of Michigan became coed in 1879. However in some cases it took the power of money to bring about coeducation. In 1889 Dr. Elizabeth Garrett Anderson gave \$500,000 to Johns Hopkins University on condition that women be admitted on the same terms as men. In 1893 Hopkins admitted its first coed class. Others quickly followed suit. By 1944 Harvard had become coed. The last male medical school to admit women was Jefferson Medical College in 1960. With coed schools becoming more common, schools devoted exclusively to women disappeared with the exception of Women's Medical College, which finally admitted men in 1970.

Organized medicine was not openly accepting of women. The American Medical Association (AMA) struggled for years with the role of women. In the late 1800's the AMA proposed a resolution denouncing the mixing of sexes in schools and hospitals as 'impractical, unnecessary and derogatory to the instincts of true modesty in either sex'. Largely due to their reception in organized medicine and out of their feelings of isolation, the American Medical Women's Association was formed in 1915. The first woman to serve as president of the AMA was elected in 1998.

The women physicians of this era were of two types, one small militant group and the other quietly practicing and attempting to blend with their male counterparts. Most schools took the same number of women year after year, though all denied a quota system. In 1870 0.8% of physicians were women, by 1900 6% were women, but by 1940 only 4.4% were women. Dr. Virginia Apgar became the first woman chair (anesthesiology) in a major teaching hospital. During World War II the number of women medical students rose, though some were told their spot would have to be relinquished if the war ended and the men returned. The increase in women medical students and physicians was short lived, for after the war the number of women medical students returned to pre-war levels.

The era immediately post WWII was not supportive of working women. Emphasis was placed on the role of the housewife and mother. There was a physician shortage and medical school spots were scarce. Women physicians who chose to practice part-time or take time off for children were viewed as a 'waste'. Women were told they should be less intelligent than their husbands, earn less, or face a life without marriage/children. High school and college advisors frequently painted too bleak a picture for women applicants. Women physicians of this era reported little family support particularly from their mother. This was largely a US phenomenon, however, for in Europe and Russia women physicians became common.

In the late 1960's/early 70's the mood of the country changed once more. Women began applying to medical school in greater numbers. Title IX of the Education Act passed in 1972 prevented federal funding of educational institutions that discriminated against individual on the basis of gender. The percentage of women medical students rose quickly from 8.4% in 1969-70 to 16.2% in 1975-76. However the marked increase in women posed new problems. Call rooms in teaching hospitals were often inadequate. Surgery was often taught in the doctor's changing room, off limits to women. Women physicians struggled with their homemaker and mother role. In a survey in the early 1970's women physicians gave inadequate household workers and childcare as their number one problems. Several specialties began to consider part-time and more flexible training programs. Women were paid less for equal jobs and more often given lower level jobs without opportunities for advancement. Though the number of women physicians continued to climb, there were still doubters. In 1965 the Council of Deans predicted that the number of women physicians would peak at 30% by 1985 but never go higher. They added an interesting proviso. If there was universal health insurance, they decided monetary reimbursement would drop so low that only women would enter the field.

Women today are entering higher education and medical school in record numbers. In 2000 the US Education Statistics show that 56% of college students are women; 24% of physicians are

women. At the same time nearly 50% of medical students are women. The past few decades have seen the first woman dean, the first woman surgeon general and the first woman chair of each specialty. These 'firsts', though cause for celebration, are reminders of the struggles of the past. Equality is not yet attained. In 2000, there were only nine women serving as dean (though many more serve within the deans office). Women have been slow to rise in academic rank within medical schools. Despite having grown to 27% of medical school faculty, women represent only 12% of the deans but over 37% of assistant professors and instructors. The income of women physicians remains lower than that of her male counterpart. In 2000 median unadjusted net income for nonfederal women physicians (excluding residents) was roughly 60% of that earned by men. These data however do not reflect age differences (women physicians are on average younger than men) nor differences in specialty or employment status.

The struggles of women physicians are not over, but each decade brings its own trials and its own rewards. The full and equal integration of women into medicine is perhaps on the horizon, however today's women (and their partners) continue to face the challenges of integrating their personal and professional lives.

"Seek and take advantage of opportunity; despise no opening wedges, however formidable. Every improved circumstance comes as a helping hand, not only to the profession, but to our sex."

-Dr. Clara Marshall,
Graduation address to Women's Medical College 1879

The History of Women in Emergency Medicine

Diana Fite MD FACEP and Louise B. Andrew MD, JD FACEP

The first emergency department that was staffed by a group of physicians fully dedicated to caring for patients coming to that emergency department was in Alexandria, Virginia, in 1961. In that year, Dr. James D. Mills, Jr., and three of his colleagues left their general medicine practices to establish the first emergency physician group. The first national meeting of emergency physicians, with the establishment of the American College of Emergency Physicians (ACEP), occurred in 1968, in Arlington, Virginia. The first president was John G. Wiegenstein, MD. The first ACEP Scientific Assembly was held in 1969.

Dr. Pam Bensen played an integral role in the history of emergency medicine. She was the first woman elected to serve on the ACEP Board of Directors. However, her election did not come easily. She ran numerous times before being elected. Coming from the small state of Maine, Pam realized that an organization of small state chapters would be necessary for political advancement of any small state member within the ACEP Council. Founded by Dr. Bensen, the Small Chapter Caucus has been one of the most influential bodies within College elections. According to Dr. Bensen: "In 1971, as the first intern in emergency medicine, I went to an ACEP Scientific Assembly where I knew no one, but had the name of Dr. Ron Krome (past ACEP president and Annals editor) in my pocket. Ron introduced me to the other early college leaders, took me to the board meeting, and got me appointed as the first resident representative to the ACEP Graduate Education Committee. My experience in the Medical College of Pennsylvania Emergency Medicine training program helped the committee to establish the College's core curriculum and graduate education policies. These essential documents helped ACEP in its efforts to gain specialty status, residency approvals, and boards."

A specialty really cannot exist without an academic foundation, and residency training is the essence of an academic foundation. According to Dr. Daniel Danzl and Benson Munger, PhD., in 1970 the University Association for Emergency Medical Services (UAEMS) was formed, with the first presidents being primarily junior faculty surgeons who had been assigned duties in the emergency department. The first full-time practicing emergency physician to be president of UAEMS was the aforementioned Dr. Ron Krome, who served in 1978-79. Together, ACEP and UAEMS took on the task of providing education to physicians practicing emergency medicine. The next step to establishing emergency medicine as a specialty was to create a certifying board and residency training programs within the American Board of Medical Specialties (ABMS). Per Drs. Danzl and Munger, "the key characteristics of an ABMS board include: the content domain represents a distinct area of medicine; certification is tied to Accreditation Council for Graduate Medical Education (ACGME) accredited training; the board is representative of the specialty; there is broad professional support in the specialty; the evaluation system is psychometrically sound; and certification is not contingent on membership in a dues-paying membership organization."

In 1976, the American Board of Emergency Medicine (ABEM) was incorporated. ABEM's first president was George Podgorny, MD, and Benson Munger, PhD, served as the Executive Director (while also Deputy Executive Director of ACEP). An application for primary board status was filed, and the Liaison Committee for Specialty Boards recommended approval of ABEM as a primary board and referred the application to its two parent bodies. The American Medical Association (AMA) Council on Medical Education approved the recommendation. The ultimate political hurdle however, occurred when the ABMS voted 100 to 5 to reject the application in 1977.

As a compromise to overcome this defeat, several member boards of the ABMS offered to sponsor ABEM as a conjoint (modified) board. These member boards were internal medicine, family practice, obstetrics and gynecology, pediatrics, psychiatry and neurology, and surgery. After much debate among emergency physicians, a consensus was reached to accept this compromise to become a conjoint board, and emergency medicine became the 23rd academic specialty.

In 1987, ABEM filed an application to convert to primary board status, but the application was defeated by a vote of 52-48 (required a two-thirds majority). However, with lobbying efforts and

the support of the six original sponsoring boards, the ABMS voted unanimously to approve ABEM as a full primary board in 1989. Dr. Charlotte Yeh writes this about Dr. Judith Tintinalli: “Judy Tintinalli demonstrated that women can be credible academicians. If it weren’t for Judy, we probably wouldn’t be a specialty recognized by the American Board of Medical Specialties. Many years after we were a specialty, I went to work at New England Medical Center (NEMC), the teaching hospital for Tufts University Medical School. I initially started out in a division within the Department of Medicine under Dr. Sheldon Wolf, Chief of Medicine. He was President of the American Board of Internal Medicine and cast the ABIM vote to allow Emergency Medicine to become a separate specialty. He confided in me that it was because of Judy Tintinalli, who articulated so well on behalf of Emergency Medicine (EM), that EM deserved to be a primary specialty. He stated that up until that time he did not believe that EM deserved to be a specialty, but after Judy’s influential conversations and persistence he wholeheartedly believed in Emergency Medicine. Moreover, he became a staunch supporter behind the successful effort to make Emergency Medicine a full academic department within Tufts University Medical School.”

As the number of residency programs grew and academic emergency medicine matured, UAEMS changed its name to the University Association for Emergency Medicine (UAEM) and focused on research, while the Society of Teachers of Emergency Medicine (STEM) was formed for educators to meet and discuss didactic issues. In 1989, these two groups merged and formed the Society for Academic Emergency Medicine (SAEM) to promote both education and research in the specialty. Dr. Sandra Schneider served as the first female president of SAEM in 1999-2000. Dr. Schneider wrote this in a president’s message from the November/December 1999 issue of the SAEM newsletter: “Decades ago, emergency medicine (EM) became the first specialty to require 24-hour presence of an attending in academic programs. That decision committed academic physicians to life-long shift work. It was the right decision. What EM was, and is, and will always be about is the patient. We care for those no other doctor will see. We protect, and feed and at times clothe those whom society has dismissed. We sacrifice our families and ourselves throughout our career to assure 24-hour/7 days per week coverage, often as the only physician in the hospital. This is not about us - it can’t be. It’s about the patient - it must be. If we quit caring, who will? We are indeed the 'noblest' profession.”

According to Dr. Judith Tintinalli, the first women department chairs in EM were herself, Dr. Sandra Schneider, and Dr. Gail Ray. Dr. Tintinalli was the first female director of ABEM, and its first female president. Dr. Tintinalli is best known to all emergency physicians as the editor of Emergency Medicine: A Comprehensive Study Guide. Dr. Tintinalli writes this about the study guide: “The Study Guide just sort of started. I knew ACEP was looking for someone to put together a textbook to take the boards. ACEP/ABEM had developed an examination, but needed to tell candidates what sort of things to study to pass the exam. A committee had developed a set of 'worksheets' dealing with a large variety of clinical conditions that were the basis for the exam. The idea was to craft these thousands of worksheets into some sort of a comprehensible textbook. Well, by then I had been writing Case Conferences for the Journal of the American College of Emergency Physicians (JACEP) (under Ron Krome's editorship), and I thought: well, I can write, I think I can put this book together. So I called ACEP, and they quickly said I was in. I wrote about 75% of the first book, and had a number of other excellent authors who provided the rest of the chapters. The first edition was published by ACEP and we put it together out of the Lansing office. I used to fly to Lansing once a week to work on the book. My idea for that first book was to put together a loose-leaf format, so that additions could be made at reasonable intervals. That was my idea way before Scientific American Medicine came up with their format. However, it soon became clear that if I was going to work on a loose-leaf format and provide updates, I would be able to do nothing else. So that idea fell by the wayside. The Study Guide was reprinted into an ACLS-textbook like format, and then McGraw Hill heard about it. Boy, was I impressed when Bob McGraw himself flew to Detroit to ask Ron and myself to do the next edition for McGraw Hill. And things have just moved on since then.”

The second female ACEP member elected to the Board was Dr. Ellen Taliaferro. From Dr. Charlotte Yeh: “Ellen went on to be Secretary and Vice President of ACEP. While she didn’t make it to the Presidency, she showed there is life in Emergency Medicine beyond ACEP. Together with Pat Salber, MD, she established a successful nonprofit association, Physicians for

a Violence Free Society. Through their work in family violence, establishing a coalition involving many specialists, she was able to demonstrate the breadth of Emergency Medicine and all the areas it could be involved in from administrative, to clinical practice, to prevention, to injury control, to social interventions. Ellen became a true leader in women's issues in Emergency Medicine."

Dr. Charlotte Yeh became the third woman member of the ACEP Board of Directors, as well as the second officer, as Vice President. Dr. Bensen recognizes Dr. Yeh "for her wonderful public presence, quiet voice, ceaseless organization, and commitment to emergency medicine in the reimbursement arena." Dr. Yeh's work in the public relations and legislative arenas are well known.

The first woman president of ACEP was Dr. Nancy Auer. Dr. Auer brought a wonderful dignity to the office of president, as well as a colorful presence. She always had encouraging and kind words to say about her fellow emergency physicians, and opened so many doors for female emergency physicians to become more active within the organization of emergency medicine. She has been president of her state medical association, represents ACEP at the AMA, and through her accomplishments, has demonstrated the importance of state medical association involvement, as well as AMA involvement, to emergency physicians.

Another early woman ACEP board member was Dr. Patricia Salber. Dr. Yeh writes: "Pat Salber was well established in managed care at Kaiser Permanente, very politically astute and well-connected within California and nationally. It was because of her bold risk to align ACEP with Kaiser Permanente to support the prudent layperson access to Emergency Department - the keystone of the patient bill of rights in the height of the managed care era in the mid '90s- that Emergency Medicine's significant role in healthcare delivery was recognized. Her willingness to take that bold risk was what propelled Emergency Medicine to the forefront of the public, media and legislative agendas. She showed us how to build coalitions and work with odd bedfellows - she showed us how much further you can get, if you can partner with the opposite side."

ACEP's first female Council Speaker was Dr. Tina Blair, well known for her organization, reform of the Council Officer roles and articulate speech. The second female Speaker was Dr. Louise Andrew, who came to ACEP leadership through her leadership in Physician Well-Being, mentorship and advocacy. A fifth generation physician and an attorney, she has used her understanding of and empathy for physicians and knowledge of the law to help emergency physicians, particularly women, to accomplish tasks and goals that they would have thought unattainable. As Speaker, Andrew fostered leadership development and electronic communications; she has always mentored tirelessly in the art of questioning the status quo.

The American Association of Women Emergency Physicians (AAWEP) section of ACEP began as Women in Emergency Medicine (WEM) in the early 1980's. The founder and first president was Dr. Trish Blair, a font of optimism and creativity who has always been a tireless advocate for women emergency physicians. She began a series of Leadership conferences as well as a gala annual reception at ACEP Scientific Assembly, gaining respect and attention for WEM within ACEP. She has subsequently immersed herself in medical care and humanitarian relief in the former Soviet Union, particularly the Republic of Georgia. Dr. Louise Andrew was the second president of WEM. Her first official act as President was to open the membership to men, and to recruit the President of ACEP and other leaders. She authorized the incorporation of the organization and set up an operating structure. Dr. Randy Ellis was the third. She opened the eyes of WEM members to the intricacies of medical administration. During the presidency of Dr. Susan Reynolds from 1991-93, the name of WEM was changed to AAWEP, both because the name needed to reflect the national presence of the organization, and to avoid the perception of WEM as a nursing organization. Dr. Reynolds created a Domestic Violence Task Force, which was then mirrored within ACEP. The goal of this task force was to educate every emergency physician in the United States about how to diagnose and treat victims of domestic violence. Subsequent presidents, Dr. Cynthia Shelby-Lane, modeled and taught team spirit and elegant productivity; and Dr. Sarah John, demonstrated persistence in the face of adversity. Under the presidencies of Dr. Vicken Totten and Dr. Diana Fite, the decision was made to make AAWEP a section of ACEP in order to decrease the costs for members and to be able to use the resources of ACEP in order to continue to promote female Emergency Physician leadership development.

One of the strongest ongoing features of WEM has been its excellent newsletter. Dr. Suzette Elgin edited the earliest editions, followed by Dr. Pam Bensen and Dr. Carol Rivers. Later, Dr. Rivers dedicated her career to providing excellent educational materials to thousands of emergency physicians studying for board examinations, helping them become better clinicians in the process. According to Dr. Bensen, Dr. Rivers “is a phenomenal teacher with an absolute commitment to improving the clinical practice of emergency medicine one physician at a time.”

Many additional women contributed materially to the development of the specialty of emergency medicine, most of them WEM/AAWEP members. These include Dr. Nina Mazur who was honored with a special memorial scholarship after her untimely death. She was honored “for her complete faithfulness to all aspects of emergency medicine, especially education and EMS in New York and Rhode Island”. Drs. Shay Bintliff and Marsha Ford each demonstrated their outspoken advocacy within the ACEP Council and College. Dr. Rita Cydulka contributed outstanding research, faculty leadership, great energy and motivation. Dr. Connie Doyle contributed dedicated work in disaster medicine. Dr. Gwen Hoffman was the second woman president of ABEM. Dr. Lily Conrad served on the Board of ACEP and was the founding editor of the ACEP web site. Dr. Toni Mitchell served as an ACEP Board member and editor of ACEP News. And Dr. Susan Owens has been known for her tireless efforts on behalf of ACEP in the Washington, D.C. political arena. There are many other women who have been significant in the development of Emergency Medicine. Unfortunately, space constraints have limited the inclusion to only a few. What they all share in common is vision, creativity, energy, persistence, camaraderie and devotion to the cause, the profession and the specialty. Subsequent editors included Dr. Louise Andrew, Dr. Vicken Totten, and Dr. Diana Fite, under whose editorship an award was made for excellence in section newsletters. Many women have used a traditionally female facility with words, and a willingness to do a necessary but not celebrated duty, to advance their own leadership or that of their organizations.

Single

Michelle A. Finkel, MD

Introduction

Being a woman in Emergency Medicine has its rewards and obstacles because we are vital - yet set apart - in this male-dominated field. There is a unique set of reasons that makes being a *single* woman in the field even more complex. Issues that include the complexities of socializing with hospital colleagues, the challenges of shift work, and a distinctive need for privacy can all make being single tricky in the Emergency Department.

Problems

Socializing and dating colleagues in the hospital

One issue that's unique for the single woman doctor is the question of how much we can appropriately socialize with and date hospital colleagues. On the one hand, the people we interact with the most are at work, and people in the hospital have similar experiences to us. We naturally build friendships and bonds with many of these people. But – especially for women – there are professional and occasionally ethical issues surrounding with whom we spend our time. A single woman is scrutinized carefully with regard to whom she is dating, and a regretful in-house relationship can damage one's professional reputation even if everything is above-board. Unfairly, this destructive phenomenon seems much worse for women physicians than for men.

People will examine platonic friendships too. Whom we befriend and are seen with outside the hospital can be fodder for discussion. This is usually a bigger problem for emergency physicians who are single because they typically have more personal time than their married colleagues to go out to social events and invest in friendships. Since I am junior faculty, I spend time with some of the senior residents who have become my friends. I felt disappointed when a colleague told me he had reservations about these friendships. I have found that young women faculty (single or not) are dealt a difficult hand. We are judged by male standards of behavior when some of us have talents that go beyond this traditional model: If we are approachable or less hierarchical we may be viewed negatively - as *unprofessional* - instead of positively - as *advocates* or *mentors*.

Shift work

Shift work can be fantastic. Although we work hard in the Department, we can usually manage our personal and academic lives to our liking outside of our clinical tasks - at least once residency is completed. But just as shift work can be difficult for the married person or parent, it can also complicate a single person's life. There are times when we miss evening, weekend or holiday social engagements, which may be particularly significant if a single person is trying to prioritize meeting friends and potential dates.

Also with many evenings, nights and weekends spent working, dating can get complicated. It's difficult to negotiate time to initially encounter and subsequently meet up with people whom you want to date, especially during residency when the undesirable shifts are numerous. (For a while during residency I had a plan to go on first dates before my overnight shifts started. This way I grabbed something to eat before I worked, but also had an escape from the date if it was bad... I remember, on one of those nights, coming in to the hospital prior to an overnight shift, dressed in street clothes. As I entered the hospital, I overheard a security guard whisper to her colleague, "*This is the only time she has to go out.*" I felt absurd. I stopped the pre-night shift dates after that!)

Privacy

We take for granted the need for privacy from our patients. Unexpectedly seeing a patient in a non-work setting can be awkward and may feel invasive. But this feeling can be exacerbated and may extend to colleagues when you are a single woman. It seems that people entertain single colleagues' private lives much more than those of married individuals. When I hear about rumors from colleagues or residents that are circulating about my personal life, I try to take them in a

playful manner. But I do wonder if that gossip may subconsciously harm my professionalism and career.

Workable Solutions

There are workable solutions. First of all, having a good outlook helps. I take great pleasure in being single because of the opportunities it provides me: I travel a lot, enjoy a huge host of outstanding friends, and can focus my personal time on interests – classes, shows, books, hobbies, organizations and social events – that appeal to me. I also meet and develop connections with great people in a way that I probably would not as a married person.

Second, I've recognized that dating and socializing with hospital colleagues is a personal issue each single physician will have to consider. With regard to dating in the hospital, as a faculty member, I realize that I must be cautious. Obviously, I don't date men whom I evaluate and I do try to limit dating in the hospital. On the other hand, I've decided that befriending colleagues – even residents – is rewarding for me and is something I'll continue. As long as I treat them with integrity, I am being professional while enjoying the company of great friends.

Next I have created time to socialize and date despite the shift work. I realize of course that I will have to miss some events. But I also know that there are married people and parents who will switch shifts to allow me to go to a significant social event so they can go to their child's baseball game, for example. (These symbiotic switches can be much harder to maneuver during residency.) I also try to plan in advance so I can make requests for shifts I want off such that I can travel and attend important events.

Colleagues' attention to my personal life can be awkward. But if my space is being invaded excessively I can say something. I accept that I lack a bit of control compared to married faculty.

Rewards of being a Woman Emergency Physician

The advantages of being a woman emergency physician have presented themselves most clearly in the relationships I have developed with my female colleagues. Similarities I have with other women physicians regarding our personal and professional experiences and our unique challenges have brought me very close to some brilliant individuals. The friendships and the professional networking can be invaluable. Although the old boy's club may exclude us, we can develop alternative methods for creating symbiotic and advisory professional bonds. For example, we organize women's dinners quarterly to encourage mutual support for women emergency physicians - especially the residents - in our system.

Although challenging, another advantage we have as women emergency physicians is to be in the forefront of shifting the male model of professionalism that permeates our field. We can encourage women residents who may feel apprehensive in the mostly male system. We can voice our support for alternative work schedules to allow for professional development while women are starting families. We can ensure we promote women emergency physicians by inviting them to lecture, publicly recognizing their contributions in the Department, nominating them for appropriate honors, and accepting their non-traditional models of leadership. The women I have seen who have taken risks to support the needs and unique talents of women emergency physicians are those I respect the most. They are more concerned with the substance of promoting women in emergency medicine than how their images might be affected. I feel fortunate that by being a female emergency physician I have a special opportunity to interact and bond with these extraordinary women. These are the joys of being a woman emergency physician.

Married without Children

Jennifer Orman, MD

I did not receive very much advice when I got married; what little advice I did receive from my parents does not seem to apply today. While my parents recently celebrated their 52nd wedding anniversary, their advice on marriage longevity does not quite address the new stressors of today. My parents are from an era when women delayed or forgot their career dreams to care for their husbands and raise their families. I was left on my own to learn how to juggle my career and my marriage.

My husband and I dated for 5 years before being married and we did not live together until our engagement. My husband's understanding of what being an Emergency Physician meant did not happen while we were dating, it all happened when we were married. Not truly understanding the medical profession, my husband cannot understand why I wake up at 4 am thinking about a patient or why I cannot go to his parent's house for Thanksgiving. Additionally, having been surrounded by medical people for a decade, I do not understand why my husband does not enjoy socializing and spending time with my medical friends. However, with this being said, my husband has grown into one of my biggest supporters.

I faced many new challenges after marriage; the most important of these was a change in focus. No longer could I just think about myself. Goals that I may have thought were wonderful and exciting as a medical student or resident now did not have the same attraction because they were not congruent with my newly shared set of goals and plans. It does not mean that I gave up what I wanted to do, but many of my goals changed as I combined my husband's and my goals and aspirations.

After our marriage, one of our first arguments centered around "who's job was most important." This argument began with a discussion about who would move should a situation arise where a better job existed for either one of us, but one that required the other partner to quit their current job and relocate. Who would be more important? Or, on a more day-to-day level, which one of us should be expected to do more around the house because our job was less stressful or busy? Certainly if these questions had been asked of me when I was single, I would have answered that my job was most important-- being an Emergency Medicine physician deals with life and death. However, I have realized this importance is a relative concept. While my job may be more "glorious," my husband's was equally as important. If either one of us is unhappy, the other suffers. He is my sounding board and my support. With my husband's understanding of what I do and my understanding of what he does, we now agree that both of our jobs are equally important; day to day duties should be shared as we both are equally busy in our respective work environments.

Working nontraditional hours is part of being an Emergency Physician. When I do not work or am able to work during the day, my husband and I eat dinner together or make plans for a night out. However, when I am scheduled for an evening or night shift on a weekend, this severely limits our social opportunities. My husband's job requires him to be in the office early; going out late midweek is not ideal for him. Additionally, if I have a workweek social function, my husband goes, but our evening is often abbreviated because of his work schedule or I go to the function alone. While the amount of free time that we spend together is sometimes reduced because of my strange hours, this is often offset with other periods of time where we are able to spend prolonged periods of time together. I used to think it was funny how for most of my male colleagues, their wives send in their schedule requests. However, I now see the importance of coordinating schedules so that we have similar time off to enjoy each other's company.

Spending time with family at holidays is another challenge—my family still has a hard time comprehending that while most of the world has these days off, the emergency department does not. While we are able to work things out around most holidays, the period around Thanksgiving, Christmas and New Year's is problematic. Both of our parents live close to us, but not close enough to go to both houses in the same day. However, since I only work one of these holidays, it makes it easy on us; he gets to spend that one with his family and we divide the other two between the families. While my husband and I accept this arrangement, some of our parents are still less agreeable.

Because my husband is from a non-medical background, he was initially uncomfortable at work functions where we largely discussed medically related issues. Unlike married women who are expected to be social at their husband's gatherings, most husbands, including mine, are unable to walk into a room full of people, with whom they have little in common, and have a good time. Additionally, some of the inherent traditions make this social interaction even more difficult. As an example, when I was first hired, my husband was invited to a 'spousal tea'; an afternoon for the spouses, clearly geared toward wives of the staff physicians, to get to know each other. Some husbands may have been okay with this and attended. However, my husband had no intention of spending an afternoon with the physician's wives over tea. I do not blame him; it's an absolutely archaic concept. But, it does reinforce the stereotype that the physician is the husband and the wife should be attending social functions. Among my colleagues there is no evidence of non-acceptance; they accept me as an equal. However, when I try to socialize with my colleagues outside of the hospital, this has proven difficult. I have found it difficult to be good friends with the wives of my colleagues, especially if they do not work or work only part time, because I have nothing in common with them or I simply do not have the time. With this being said, I realize that our social circle is likely more limited by me than my husband. Because I work with mostly men, the majority of my friends at work are men. This has been most interesting for my husband to deal with because it challenges his ideas of traditional friendships for women. However, on a more positive note, it has also provided my husband with a male physician-friend at social gatherings, thus making him more comfortable and allowing me to attend more of these functions.

One of the challenges that I find myself dealing with often is the desire to take care of everything; I want to do all of the things my mother did when I was growing up. I often make the comment that 'I need a wife' to help with all of those things I cannot seem to get done in a day. Although my husband does not have extremely traditional views and does not necessarily expect me to do everything by myself, there is still the underlying expectation that I will take care of the majority of home-related matters. I realize that my own expectation to live up to my mother's version of a good wife is impossible to achieve. I have had to learn to ask for help before I could accomplish my goals. Sometimes taking care of everything means hiring someone to help or asking my husband to help with more "wifely" tasks. I also forewarn my husband that during busy periods, he cannot expect me to do some of the things that I usually am able to do.

Always thinking about work was another challenge that my husband and I encountered. I would not describe myself as someone who is overly consumed with work; workaholics never do. He sometimes feels second to my work and that there is not enough time for him. Part of this is likely due to him not being in the medical field and still not completely understanding my job. Currently, I really try to put limits on my time spent doing work or thinking about work and again, warning him that it is a busy time helps. However, this is one we continually work on and there may not be one solution that fits every time.

When I do have a problem or issue at work though, he is a great resource. He gives me a non-medical perspective on issues that I would not come up with myself. He gives me a new perspective on a situation or how to handle it. The bad part of this is that I do not always like what he has to tell me; but it is nice to know that he is on my team and I can trust what he says to be true.

My challenges are not unique and others exist. I have learned to contend with a majority of them largely through trial and error and born out of the situation from which they arose. However, there are resources available to help with the challenges that arise. In some cases family or close friends can help give another perspective on an issue but requires that you may have to share information of your relationship that is better kept private. There are several books available on the topic of medical marriages. These books are often written from the perspective that the physician is the husband. However, some of the principles mentioned apply to women physician marriages as well. Some of the books that have been helpful are *The Medical Marriage: Sustaining Healthy Relationships for Physicians and their Families* by Sotile and on an even more basic level, *Women are from Mars, Men are from Venus* by Gray. If challenges arise that are too great or not being resolved, couples therapy is an option that could be enlisted that may avert larger conflict. Only you and your husband will know what will work in your relationship.

Marriage is full of challenges. Everyone has challenges in one form or another but they are not necessarily the same to all couples. However, these challenges allow us to learn more about each other. Marriage is a compromise, not from one side all of the time, but from both sides. There are no universal solutions to the challenges encountered; they need to be approached both honestly and unselfishly. Being in a marriage is being part of a team and requires an equal amount of effort from both sides. Although this may not always happen, it should be the goal that both work towards. However, it IS possible to have a happy, wonderful marriage as an Emergency Physician, but as with all marriages, it does take attention and effort.

Pregnant During Medical School

Christine Houser, MD

Medical training is full of challenges. One of the toughest challenges of medical training, though, occurs where you least expect it -- outside the hospital or anatomy lab.

Like most other young adults, medical students are often hoping to start a family. If you're reading this chapter, you are probably among the majority of people who would like to have children as part of your family life. Perhaps you already have at least one child, but are considering having more, and are trying to figure out the best time. Most physicians complete their training around age thirty, and some significantly later, depending on specialty and the path followed prior to beginning medical school. For some students, these circumstances raise the question of whether the medical school years might be a reasonable opportunity to begin a family, or to expand an existing one.

While a lot has changed since Johns Hopkins became the first medical school in the United States to accept women students, the prospect of pregnancy during medical school can still be a little daunting.

Problems

Most parents and non-parents alike, would agree, "There is no perfect time to have a baby." That being said, let's consider the main difficulties that are likely to face a woman who chooses to be pregnant during medical school.

The most obvious issue to confront a pregnant medical student is fatigue. Fatigue is, of course, not unique to women in medical school. In fact, it is rather common among career women, mothers with other small children at home, and other busy people. Fatigue is not likely to be any worse for you, or your baby, simply because it is "medical school fatigue." On the other hand, the increased fatigue could have a negative impact on your studies. Most medical students will weigh their desire to increase their family against the pregnancy's possible impact on their timely completion of medical school courses and requirements.

For students already in or approaching the clinical years, exposures to infectious diseases, needle sticks and medications, may be a concern. Similarly, students in the first year will want to consider the fairly significant exposure to formaldehyde encountered in the anatomy lab before deciding whether pregnancy and the requirements of the first year curriculum are compatible for them. (Although formaldehyde may temporarily decrease fertility and has been linked to a small increased risk of first trimester pregnancy loss in workers with chronic formaldehyde exposure, rest assured that women medical students have carried babies through anatomy lab – and passed the course, too!) While the smell may be even less tolerable while you're pregnant and those little metal stools a bit harder to balance on, I speak from personal experience when I say it can be done.

Another worrisome question for pregnant medical students, or those considering a pregnancy, is how to handle the demands of the first few years of child rearing. Fatigue and "time sharing" issues are not likely to disappear after the new baby's arrival! Depending on your particular situation, finding a satisfying childcare situation can be a time consuming and frustrating endeavor – especially if funds are limited. For a more in-depth discussion of the challenges of childcare, please refer to chapter ten.

While the physical challenges of pregnancy and the early years of child rearing during medical school may be fairly obvious, there are some less obvious challenges that often arise. Although it may seem like a small matter, don't forget that you will need to factor in some time to prepare for baby's arrival. Whether your dreams of motherhood feature a freshly painted baby's room, or evenings by the fire picking out names with your partner, making sure that you have time for the preparations that matter most to you can sometimes be difficult. Don't forget, also, that you will need to make time for regular obstetrical appointments, occasional lab work, child birth classes (if you would like to take them), and developing an opinion about birth-related questions – such as your preferences regarding circumcision and your thoughts about epidural anesthesia.

The financial impact of a new family member is another matter that is likely to be a concern, especially in medical school. Children are notorious for putting a dent in your financial planning. While you have a few years before the new life you are contemplating heads off to college, you will need to consider the financial resources needed in the short-term. If you are primarily surviving on financial aid during your medical school years, this is especially important.

Although I have mentioned several practical challenges, one of the most significant obstacles many women face in contemplating a pregnancy during medical school is not rooted in the physical strains of expectant and new motherhood, the financial challenges of providing for a new family member, or in the limited time available for a multitude of tasks. It is overcoming the trepidation many women feel as they violate the traditional notion that medical school is an all-consuming task. You may also be concerned about the reactions you will encounter in the medical community. If actions speak louder than words, then choosing to have a child during medical school makes the statement that you are willing, and you believe able, to devote a significant amount of your time to non-medical pursuits and still succeed in medicine. Fellow medical students may be critical of a decision that seems to fly in the face of what they think is reasonable. In some cases, faculty and fellow students alike may question the commitment or judgment of a student who is willing to “multitask” parenthood and medical school.

Remember, it was not very long ago that most medical schools reached the goal of fifty-percent female enrollment. While it has been fairly common for the non-medical wives of male medical students to have children during their spouse’s education, the reality of the students themselves being pregnant is still novel enough to create a stir. Just as medicine has slowly adapted to a significant female presence, even in traditionally male fields like surgery and emergency medicine, the medical school environment will very likely become more open and hospitable to pregnant students as schools develop more experience with the “pregnancy phenomenon.”

Take pride in knowing that you are a trailblazer in medicine, and remember that being a trailblazer is never without its challenges.

Workable Solutions

While medical training is an exciting and fulfilling time in most students’ lives, it is also an experience that most people look forward to finishing! The prospect of taking on more challenges to your physical stamina and time management skills, as well as the unknowns of a pregnancy, may make you wonder whether you will really be able to finish your studies on schedule.

A large part of completing your studies on time despite a pregnancy depends on your support system and planning. If you are fortunate enough to have excellent help at home, such as live-in household help or a family member available to do childcare, you are definitely ahead of the game. If you don’t have that level of support, and many students don’t, start working on the best system you can manage as soon as possible. The system you devise should address household management tasks that will ease your workload whenever possible, in addition to providing care for your future family member.

That being said, if it is absolutely critical to you that you graduate on time, then medical school may not be the best time for a pregnancy. There are many unpredictable aspects to pregnancy, from unexpected bed rest, to the birth of a premature or special needs child. It is important to approach a medical school pregnancy with some flexibility, and recognize that if a situation arises that makes it impossible for you to focus or perform your work properly, you are putting both yourself and the school you are attending in an unfortunate position. Prepare for the possibility of needing time off, even if you don’t think you need or want it.

Some students try to time the birth of their child and the latter stages of pregnancy during less physically challenging portions of their curriculum. While it is a good idea to organize your studies so that you won’t be overly stressed during the pregnancy and early months of baby’s life, it is better to adjust your schedule after becoming pregnant rather than trying to plan the delivery for a convenient time. Conceiving can be very unpredictable, and the baby you were so sure would be due by May may not arrive until December.

If all goes well, and your studies and family plans are both proceeding at the pace you would prefer, you likely won't need time off. You will however, need to be very practical and efficient. The practical and time-efficient strategies you develop during the pregnancy will serve you well as you continue on through the first few years of raising your child. I remember one fellow medical student telling me that she did a lot of her preclinical reading while breast feeding her infant daughter – often at night when all was quiet.

The simple preparations for baby's arrival are relatively easy to find time for – even in medical school. A quick trip to the local bookstore or online book source will provide the essential references to guide you through pregnancy, choosing names, and the first few years of baby's life. The pertinent parts of these references are easily consumed during lunch breaks, subway rides, or while waiting for your OB appointments! Books on specific matters, such as particular childbirth techniques, breast-feeding, or circumcision are also available from these sources.

Scheduling the necessary obstetrical and laboratory appointments can be a bit of a challenge, given the medical school schedule, but for most of a low-risk pregnancy you will not be visiting your physician more than once per month. If your pregnancy will include the clinical years of training, then appointment scheduling may be a little tougher than during the pre-clinical years. It is very important to avoid scheduling your appointments during times when the group you are rotating with is relying on your help or input. In other words, do your very best not to miss rounds, assigned call times, or any vital periods during which you would normally prepare materials for rounds. If a scheduling conflict with these activities is unavoidable, let the team know as far in advance as possible, and do what you can to minimize the impact of your absence.

All of this discussion about how best to schedule appointments raises another important question – should you deliver at your own institution? There are certainly some positive aspects to delivering at your training hospital. You are probably already familiar with the physical layout of the hospital. You will have many people close by who know you, and it may be easier to fit your appointments in with a minimum of disruption. The downside to giving birth at your own institution is based on the same factors that give it its positive features. Because you will know a variety of people in the hospital, along with the added comfort and nice stream of visitors, may also come a decreased sense of privacy during a time when you very much want it.

Don't forget that utilizing your own hospital also means that your lab studies, radiological procedures and other diagnostics might be evaluated or inadvertently seen by attendings, residents and medical students you know. Working within the institution makes inadvertent compromise of confidentiality much more likely, although hospital procedures are designed to maintain the confidentiality of medical information whenever possible. If you choose to receive your obstetrical care at your training hospital, be sure that you and your partner are comfortable with this possibility, and how you will handle the situation, if it occurs.

Breast-feeding is tremendously popular among highly educated women in the United States. Being a medical student certainly puts you in that group, so it is very likely that you have been wondering how you will manage to incorporate this aspect of parenthood into your medical school routine.

Breast-feeding after you have returned to your studies will present a challenge. It is a surmountable one, if you are very committed to doing it. It will however, require use of a breast pump and acclimating your infant to taking the bottle when you are unavailable.

On the other hand, if the challenges of breast-feeding are stressing you out, please remember that a huge number of infants have been raised on formula without any ill effects. I remember a college Dean of mine who used to keep a spray bottle of "Guilt Away" on her desk. Considering the current popularity of breast-feeding, you may find you need a little spritz of it if breast-feeding doesn't seem to be for you.

Despite the huge intuitive appeal of breast-feeding, hard evidence of its superiority to formula is really quite limited. A safe food source provided with love and cuddling is all most babies require. If you can provide a more relaxed and happy environment for your baby by feeding him or her formula, take a squirt of "Guilt Away," if you need it, and move on.

The best ways to handle the physical stresses of pregnancy during medical school are common sense – just be sure you make time for them. To minimize edema in the later stages of pregnancy, take brief walks between lectures, find seating that allows you to elevate your legs

whenever possible (including sitting in the front row with a chair in front of you for your feet!). Spending time in a pool with your torso under water is also an excellent way to reduce edema by improving the return of venous blood to the heart. Remember that hot tubs are too hot for the developing baby, but a pool can be a good source of exercise *and* relief for the struggling venous system.

For those of you already in the clinical years, try to schedule less physically strenuous rotations when possible, especially for the latter part of the pregnancy. Your back and feet will appreciate rotations that minimize time spent standing for rounds, as well as for activities such as assisting in surgery.

Finding the financial resources to provide for the additional expenses a new child brings is, surprisingly, one of the easiest challenges to address. For some fortunate students, a partner or other family member may be able to take care of the necessary expenses. If this is not your situation, don't worry. Your financial aid package can be increased to accommodate the reasonable expenses of the adventure you are about to have. Schools that have previously provided financial aid packages to pregnant students, or students with small children, will often have expected cost guidelines. If your school does not, it is usually possible to submit a list of the expenses anticipated. With approval from the office of financial aid, this sum can then be funded. Generating the list of expenses will require a little legwork on your part, but is well worth it. (It also gives you a clearer idea of what is involved!) Also, don't forget to submit your anticipated childcare costs for approval and funding, when you have determined how much they are likely to be.

Some cost areas that you should think about while preparing your budget are:

- Co-pays for medical appointments
- Costs of medications (including prenatal vitamins, iron, Rh immunoglobulin, etc.)
- Co-pays for you and your baby at delivery
- Furniture purchases for baby
- Clothing and a few decorative items for baby
- Playpen(s), stroller(s), car seat(s), high chair(s)
- Miscellaneous items such as bottles & nipples, a breast pump, and diaper bag(s)

(Don't forget that duplicate items may sometimes be needed for your childcare provider)

If you are considering taking time off during or after your pregnancy, and you have used financial aid to pay for medical school, there are sound financial reasons to take the time off *before* officially graduating from medical school. Psychologically, deferring graduation may not be comfortable, but it could be worth it to avoid your loans going into repayment!

As you struggle to make a decision about whether a medical school pregnancy is right for you, the best advice is very old advice – know yourself. Regardless of the possible benefits, it is difficult to be the parent you would like to be if you're too stressed out. If taking on these considerable additional responsibilities during medical school makes you uncomfortable, then waiting for another opportunity may be the best choice. On the other hand, if you choose to pursue pregnancy during medical school, a realistic appraisal of what you expect -- both in terms of your workload and the reactions of others around you -- will certainly help.

Medical school is widely considered to be one of the most rigorous educations in existence. Remember that partners and family are also invested in your success and anything that seems to jeopardize your progress toward a medical career may be difficult for them to support. Only you know whether you are willing to proceed, even if it is initially difficult for these important people in your life to accept the idea.

Make it clear to fellow students and faculty that you are very committed to becoming the best physician you can be and limit the special accommodations you pursue during your pregnancy to only the most essential and reasonable. If colleagues or others seem unsympathetic to your situation, remember that physicians are frequently (regrettably) unsympathetic toward the physical needs of other physicians. It is part of the "medical culture" to expect physicians and physicians-in-training to persevere in the face of illness, hunger or lack of sleep. It may help to

recognize that this response is not specific to you as a pregnant medical student, but is typical throughout medicine, and partly reflects the very positive dedication for which physicians are well known. Sometimes, fellow medical professionals who would like to have started families themselves may also feel uncomfortable with a pregnant colleague, because you serve as a reminder of their unfulfilled hopes. Don't take these reactions personally. When possible, avoid crossing paths with colleagues who seem uncomfortable with your situation, and continue to work your way toward the goals you have set for yourself.

Any medical student facing an unusual life situation may feel isolated from the rest of their medical school class. Pregnant medical students are no exception. Try to befriend classmates with children or those with non-traditional backgrounds whenever possible. They are most likely to relate to the challenges you are facing. Don't forget that, in addition to the support of your partner, family and friends, you may also find champions in your obstetrician, colleagues a little further along in their training or in other medical roles, and in alumni who have also had children during medical school. Latch onto these sources of support while accepting that being a pregnant medical student does set you apart from your classmates in certain ways. Having your baby will make it worth it.

Rewards

The rewards of having a baby are obvious – nothing can replace the bundle of joy you greet each day! There are particular rewards to having your baby during medical school, though, that may not leap so quickly to mind.

First, it is important to remember that, as tough as it may be to carry and rear a child during medical school, you have fewer professional obligations as a student than you will as a resident or new attending in a practice – emergency medicine or otherwise. Although medical school is a time of both wonderful and demanding personal and intellectual development, you may have more flexibility and control over your schedule than you are likely to have for many years to come. If personal preferences or medical conditions dictate a student can delay rotations, or even take a year off to focus on family or health-related matters.

If you are planning a large family, getting started in medical school can be a big help. Women who have children in medical school are in a position to enjoy a more leisurely pace of childbearing than women who would like a large family but delay pregnancy until their training is completed.

Childbearing during medical school decreases the likelihood of complications related to advanced maternal age for yourself and your baby. It also provides the long-term benefit of being younger when your kids reach milestones, such as high school graduation or children of their own. You certainly want to maximize your chances of being fit and in excellent shape to enjoy these sentinel events of life.

Finally, there is satisfaction in knowing that you have contributed to making the medical field a more hospitable place for all women who choose to pursue our calling. The diversity of life experience that women bring to medicine -- including pregnancy, birth and child rearing -- should be considered an asset. As more women successfully deliver "med school babies," other interested women students will be emboldened to consider pregnancy during medical school themselves. Negative reactions, both in ourselves and in our colleagues, will decrease and eventually disappear as familiarity and comfort with this life path gradually increases.

Pregnant During Residency

Rita A. Manfredi-Shutler, MD and Rikki Lane, MD

The phone is ringing.

The baby is crying.

You just nursed her 30 minutes ago. How can she be hungry so soon?

You haven't showered yet and it is already 11:00 am.

You thought you were going to the grocery store yesterday, but you never made it and it looks as though the same thing is going to happen today.

Even the beds aren't made!

What happened to the relatively organized life of an emergency medicine resident immersed in a residency that is typified by chaos?

ANSWER: *Childbirth.*

Having a child was one of the smartest decisions I've ever made in my life. It is joyous, fulfilling and humbling. Whether the event is biological or adoptive, it is a wonderful experience, and external circumstances can, and will, adapt to accommodate this extraordinary life event. But, as much as it is amazing, it is also stressful. As the number of women entering emergency medicine increases (28% of emergency physicians were women in 2001), the stresses and joys of pregnancy and motherhood will affect more and more emergency physicians. Over the past decade there has been a flood of young female emergency physicians into the specialty. Consequently, more pregnancies will occur during residency training.

Timing a pregnancy can be difficult. It may be a planned event, an "accident," or dictated by fertility. Given the stresses already inherent in a residency, the optimal time for parenthood, logistically and psychologically, may be after completion of residency. However, some residents feel they must start a family during residency because of the pressures of increasing age and fertility.

"For my husband and myself, we agreed that with busy medical careers, there might never be a "good" time to have a baby. In fact, if pregnancy did not come easily whenever we were ready, it might create even more pressure in an already stressful life. So, timing was left to chance and I became pregnant with our first child one month into my EM1 year, when we were both PGY2's. Amid much trepidation, we started figuring out HOW to make it work, not IF it could work." R.L.

One option is to wait until after you've finished your residency. Your working hours will be less and you will have more control over your schedule. You will be much less physically tired and have more to offer your children. A secure and peaceful person makes a much better parent than one who is hassled and overscheduled.

If you DON'T have the option to wait and do become pregnant during residency, then knowing beforehand about scheduling, leave policies, breast-feeding and child care will help you to smoothly transition through pregnancy and childbirth.

What You Need to Know About Working While You are Pregnant

Maternity, childbirth and parenthood are realities that every residency program and its director and chief residents must face. However, emergency medicine residencies have a unique flexibility that other programs might not have. Shift work accommodates obstetrical check-ups and morning sickness because shifts can be traded as the need arises. The more physically demanding rotations can be scheduled earlier in the pregnancy. With the assistance of your program director, you can create a schedule that will provide for your wellness and still be equitable to other residents. Residency programs that have thoughtfully devised specific policies

for pregnant residents are those that encourage their residents to support each other and to avoid the resentment that can occur when a colleague is pregnant.

Residency is the time when you work the most clinical hours and have the least control over scheduling. For these reasons, it seems like a less than ideal time to have a baby. A 1986 study of residents and program directors of Harvard-affiliated residencies found that the support of the program director, open discussion of pregnancy and the ability to return to work part-time initially after maternity leave, largely determined if a resident found her pregnancy experience “pleasant.” Additionally, pregnancy rarely affected achieving board certification and all pregnant residents completed residency.

In two surveys done in the United States (U.S) and Israel, over half of the residents found pregnancy during residency “pleasant” and a small minority found it “miserable.” Another study in the U.S., reported pediatric residents describing pregnancy as “pleasant,” “tolerable,” and “miserable.” In spite of their experiences, the clear majority of these respondents stated they would have chosen again to be pregnant during residency.

“Immediately after announcing my pregnancy, I found that there were many extremely supportive colleagues. Two of my co-residents (one male, one female) already had children and were very helpful. Attendings who were parents encouraged me, and helped me gain perspective on life’s priorities. Residency can be all consuming, but it became part of my life, not my life. I read books and articles about emergency medicine, but also about pregnancy and becoming a mother. I became a role model and mentor for others in a similar situation, sharing the wonderful rewards of parenthood. Surprisingly, in becoming a mother, I had also become a more responsible and confident physician.” R.L.

Women of older maternal age may not wish to reveal they are pregnant because they fear that they will not carry the pregnancy to term and do not wish others to know until they feel the pregnancy has a good prognosis. Especially in residency, this can trigger conflict and upheaval because the schedules of the entire residency may need to be rearranged on short notice. Therefore, it is best to confide in the program director as soon as possible.

Residents may have a higher risk of preeclampsia than the general population, but the rates of miscarriage, neonatal morbidity and mortality are probably no different than the general population. Many pregnant residents experience subtle pressure to ensure that all their shifts or rotations are completed. This pressure may be self-imposed, originate from the residency program or come from peers. But the pressure is there, and with it is the tendency to say, “I’m tough. I can do all this and more, even if I am pregnant.” Certainly, there are professional responsibilities that you must fulfill, but there must be a balance between residency duties and your safekeeping of the unborn child developing in your body. Your health and well-being determine how healthy your child will be.

Taking a few extra months to complete residency because you are unable to work full-time or 12-hour shifts, will have little or no impact on future achievements. On the other hand, a pre-term or sick neonate can be heart-breaking and the situation that precipitated it may have been avoidable. The expectation to perform optimally in the residency is challenged by the knowledge that, for the first time in your residency, you **really** need to take care of yourself. That means eating, exercising and sleeping properly. You are training for the marathon of your life. You are preparing to give birth.

“At eight months, I called my program director and explained that I did not want to stop working, however 12 hour shifts were too difficult. She suggested we change them to 8-hour shifts. At that pace, I was easily able to continue working until I delivered.” R.L.

What You Need To Know About Time Off

Guidelines regarding time off are vague. That leaves it to you and your residency director to determine the best policy for you. Many of our supporting organizations, the American College of Emergency Physicians (ACEP), the Society for Academic Emergency Medicine (SAEM), the Emergency Medicine Residents' Association (EMRA), Coalition of Residency Directors (CORD) and the American Board of Emergency Medicine (ABEM) have indistinct policies dealing with pregnancy and leaves of absence. In fact, SAEM, CORD, EMRA and ABEM have no explicit policy statements or official positions on family leave during residency.

On the other hand the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) have remarkably detailed and well-documented policies for residents anticipating family leave. Be proactive and make your residency aware of the AAP and AAFP policies.

Most individual residency programs do not have established guidelines. This can lead to several difficulties. Our pediatric colleagues in the AAP have identified that policies regarding parental leave must be **written** and must not be ambiguous. They have identified the following problems.

1. Residency leave policies are often unclear and confusing. This results in considerable anxiety.
2. The pregnant resident often faces resentment from colleagues who anticipate that there may be extra work because of a prolonged absence.
3. The work schedules of peers are greatly affected when absences are not planned in advance.
4. Morale problems may occur when improperly planned strategies are used to replace or cover absent residents.
5. Because departmental policies within and among programs are so inconsistent, dissension results among the residents.

Therefore, programs should adopt written policies for equitable and effective parental leave, which promotes wellness among our pregnant colleagues and each other. A 1989 position paper by the American College of Physicians suggested that a residency program that anticipates pregnancies and develops parental leave policies would be better equipped to support the mental and physical health of all residents and their families.

So, what should you do? Find out about the leave policy for your program. If it has not been clearly established and written down then review the following table compiled by our emergency medicine colleague, Dr. Matthew Lewin at USC- SanFrancisco-Fresno. This plan suggests components of a comprehensive, resident-specific, and family leave policy. You may want to develop a policy in your program with your residency director using this template if one has not been established already.

Recommendations	Explanation
I. Be consistent with the federal Family and Medical Leave Act and state laws.	By law, employees are entitled to 12 weeks of unpaid leave every 12 months and during this time the employer must continue to cover health insurance benefits.
II. Resident and patient safety must be primary considerations.	Thought and planning are required here. Rotations should be modified at the discretion of the program director and the pregnant resident's physician.
III. Pregnant residents, expectant fathers, and parents planning to adopt must notify the program director about their situation as soon as possible.	This optimizes schedule rearrangement to coincide with vacations, electives and off-service rotations. Notify early as a courtesy to other colleagues whose schedules may be affected.
IV. Duration of the time taken off should be decided jointly between the pregnant resident and her physician.	Time off before and after the birth of the child is determined by the condition of both mother and child. Extension or shortening of time off should be made as needed.
V. Primary caregivers, male or female, should be guaranteed 2 months' paid leave after the child's birth.	This time may be a pregnancy benefit or may be drawn from vacation or elective weeks.
VI. Members of nontraditional families should be given the same consideration as parents in traditional families.	
VII. If the leave has been less than or equal to 2 months, training requirements should not be affected. If more time off is needed, the resident can extend her residency as needed.	36 months of training are required by ABEM. Programs should have mechanisms set up to accommodate family-, pregnancy-, and sick leave interruptions in training.
VIII. If the absence is greater than 12 weeks, the program must have clear and consistent policies for making-up that time.	Program directors must give residents a complete list of requirements to be completed so that board eligibility can be maintained. Policies for "payback" to residents providing unexpected and extra coverage should be predetermined. These plans must be clear and consistent.
IX. Each program must determine the most effective and least costly approach to coverage during parental leave.	Consider program size and duration when choosing a program. 3-yr programs and smaller programs may not have the same flexibility as a 4-yr program.

The Residency Review Committee (RRC) has developed no specific rules about maternity leave, although residencies must comply with the **U.S. Family Medical Leave Act of 1993**. This federal law states: If you have worked in the same company for at least 12 months, have worked at least 1250 hours in the past year, and work for a company with at least 50 employees within 75 miles of your work site, then you are entitled to take a total of 12 weeks off of work without pay. You maintain any health insurance you already had during the time you are on leave and you retain your current job position, status and benefits when you return.

"My residency director insisted that I take a minimum of three months off and wanted to make sure I was paid the entire time. I hope other program directors would be equally supportive. The three months was a good amount of time for me. I feel that if I took less time, I would have resented that my residency interfered with mothering. Returning to residency after three months limited further anxiety I had about losing my skills after not practicing medicine for that period of time. I was afraid that if I stayed

away any longer I might become afraid to ever go back. It gave me just enough time to feel physically well from my c-section, comfortable with breast-feeding and competent in all the motherly tasks I knew nothing of before motherhood: diapering, bathing, dressing, going out together, etc. At six weeks, I first felt confident that I had a unique bond with my daughter and could begin to teach a caregiver to care for her the way I wanted.” R.L.

The amount of maternity leave authorized varies between residencies, as does compensation during time off. Reactions of your program director and colleagues may affect how much you enjoy your pregnancy and motherhood during residency. However, whether or not you allow this to impact your *decisions* is really up to you.

“I had my children right after residency and took off different amounts of time after each one to determine the perfect amount of maternity leave following childbirth. After my first child, I took three months off. This proved to be too short after I started back full-time. With the second child, I took off five months and then went back to work part-time. This seemed to be a bit too long. After child number three, I seemed to find the right balance. I went back to work part-time at about four months. There was another woman emergency physician with whom I worked who also had young children and she agreed to split our 8-hour shifts so that I could continue breastfeeding my son. I worked 4-hour shifts until my child was a year old and then resumed my usual 8-hour shifts. I learned to think “out of the box” and create innovative solutions so that I could continue working and contributing to the Emergency Department and still give the best care to my child.” R.M

Other options to consider include rearranging research and elective time, taking a year off, perhaps to do research, or returning part-time at reduced salary and just taking longer to complete residency. There may be other emergency medicine colleagues (male or female) in your residency who have small children and would like split a position. This would allow you to participate at a 50% level in the residency and be a parent the remainder of the time. You would extend your residency commitment with this option and finances might dictate whether this is a possibility.

What You Need to Know About Breast-feeding

A 1996 study showed that most female residents began breast-feeding and continued throughout their seven weeks of maternity leave, but half stopped once they started working again. Only a small minority continued to breast feed at six months. Residency work schedule was the most common reason for discontinuing. The residents who did continue with breastfeeding pumped breast milk during their shift, but felt there was insufficient time at work and that there was no appropriate place to express milk.

There are now several options available to you if you wish to nurse your child beyond your leave of absence. The newest option is a hands-free battery operated pump that fits underneath your clothing and bra, discreetly pumping while you are working. This type of pump has its own microprocessor programmed to mimic an infant’s suck and release pattern. Milk is collected in a sealed, sterile bag, which can then be disconnected and stored in a cooler. This type of technologically advanced pumping allows you the freedom to continue caring for patients in the ED and does not require you to stop everything that you are doing and arrange for coverage while you step out to pump. These pumps are sold under the name *Whisper Wear* and can be purchased on the Internet.

The other option is to use a conventional, compressor breast pump where you will need to break free from clinical duties for 15 minutes every several hours. If this is the case, then residency programs will need to designate a private, non-bathroom area for this purpose. Fellow residents should be informed of these arrangements and be able to provide coverage during

these short intervals. When establishing policies like these, consideration must be given to our non-physician colleagues who also may be breastfeeding. Special privileges for physician staff may spark resentment, so these policies should be coordinated with other staff supervisors to prevent conflict.

“If you plan to breast-feed when you return to work, shortly after you have your baby, begin pumping every day after you have nursed your baby (especially in the morning when your supply is largest). You will still have milk available and this will further stimulate lactation. Store your milk in the special plastic bags you can purchase from the lactation consultant, and freeze this milk. It can be frozen for up to six months in a deep freezer. By the time you return to work, you will have a large supply and not have to worry about running out of frozen milk.” R.M

Once breast-feeding is successfully established, giving at least one bottle of breast milk a day, instead of nursing, will help to make your transition back to work easier for the baby and for you. One last option is to breastfeed a few times a day without pumping, and supplement with formula for other feedings.

“With both of my children I nursed between two and four times a day, without pumping, for six months. My body adjusted and I found it rewarding to continue nursing when I was home, without the stress and inconvenience of pumping.” R.L.

What You Need to Know About Child Care

There are several issues unique to parents in Emergency Medicine residencies. We may need childcare during the weekdays, on the weekends, or before and after night duty. We may not need childcare for days at a time between shifts. Traditional 9AM to 5PM work hours are not the norm in Emergency Medicine; so traditional childcare choices will not work for us. Options include care by a spouse or partner, care by a family member, day care centers, or childcare in your own home with either a live-in or live-out nanny who can be employed solely or shared with another family. You may decide to creatively combine some of these alternatives to arrive at the best childcare situation for your family. See Chapter Ten.

There are advantages and disadvantages of each type of childcare. Different types work best for different families. It is crucial to have a back-up plan in the event your child or caregiver becomes ill or injured. All of us have heard horror stories about bad nannies and bad childcare centers, but with careful planning and investigation you can avoid those pitfalls.

“Throughout residency and beyond, my husband has been at least an equal partner in parenting. We have had nannies that come daily and work flexible hours. They help with housekeeping, laundry, ironing, meal preparation, grocery shopping and other errands. Occasionally, they even sleep over, if needed. When I had less stressful rotations, our nannies benefited from less demanding hours and had extra days off.” R.L.

Prioritize to Make the Most Out of it

During a residency there are countless demands competing for your time: clinical shifts, lectures, conferences, research projects, reading, children, husband, other family members, friends, exercise, household chores, bills, errands, traveling and sleeping. Come up with mutual priorities with your spouse or partner. Spend your time doing the things that are most important to both of you. Your top two concerns will be childrearing and successfully completing the residency, so work closely with your spouse and program director to make this a reality.

“My husband and I were both residents for the first two and a half years of our daughter’s life. While our time was limited, we both wanted to spend almost all of our

free time with our daughter. We set her bedtime at 10-10:30PM so we could both spend quality time with her after work. She slept in our room and bed longer than many would recommend. We took her everywhere and were together as much as possible. I feel like I missed out on a spotless house, home-cooked meals, a few holidays and a few research projects I turned down. More importantly, I do not feel like I missed any significant clinical experience of residency, nor any important event in our daughter's first two years of life. I would do it the same way all over again." R.L.

Having a child during residency can be a daunting undertaking, but it need not be overwhelming. It is truly a time of personal growth and new understanding. Indeed, many parents find that there will be no other experience as gratifying and uplifting as this. So prepare well, and get ready for the adventure. It will be one of the best journeys of your life.

Resources for Residents

Preparation is critical when you are having a baby. Here are some web sites and telephone numbers that will be most valuable to you.

*American Academy of Family Physicians (AAFP) 202-828-0400

Here you can find specifics on maternity and paternity leave.

<http://www.aafpfoundation.org>

Email: foundation@aafp.org

*American Medical Women's Association 703-838-0500

This organization publishes the Journal of the American Medical Women's Association.

There have been issues on maternity and medical practice.

<http://www.amwa-doc.org>

Email: info@amwa-doc.org

*American Academy of Pediatrics (AAP) 847-434-4000

You can find great resources on everything from childcare to breast-feeding.

<http://www.aap.org>

Email: kidsdocs@aap.org

*American Medical Association (AMA) 312-464-5000

<http://www.ama-assn.org>

*Association of American Medical Colleges (AAMC) 202-828-0400

Here is a wealth of information on medicine, parenting, and references about pregnancy during residency.

<http://www.aamc.org>

*Horizons

<http://www.ama-assn.org/ama/pub/category/2178.html>

Horizons is a free quarterly newsletter for and by spouses of residents and medical students. It provides helpful information on raising children during and after residency and handling the pressures of a medical marriage.

*Women Physicians Congress (WPC)

<http://www.ama-assn.org/ama/pub/category/172.html>

The WPC address women's health and professional issues.

Beginning Your Family after Residency Training

Colleen O. Davis, MD MPH

Introduction

Career. Family. Most female physicians 'want it all'. There are no well-defined timetables to follow when carving out your individual family and career path. Women in medicine face many challenges when beginning a family in their post-graduate years. The concurrent demands of a female physician's biologic clock and the pressures of either the academic timetable or a new clinical position are at the heart of this challenge. Although the dual responsibilities of career and family affect both men and women, as long as women continue to be the primary caregivers, our experiences juggling professional and personal responsibilities will be different from those of our male colleagues.

It is not until formal medical training is done that a young physician begins to fully realize the tremendous rewards and vast responsibilities of a career in medicine. Similarly, motherhood and family can be hazy, vague notions until a woman has her first baby. Suddenly, seemingly out of nowhere, the overwhelming joys and responsibilities of raising a child become obvious. Beginning a career and a family within the same time period ensures that life is busy and rarely dull!

Over the past 14 years one of my primary goals has been to achieve balance between my career and my family. My husband and I married two years after I finished training. Two years later, we had our first child. We now have three wonderful daughters ages 10, 6, and 4. While my quest for balance has been unwavering, my professional schedule has varied tremendously as we had our children. I have worked full-time, part-time and have taken an extended leave of absence. Because of these many experiences, I have been asked to provide tips and insight on raising a family and balancing a career in medicine.

Emergency medicine is a wonderful career choice for women because of the flexibility it affords young physicians with families. As a junior faculty member I worked full-time. Additionally, my husband and I both were studying to obtain masters degrees. These were very busy times for us. Like many physicians, I was incredibly busy both at home and at work. Life was full; fortunately, full of good things.

Working During Pregnancy

During each of my pregnancies, I was healthy and able to continue full-time work. Other than resting more before and after clinical shifts, I made no changes to my required clinical schedule. In my first pregnancy, I worked extra shifts to bank hours for the approaching maternity leave. During my second and third pregnancies, I was too busy managing work and family life to work extra hours. I told my chair and division chief about each pregnancy early on. They were very supportive. Also, I told our schedule guru and practice group far enough in advance to allow them time to adjust the schedule.

Occasionally when I was pregnant and working full-time, I felt like I needed vacation more than ever before. I resisted the urge to take vacation and saved the time until after the baby was born. Also, I was able to rollover vacation from one year to the next. It is wonderful to look ahead to an extended time off with your new baby. The decision about how much time to take off for maternity leave is difficult and very personal. Work related issues and priorities pale once your first child is born. It is important to be honest with yourself and your schedule coordinator as you make your plans. Leaving your new baby and returning to work after a mere six weeks seems to be very difficult even for the most ambitious career women. I realized how much I would enjoy being home with my new baby and I tried to schedule as much time as possible after each baby was born. By accumulating maternity leave, vacation time and banked hours I remember staying home about 14-16 weeks when my first two daughters were born. These were special times that I remember now with great fondness.

Clinical work during pregnancy is interesting. The medicine doesn't change of course, but there are subtle differences in the art of the practice. One unexpected aspect of providing patient

care while visibly pregnant occurred to me, in part, because pediatric patients are often uninhibited. When I was pregnant, many patients and families related to me in a more familiar way than they had before. This surprised me. No physician or teacher had ever described this type of experience to me, yet it happened with all three of my pregnancies. Patients liked to ask about when the baby was due, what the sex of the child was, how many children I had, did I have heartburn, and many other personal questions. For example, when I was 33 years old and pregnant with my first child, I remember being asked by a teenage mom “why I waited so long” to start my family. This led to a nice chat about her job and mine and how long it takes to become a doctor.

In typical patient interviews, physicians ask many questions and patients have to provide many personal answers. For some reason, pregnant physicians must seem more approachable to patients and families. I enjoyed these brief conversations and the families seemed to as well.

Planning research studies and national presentations is a bit tricky when looking towards an extended absence. I limited my travel in the third trimester of each pregnancy; other authors on our study team presented our work.

Maternity Leave

Maternity leave with my first two daughters offered me the rare opportunity to have a solid block of time to work on academic projects. I felt good after each delivery and seemed bounce back physically very quickly. After being home for a while I missed the academic stimulation. I remember our second daughter slept a lot during the days. I felt great and was wide-awake. When she was sleeping I would try and get a bit of work done. I worked on abstracts and other projects. In many ways it was easier to focus because I had no clinical or administrative responsibilities. It was a rare opportunity to focus on research and relax in the comfort of my home.

During each pregnancy, I carefully planned my maternity leave so as to maximize the time off immediately after the baby was born. Once you are pregnant, it is important to carefully read your faculty or employee handbook and become familiar with the various types of leaves. Your practice administrator or human resource representative will guide you to the proper decision. Planning ahead is important. In the US, the various types of leave include: maternity leave, family medical leave and leave of absence (long and short term).

In most cases, in the United States, uncomplicated maternity leave is a form of medical disability for which six weeks leave is allowed. If the baby is born via cesarean section two additional weeks are allowed for a total of eight weeks. This is a paid leave. When you are on disability leave you cannot work in other settings, including working in the lab, office, etc.

Using accrued vacation time after your maternity leave has expired, can extend the amount of paid time off available to you. If you plan on taking additional time off after both maternity leave and accrued vacation time have expired you must decide which type of leave best suits your needs. Once again, your practice administrator or human resource representative is invaluable in helping you make the proper decision.

Family Medical Leave Act

The Family Medical Leave Act (FMLA) is a federal law (PL 103-3) enacted in 1993 to balance the demands of the workplace with the needs of families. This law was designed to protect workers from losing their jobs when they need time off to address critical personal and family matters. The FMLA requires employers to provide eligible employees with up to 12 workweeks per year of job-protected leave with continued medical benefits, for the following reasons:

- To care for an employee’s newborn son or daughter.
- Because of adoption or foster care placement of a child with the employee.
- To care for the employee’s spouse, son, daughter, or parent who has a serious health condition.
- Because of the employees’ own serious health condition.

This law guarantees that employees can resume their previous position or an equivalent position when they return. Many people mistakenly think FMLA assures 12 weeks of paid leave. Currently, time off under the FMLA is unpaid leave.

Leave of Absence

Hospitals, universities and practice groups have specific definitions of both leave of absence and disability. Leave of absence is not the same thing as disability leave. There are long term and short term leaves of absence and long and short-term periods of disability. Benefits such as dental insurance, health insurance, flexible spending accounts, life insurance, disability insurance, retirement contributions and tuition benefits are often suspended during a long-term leave of absence.

Clinical Practice after Having a Baby

Like all new parents, our world changed when we had our first daughter. What a wonderful experience! My practice as a pediatric emergency physician also changed. I have more empathy for worried new parents and I appreciate more fully the value of educating parents about common childhood maladies.

One aspect of emergency medicine that I underestimated initially, and now cherish, is the flexibility in the clinical schedule. When I first started working, I preferred day shifts. Now with school-age children, I prefer to work clinically in the evenings. Being able to shoulder my share of clinical hours primarily in the evenings has been very helpful for my family.

Having a Child with Medical Problems

During the routine prenatal ultrasound for my third daughter my husband and I were shocked to learn that the baby had serious medical problems. I will never forget sitting in the obstetrician's office for the ultrasound. I was 38 and 'high risk' for complications because of my 'advanced maternal years'. Suddenly it happened. The OB fellow told us there seems to be a problem . . . a serious problem.

Worry and genuine angst caused by the possibility of life-threatening disorders was ever-present during that pregnancy. Fortunately, the most serious concerns failed to occur. Now, when I see a mother in the pediatric ED, with a bed-ridden, technology dependent child, I pause for a moment and remember. Our daughter's present medical concerns seem small in comparison.

Having a child with complex medical problems changed me. I experienced the medical community, a community that I had been a part of for over ten years, in an entirely new way. Making informed decisions about our youngest daughter's medical issues opened my eyes to patient concerns in ways that the routine well child care of our other children never had. It is easy to attend faculty meetings and proclaim that patient care and safety come first. It is entirely different when you realize that you are dependent on others to ensure that your child's care truly is paramount.

My Leave of Absence

Once our youngest was born, my husband and I realized that the balance had shifted. Actually there was no balance. There was no way for me to try and continue to juggle career and family. Our baby needed me to be with her. I took an extended family medical leave and remained out of work for sixteen months. My daughter and our family were my entire focus during this time. The support of my Chair and practice group was tremendously helpful; something I valued from a distance. No longer did I try to work at home.

Our daughter taught us so much in her early days and she continues to do so now. Fortunately, she is doing terrific. She is thriving and is a social, out-going, warm little four-year-old.

Working Part-Time

When our youngest daughter was 16 months old, I returned to work part-time. Working part-time is a unique and often frustrating experience. At times it can feel like you just can't satisfy anyone. One risk at work is that although your salary is clearly cut, if you are not careful, your work hours can easily go over the agreed upon amount.

When I was a resident, I worked with a Pediatric neurology attending who decided to work part-time. She told the women in our group that the only way she could avoid working full-time hours and receiving part-time salary was to completely cross off certain days from her schedule. I remembered this and try to use her technique with my own schedule. For the most part this works well.

The benefits of part-time work when you have a young family are many. It is clear to me now that I have struck the right balance. I have been available for early intervention therapy sessions for our youngest daughter and I take her to scores of doctor's appointments. Also, I have been able to get more involved in activities at my daughters' school such as attending field trips, teaching first aid to the girl scouts, and helping teach science labs. It is so rewarding to see all three of our children happy and doing well. Work is going well and I have been able to resume an administrative role that I really enjoy. Success as a part-time faculty member is an art unto itself. I have not mastered it – but I am trying!

Child Care

Our family's childcare needs and solutions have changed over the years. What was the ideal answer for us with one infant clearly would not suffice now with three active school-age children. Initially we had a nanny care for our oldest daughter. The main advantage of the nanny was that our daughter stayed home and received one on one care with someone we respected. Disadvantages occurred when the nanny was ill or called for jury duty. Often with very little notice, we had to scramble to make alternative plans. My mother often traveled from her home two hours away to help us out.

Two years later we enrolled our daughter in a highly recommended local daycare center. She was very ready to socialize and seemed to love it. Our second daughter attended daycare from six months of age. Advantages of the daycare setting far out weigh the disadvantages for us. It is reliable, has a wonderful staff, and plenty of kids for our daughters to play with. Currently, we use a combination of daycare, school and after school care.

Childcare arrangements are challenging for all working families. In many ways emergency medicine offers much more flexibility than other types of medical practice. We have a bit more flexibility in our clinical schedule. Shift work opens up time during the day when – given advance notice - it is possible to attend school activities and other events that are so precious.

Family Life

Balancing professional and family obligations takes constant attention and dedication. To be successful at home it helps to set family priorities with your spouse or partner. My husband and I share long-term goals and decided very early on as a couple what our priorities for our everyday life would be. For example, eating dinner together whenever possible is a priority for us.

When both parents work, you may need help caring for your children and help managing your home. Decide which household chores and maintenance items you can do and which ones you cannot. Budget for those chores that you can afford to have help with. We have help with house cleaning, lawn care and snow removal. We also have plenty of backup baby sitters. Consider also hiring help with laundry and shopping. Car-pooling children to and from preschool and extracurricular activities is also very helpful.

Our children are involved in lots of activities including: dance, tennis, swim team, soccer, softball, cooking lessons, girl scouts, basketball and art class. My husband and I try to attend all

of our children's special events. We can't go to everything, but between the two of us, we make most of their activities.

Support Systems

My main support comes from my husband. We are in it together. Sharing dreams and goals is vital to our relationship. Additionally, we both have families that offer us endless support. Having a sense of humor helps a lot too!

There are two major sources of support for me at work, my colleagues in our division of Pediatric Emergency Medicine and my Chair. Over time most people need backup help for one thing or another. It feels good to do a shift for someone who worked extra for me while I was on maternity leave. Our Chair's support is the underpinning for the variety in my clinical schedule over the years. She allows for the flexibility in the department and the schedule to accommodate our faculty's changing needs.

Another source of support is from the university. Many universities have information available online and in print that help faculty locate local childcare centers, summer camps, birthday party sites etc. This sort of information can be especially helpful when you are new to an area and not familiar with the local activities for children.

Conclusion

Most things worth doing require a lot of effort. Balancing a career in medicine and family life is no exception. A successful career in medicine lasts for many decades. Being a mother is forever. The responsibilities of each role are tremendous and the rewards are immeasurable. In my opinion, it is a gift to be able to experience the wonders of both roles.

ED Doc & Single Mom: Advice from a Survivor

Lynne D. Richardson, MD, FACEP, Mother of Kristin and Lauren

Raising children is always a formidable undertaking; raising children alone is all the more difficult. There are many circumstances that may result in the absence of a partner: death, divorce, break-up with a significant other, abandonment, or a deliberate choice to have or adopt a child without a partner. Whatever the circumstances, the single mother has exclusive, continuous responsibility for the well being of her child(ren). She is never off-duty. She must assure that they are safe, happy and well cared for, every minute of every day. There is no more stressful, joyous, frustrating or rewarding task.

My daughters were aged three years and eight months when my marriage fell apart. That was almost fourteen years ago. During those years, I have worked full-time in emergency medicine, raised two daughters and managed to keep both my sanity and my sense of humor. I've learned a few things about raising children and a lot about myself. While everyone's experience is unique, perhaps some of my observations will be useful to others who find themselves in this situation.

The Challenges

Two demanding roles

As an emergency physician (EP), you have a career that is physically, mentally and emotionally demanding. You spent years in school and in residency preparing for that role. For the equally challenging role of parent, most of us have had little or no preparation. Fortunately, many of the skills that make you a good EP will help you to be a good parent. Your sense of adventure, your ability to make decisions in the face of uncertainty and to remain calm during crises, your confidence in your ability to handle difficult situations, your physical stamina and your resourcefulness, all of these will serve you well. Some of the other qualities you need may not come as easily: patience, tolerance for mistakes (especially your own), forgiveness and perseverance in pursuit of long-term goals. As a single parent, you must cultivate all of these.

Unless you take a non-clinical position, your schedule will never be a normal one. In emergency medicine, irregular hours that include working nights, weekends, and holidays come with the territory. This will present significant challenges to all of your relationships: with your child, their teachers and friends, childcare providers, as well as with your own friends and family. Finding a childcare provider who is willing and able to work the schedule that you work will be a huge challenge. You will have to constantly remind people of the peculiarities of your schedule, even when you think they ought to know and understand. You may find that your needs and preferences with respect to the predictability and/or flexibility of your work schedule change as a result of your parental responsibilities. Be proactive in negotiating for your needs while taking into account the needs of your ED group or department.

The intensity of what we do in the emergency department usually requires a period of "unwinding" at the end of a shift. This is a time to process the situations we have experienced, or to emotionally disengage from the sustained excitement of the ED, or to simply relax. Immediately responding to a rambunctious toddler or a moody adolescent is not the ideal end-of-shift activity. The first challenge is to smoothly change gears, not bringing the ED home with you. Don't forego your wind-down period; postpone it until after you've dealt with your child(ren). To handle both roles successfully requires that you learn to compartmentalize, without repressing your own needs.

Special knowledge: an occupational hazard

As emergency physicians, we see many injuries. While this gives us a healthy appreciation for the importance of safety practices and devices, it also exposes us to unusual or freak occurrences that result in tragedy. I remember a six-year old child who was crushed and killed when she climbed up on a bookcase that toppled over on her. I saw another girl who died in the ED after being impaled on a fence when the playground swing she was standing on broke during a race with her friend to see who could go the highest. I can still see the mangled hand of a little

boy who was trying to make something in a blender while his mother was asleep in another room. This kind of special knowledge can create special anxiety about the safety of our children.

It is easy to become overprotective or to over react to situations. While all emergency physicians who are parents are prone to this occupational hazard, most have a spouse or partner who is not an EP to provide some balance. Single parents are at greater risk to allow their unchecked anxiety to inappropriately influence their judgment and behavior. You must control your own fears, not allow them to control you. You must learn to keep your child safe without making them afraid.

A single woman in a couples' world

Quite aside from the burdens of single parenting, you will be facing a whole set of issues and problems as a woman alone. If you were previously part of a couple, these will be a new and unwelcome experience. If your partner has died, you must deal with your own grief and the grief of your child(ren). If you are separated or divorced, you will have to deal with the personal aftermath of the failed relationship and often with ongoing tensions with the child(ren)'s father around custody and visitation issues. If you chose to have a child on your own, you may find that many people make unpleasant assumptions or unwarranted judgments about your situation. Whatever your particular situation, you may find that an un-partnered woman with children is regarded as a threat by many women and some men, and as easy prey by certain men.

Parenting without a partner

Each day, you will make decisions about your child(ren) and choices about how to spend your time. There have been times when I put my children ahead of my career; and there have been times when I put my career ahead of my children. There is no single correct answer; each time you face a choice, you must do what seems to be most important at that moment.

One of the hardest things about parenting is that you often get no feedback about the correctness of any of your decisions. It is easy to become overwhelmed by guilt, uncertainty, regret or anxiety. As a single parent, all of the decisions are yours. There is no one with whom to consult and no one to reassure you when you are plagued by feelings of inadequacy. There is also no one to share your pride in his or her achievements, the joy of watching your child(ren) grow and develop. Fortunately, the resilience of your child(ren) and your love and commitment to their well-being will be more than enough to see you through.

Meeting the Challenges

Get organized

Time is the one thing that you never have enough of, so it's important to make the most of it. Motherhood has a way of teaching organization. You have to plan things carefully, you have to anticipate your child(ren)'s needs, and you have to be prepared for whatever circumstances arise. Even with excellent organizational skills, you will have to accept that, on most days, there will be more things to do than there are hours to do them. Make sure that you are the one who chooses what gets done and what doesn't. Don't let things happen by default. Try to avoid wasting time on low priority activities, even if they seem urgent. Don't get sucked into other people's agendas; set your own.

Build yourself a support system

No matter how organized you are, there will be times when your carefully planned arrangements fall apart or some completely unanticipated situation arises and you need help, sometimes on very short notice. Since you don't have a live-in partner to count on, you will need to identify people who are willing and able to help you when you need it. If you are fortunate, you will have supportive and available family members living near you who can pitch in when you need them. If this is not the case, you will have to cultivate relationships to build a network of individuals who are available to help you. The most satisfying arrangement is one of mutual support. Offer to care for the child(ren) of a friend or co-worker; they will probably be pleased to return the favor and take your child the next time. If your child(ren) is in daycare or pre-school,

develop this kind of relationship with some of the other parents. If you have a friend or relative who is willing but inexperienced with children, invite him/her to spend time with you and your child(ren) so that you will feel comfortable with their ability to care for your child(ren) on their own.

Don't make the mistake of thinking that you should only use these resources when you have no alternative. Your child(ren) will benefit from learning that there are adults, other than you, whom they can trust and depend on. You will benefit from being part of a group of concerned and responsible adults who depend upon each other for help and support.

Pay for help

While identifying a support system is essential, it is very difficult to meet all of your childcare needs through the generosity of family and friends. Constantly scrambling to patch together arrangements around an EM physician's work schedule is extremely stressful. Unless you have a family member who can provide full-time care to your child, a paid caregiver will provide your major childcare services, either in your home or in a child care facility. (See Chapter Ten on child care arrangements.) In my experience, full-time help (live-in if you have sufficient space) is by far the most flexible and reliable arrangement. A full-time babysitter can accommodate your schedule, and that of your child(ren), because they have no obligations to another employer. Such an arrangement also makes it possible for you to travel for professional reasons. When your children are young, take them and your caregiver with you. Once the children start elementary school and are not free to travel with you during the school year, they can be left at home without disruption to their routine.

In addition to your childcare arrangement, do not hesitate to pay for other kinds of help. As I said before, time is the scarcest of all commodities. Once you are past residency, lack of money is not usually as much of an issue as lack of time. Accept that you cannot do everything and that you may have to run your household in a very different manner than what you were accustomed to as a child. Pay someone to do your housework/yard work so that you can spend your days off with your child(ren) instead of doing mundane chores. If there is a special task that you enjoy such as cooking or gardening, by all means share that with your child; but pay someone to do everything else.

When your children are young, it is very useful to identify an agreeable and responsible teenager who lives in your neighborhood who can help with babysitting and running errands. Whether you prefer to send them to the grocery store or leave them with your child for an hour while you go, it is well worth the \$5 or \$6 you will pay. Such a teen can also function as a mother's helper. Some desirable excursions (the beach, the museum, the amusement park, the shopping mall) are extremely daunting by yourself, especially if you have more than one child under the age of six. Having an extra pair of hands (and feet to chase slippery toddlers) can be the difference between a nightmare trip and a pleasurable family outing.

Don't fall into the trap of thinking that just because you can do something, you must do it yourself. Your time is valuable. Whenever you can, choose the most convenient option, even if it is more expensive. Use the dry cleaning service or the video store that picks up and delivers. Buy dinner on the way home or better yet, call and have it delivered. Look for ways to simplify your life so that you can make time for the things that are really important.

Do not make yourself indispensable to your child's routine

This was perhaps the hardest lesson for me to learn. My desire was to spend as much time as possible with my children, even if this meant changing their routine to accommodate my schedule. Since there were often times that I could not be present for their usual morning or evening routine, this left them with little predictability or continuity. Young children need the security of a structured routine. It is more important that they have dinner at the same time every day, than that they have dinner with you. It is more important that they go to bed at their regular bedtime than that you be the one to put them to bed. As difficult as it is to accept emotionally, you must not make yourself indispensable to your child(ren)'s routine. You must adapt your activities to accommodate their schedule, rather than having their activities accommodate yours.

You can remain connected and involved with your child(ren) on a daily basis. Use phone calls, notes, signs and faxes to communicate with them when you can't be physically present.

You can establish family rituals and traditions that are your own. You can demonstrate your constant love and concern for them in many ways, but you must give them the security of a predictable routine that is completely at odds with your professional schedule.

Give Yourself a Break

Both literally and figuratively, you must give yourself a break. In the literal sense, you must take time for yourself away from both your job and your child(ren). This is perhaps even more important and more difficult for single parents than for parenting couples. Our lives are so busy; it is very difficult to find time for oneself. There have been frequent periods in my life when I lived in a state of almost constant near-exhaustion. Whenever I have allowed this to occur, it inevitably affects my children. It is not selfish to take time to relax and restore oneself; it is essential.

It is also important to give yourself a break in the figurative sense. Don't hold yourself responsible for things that are not under your control; don't beat yourself up about things that you cannot change. When you make a mistake, (and you will make many mistakes), learn from it, then let it go. Do not set unrealistically high expectations for yourself or your child(ren). Abandon your idealistic notions about a perfectly behaved child and a well ordered home. You will doom yourself to constant disappointment and make yourself and your child(ren) crazy in the attempt. Be very selective about rules; limit them to a small number of safety-related issues. Be flexible about everything else.

Over the years, there have been many people in my life - family, friends and co-workers, who have provided support, encouragement and comfort. But there have also been a few who offered nothing but criticism or disapproval. It is important to avoid negative people. This can be difficult if the person is a close friend or family member. Even if their comments are sincere and well intended, you cannot allow them to undermine your confidence in your ability to care for your children. There is no place in your life for anyone who is constantly critical of the way you live your life and raise your children. I am not talking about friends who will tell you when they think you are wrong, even when you don't want to hear it. But people whose perspective is always unconstructive and disapproving should be told that they are being unhelpful. Those who cannot or will not change should be avoided.

Let them grow up

As your children grow, their needs will change and certain aspects of your relationship with them will change. The parent-child relationship is unique in that it is the only kind of love for which separation is the desired ending. One of the hardest parts of parenting is learning to let them go. It is not just a matter of keeping them safe until they grow up, you must prepare them to function independently in a dangerous complicated world. The way children learn to make decisions is by being allowed to make decisions. When they are small, allow them to choose among acceptable options. (Do you want to wear the red shirt or the blue shirt?) As their judgment improves, allow them to make more important decisions. With each passing year, it becomes more and more difficult to know when to allow them to use their own judgment and when to superimpose your own.

As they grow older, you will have to allow them to take risks and allow them to make (and learn from) their own mistakes. Again, you will have to do this alone, always wondering if you are making the right decision. Try to consider their need for independence, not just their safety or your fears. My children constantly want to try things that are beyond my comfort zone, increasingly, they are right. You must try to determine if it is they who aren't ready for the new experience or responsibility, or if it is you who isn't ready. Talk to friends, family and the parents of your children's friends, but never abdicate your responsibility to others. My children don't even bother with the "everybody else's parents are letting them do it" argument anymore; they know it never works with me. But a well thought out presentation that shows me they have all the necessary information and have considered all relevant factors does work.

So far, so good

Raising children is the single hardest thing that I have ever done – harder than medical school or residency, harder than practicing emergency medicine in a busy inner city trauma center or a prestigious academic medical center, harder than running a residency program and harder than writing grants. The most difficult decisions I've ever made, the most complex problems, the most painful choices and my greatest fears: all of these have involved my children.

So far, it seems to be turning out okay. My kids are teenagers now (ages 16 and 14); they are healthy, happy, active, inquisitive, engaged and occasionally infuriating. (They are also smart, talented, beautiful and strong but I don't want you to think I'm bragging.) To the extent that I have sacrificed my children for my career, they seem to have emerged unscathed. To the extent that I have sacrificed my career for my children, I have no regrets. My children are the greatest single source of joy and satisfaction in my life. Being their mother has made me a better person and a better physician.

Suggested Readings

My favorite book on "self-improvement"

Stephen R. Covey, "The 7 Habits of Highly Effective People". 1989. Simon & Schuster, New York, N.Y.

My favorite book on "parenting", ages 0-5

David Lewis, "How to be a Gifted Parent". 1982. Berkeley Publishing Corporation, New York, N.Y.

My favorite book on "parenting", ages 5 & up

Adele Faber & Elaine Mazlish, "How to Talk So Kids Will Listen and Listen So Kids Will Talk". 1982. Avon Books, New York, N.Y.

Adoption

Linda Spillane, MD

Introduction

Like many professional couples our age, my partner and I waited until we completed medical school and residency/fellowship training before starting our family. At age 35, we discovered the frustration and disappointment of infertility. After much soul searching and research, we decided to adopt internationally. This was the best decision we have ever made as a couple. We are now the proud parents of three and a half and five and a half year old girls from China. The decision to adopt is a personal one but there are several issues specific to women in emergency medicine. Becoming a mom, no matter what the route, changes your perspective on career and life priorities. The process of adoption adds it's own challenges. The rewards are immeasurable.

Problems and Challenges

There are several challenges to adoption that are shared by all, irrespective of career. Some of these include the decision to adopt domestically vs. internationally, what country, which agency, and completing the right paperwork. There are several challenges specific to emergency physicians including, planning childcare, planning time-off and feelings that inevitably come up because of the kind of work we do and the patients that we see.

Solutions

After making the decision to adopt, we did a lot of research. Fortunately, there are many books on adoption and on-line resources that can help with the decision-making process. An excellent website regarding both domestic and international adoption is www.Rainbowkids.com. There are links to additional adoption sites that we found helpful. The Tapestry Books website, www.webcom.com/tapestry is a comprehensive listing of fiction and non-fiction books on adoption topics, with a brief description of each book. A good starting site regarding adoption from China is the Families With Children from China website, www.FWCC.org. I have read several books pertaining to adoption from China and highly recommend *Lost Daughters of China: Abandoned Girls, Their Journey to America, and the Search for a Missing Past* by Karen Evansn. I have particularly enjoyed several children's books including, *The White Swan Express: A Story About Adoption* by Jean Davies Okimoto and Elaine M Aoki and *I Love You Like Crazy Cakes* by Rose Lewis. The amount of available information is overwhelming but reassuring.

After deciding to adopt internationally, we took several things into consideration. We had to select a country and an agency. This is a complex process beyond the scope of this chapter that requires a lot of thought. Briefly, in choosing a country we considered the political stability of the adopting country, the average age of the children available for adoption, health of the children, average wait to receive a referral and whether one could adopt as a single parent or as a married couple only. These issues were the most important to us, but because it affects scheduling time off it may be important to consider whether or not travel to the adoptive country is required and if so, the expected length of time one would be out of the country. In choosing the agency, we sought information about their reputation as well as the age and size of their program. It was helpful to know the average time it took from referral to travel. At the time we adopted our first daughter, the average age of the child was eight to 12 months, the time to referral was approximately ten to 12 months and the time between referral and travel was four to six weeks.

After choosing a country and an agency, we had to process a large amount of paperwork. For each adoption, spaced two years apart, we had to obtain local child abuse clearances and were fingerprinted more than most criminals. We also had to arrange several social work visits to obtain home studies. In this process, because I work shift work, it was actually easier for me to arrange time off during the day than it was for my partner who sees patients primarily during the day.

Time Off

There may be a sense that you can control the process to some extent and plan for time off in advance. You can't. There is no way to predict the occurrence of international events such as the accidental bombing of a Chinese embassy, acts of terrorism or the epidemic of SARS that effect travel plans.

Although some institutions provide paid adoption leave, many institutions make no allowances for adoption and require adoptive parents to use vacation time or take unpaid family leave. I was able to take five weeks off for my first child and approximately four and a half weeks off for my second child. I was able to rollover vacation time from one year to the next, work extra hours in the months preceding travel and have someone cover my administrative duties. Because this affects the schedule of your colleagues, it is important to have the support of your Chair or group. I talked to the scheduling physician and to my colleagues. I was able to trade shifts that had already been scheduled prior to travel dates for the adoption being set.

You will need the understanding and assistance of your boss. In order to adopt from China, you need a letter stating that you are employed and that your job is secure. You need a financial statement and sometimes a letter of recommendation from your place of employment.

Child Care

Arranging childcare is difficult if you don't know the sex or age of the child and when they will be starting. Whether or not you can wait until you bring your child home before choosing a daycare or nanny will depend on time off arrangements and the availability of daycare, etc. in your area.

I started calling local daycares several months before we received our referral. I will never forget the experience because I have never felt more flustered and inept in my life. It deteriorated after "Hello." The first question was what's the child's last name? I stumbled and said, "I don't know". My partner and I hadn't decided which last name to use or whether the name would be hyphenated. The patient person on the other end patiently informed me that it was customary to use your last name. How old? I don't know. Health? I don't know. When would you like to start? Immediately, but that's not how it works. Despite my facile phone conversation they invited me for a visit and things worked out in the end. We reserved a place for a child between eight and 15 months old and paid to hold a spot. Making plans is a good idea but one quickly realizes that plans may have to change based on the health of your child and any adjustment problems either of you may be having.

Adoption Issues

I am often asked questions about my own reactions to adoption and about the reaction of my children to being adopted. I can't imagine loving any child, biologic or not, more than I love my children. I am surprised at how often I have been asked this question. With each adoption, the bond started as I gazed seemingly endlessly at a tiny 1x2" picture and grew exponentially the minute I held them in China. I can't adequately describe the joy of holding them for the first time or how lucky I feel to be their mother.

From the beginning, the children have heard the word "adoption" and have been told the story of their adoptions. At this point in time, adoption is a story – their story, and birth mother is a word, not an actual person. I am preparing myself to answer harder questions about why their birth mothers could not care for them. Despite describing in simple language, where babies come from, my current challenge is to convince the children that not everyone is adopted and that babies do not come from airports. My five year old will point to other children and say things like, "I think those children came from Greece." She has expressed the concern that the world will run out of babies and there won't be any left for her if everyone keeps adopting them.

Rewards

There are countless rewards to being a mother. It has affected me personally and professionally in a positive manner. It has changed the way I think about the world.

Listening to my children's questions helps me to put my life and career in perspective. I don't have the answers to all of life's questions. Why do mosquitoes like blood? Why is there a ring around the moon? What's under your skin? (The only question I was able to answer with my medical training.) Who's going to die first?

I sit on my hands a lot and bite my lip to avoid yelling "STOP" as I watch the kids jump from the top of the sliding board, climb two branches higher than I am comfortable with, careen down hills on bikes and hang upside down by their knees. I compensate by buying expensive car seats, life jackets and helmets. I call my partner more often than I care to admit, to ask if every drop of water has been dumped from the wading pool and if the kids could possibly fall through the screens from our second floor windows. I call home a lot to say, "I love you", because I know that bad things can happen at any moment.

I am more sensitive to racism and cultural stereotypes. Our children are obviously not our biologic children and inevitably are asked where they are from. They proudly say China or New York (depending on the day of the week and phase of the moon) and I wonder when these questions will start to annoy them. I cringe at work when I hear staff or patients make derisive comments about people of different races or ethnicities – knowing that I am "privileged" to hear these comments because I am white. At times like these I know that my children will have experiences that I have not had to face and I feel helpless to protect them.

I am more sensitive to work issues surrounding adoption. Whenever I ask a patient their family history and they answer, "I don't know. I was adopted", I want to ask them how they feel when someone asks them that question and if I should have asked the question differently. I immediately want to know how they feel about being adopted. I resist the urge to ask.

My partner and I have discovered the very supportive adoption community. We have made new friends – outside of medicine, with other families who have adopted internationally. We have emotional ties to the families who journeyed with us to China. We keep in touch, share our latest pictures, and try to get together at least once per year. These children, from the same orphanages as our children, may be the closest link to their past. This may or may not be important to them some day.

After a period of adjustment, I am much happier with my career. I have learned to be more efficient at work. After an evening shift, I have to get home in time to get enough sleep so that I am not a bear to the kids if we have the next day off together (they get up at 6:30 am). I have to get out on time to pick the girls up from preschool/kindergarten or get home in time to read a bedtime story. I used to stay after the end of every shift to do two hours of charts. I now do most of my charting as I see the patients. Happily I've stopped making meticulous "To Do" lists only to rewrite them after crossing out a few items. Now I make shorter lists and do the work. I am more careful about committing to projects that I am not interested in and as a result, I am enjoying the projects that I am doing much, much more. I've learned to work more steadily on my academic pursuits instead of having periods of frantic activity and productivity, followed by periods of fatigue and academic burnout.

Conclusion

To put it simply, "Life is good".

Child Care

Katherine Heilpern, MD FACEP, Tammie Quest, MD

General Principles

Define your Childcare Needs

In order to make the best selection of a childcare option, you must first make a detailed assessment of what your childcare needs are. As an emergency physician (EP), there are special considerations to finding childcare. General factors to consider include the age of your children, your current career demands (clinical, administrative and educational) and the amount of extended support you have available to you.

Think about your 'special' demands as an Emergency Physician

Examine your day-to-day clinical and administrative commitments. Emergency physicians have a host of special issues regarding childcare, mostly related to the irregularity of the clinical schedule. Unlike most of the working world, you frequently work a mix of days, evenings, nights, weekends and holidays. In spite of that, emergency medicine etiquette requires that EP(s) be at work and on time. Consider that in any given week, you may need childcare one morning at 6AM and on another day until midnight. There is no faster way to lose points among your colleagues than to be late for your shifts. You may find that you need childcare to ensure that you get the needed rest after night and swing shifts.

Think about the age of your child

No one would argue that the more time you can spend with your child, the better. Each age group however, has special needs that may need to be addressed. When children are newborns/infants a high degree of safe/reliable custodial care is needed. As a child moves to the toddler stage, object permanency is a very important part of their development and your ability to provide a reliable, consistent care system may outweigh other factors. As your child approaches school age and as their verbal skills improve, their interests and activities become more varied. School age children must adhere to more strict and dictated schedules than previously encountered (e.g. start and stop times dictated by their school system). The preschool/school age child may become involved in a variety of extracurricular activities that require a reliable transportation source. This entails detailed consideration of your childcare provider's ability to provide safe, consistent transportation.

Think about your career path and your practice setting.

Your schedule will largely dictate your childcare needs. This will help you decide if you need care full-time or part-time help and if you will need very early mornings (before 7AM), evenings or weekends. You should ask yourself several critical questions. Is your practice predominantly clinical, mandating day, evening and night childcare? Is your clinical practice one where your shifts may be scheduled at eight hours, but really turn out to be ten hours or more? Is your clinical group big or small? Will your colleagues switch schedules with you to help you meet the unexpected needs of your child? Are you in an administrative role that necessitates early or late meetings, report deadlines or travel? Do you participate in research, which may necessitate unpredictable patient enrollment call groups for clinical trials, travel to research meetings and the time pressure of grant and publication/revision deadlines? Will you be in an unpredictable grant/funding cycle that will suddenly require you to work more or less? If you have the opportunity to work a fixed schedule (for instance work with an EM group that uses templates) and you have little outside commitments (academic or otherwise), the option of sharing various types of childcare, in-home in particular, with another family may be a very good option (the so-called "nanny share" arrangement).

Critically examine your extended support system

How much childcare you will have to provide for your child will depend on your extended support system. Are you a single parent or are you married/in a committed relationship? What is

the “true” schedule of your spouse/partner, factoring commute time? Is your partner’s schedule flexible or rigid? Do they have the ability to call in sick/take leave? Do they have business-related travel or unusual work hours? One of the most difficult factors to weigh is that of relying on family/friends to care for your child. One must realistically consider the schedules, willingness, and “burden factor” of extended family/friends role in your childcare plan.

Consider your budget

While some people cringe at the thought of factoring money into the equation, the fact remains that there is tremendous variability in childcare costs. Spend time exploring and becoming comfortable with the “going rate” for each type of childcare option available to you in your community. *Talk to as many parents in your community as possible about childcare options.* While their successful experience does not guarantee yours (and vice-versa) you can at least gain some knowledge regarding general trends in your community regarding types of care, cost and quality.

In Home Childcare

The Nanny

The International Nanny Association (INA) is a non-profit educational organization for nannies and those who educate, place and employ professional in-home providers. (www.internationalnannyassociation.com) The INA defines a *nanny* as a childcare specialist who works in a private home providing one-on-one attention and care to the children. The nanny may or may not live with the family. This individual should be supportive and provide loving, trustworthy and loyal companionship to the children. According to the INA, the role of the nanny is to provide complete care of the employer’s children. This should include, but is not limited to, the following duties and responsibilities: physical needs, meal planning for the children, laundry and clothing care, play activities and outings, behavioral guidelines, appropriate discipline, intellectual stimulation and transportation. This requires excellent communication skills both with the children and the parents. Maria, the role played by Julie Andrews in the Sound of Music, personified the quintessential Hollywood version of a nanny.

Qualified nannies may not have formal training, but formal nanny training programs exist in many countries, including the United States. The classic British nanny model requires two years and 2,200 hours of classroom and practicum training, followed by a national certifying examination. In the US, Australia and New Zealand, programs range from six weeks to 12 months. The INA has developed a Nanny Credentialing Examination. This is a 90-minute multiple-choice exam that tests communication, safety, nutrition, professionalism, child development and diversity awareness. The test is described by the INA as “challenging” and the organization recommends that anyone sitting for the exam have at least 2,000 hours of childcare experience and certification in infant and child CPR and basic first aid. Nannies who pass the examination receive a certificate from the INA, which may be added to the nanny’s resume or portfolio.

Salary and benefits for a nanny vary tremendously, depending on the level of training, experience and live-in versus live-out model of care. The workweek is generally 40 to 60 hours with two full days off per week. A live-in nanny is usually granted free room and board, a private room and bath, two weeks paid vacation, paid major holidays, health insurance and use of a car. The salary range is from \$250 to \$400 per week for a beginning nanny and up to \$1,000 per week for an experienced nanny. In general, nannies that do not live with the family earn from \$350 to \$1,000 per week, depending on the number of children, the ages of the children and special childcare needs. As an independent contractor, a nanny is required to pay social security and federal income tax. The employer is responsible for the employer’s portion of the social security tax and, in most states, the state unemployment tax.

The Au Pair

From the French word for “as an equal”, the au pair system was designed to create an opportunity for cultural exchange. This system encourages a young person, usually a female

between the ages of 18 and 27, to come to the United States and live with a family for a limited period of time (one to 24 months). For example, an au pair from Italy would work in the United States to learn English, the American culture and way of life. In addition, the au pair provides care for the children. In return, the host family would learn about the Italian language and culture, provide room and board, a small weekly allowance and would get assistance with their children. The host family should consider the au pair a temporary member of the family and should include them for family meals, outings and cultural experiences.

The qualifications and training for au pairs are not standardized. In general, au pairs should have a high school equivalent degree, commit to one full year in the United States, be proficient in spoken English and documented previous childcare experience. Some agencies require formal training and will hire only non-smokers.

In the United States, an au pair can expect to earn at least \$140 per week (USD) for a 45-hour week. These hours can be allocated throughout the day. For example, the au pair could work from 7-9AM and then 2-8PM, which is a total of eight hours per day. Au pairs should be given one and one half to two full days off per week, one full weekend off per month and two weeks paid vacation. The au pair should be given a private room and responsibilities should be limited to childcare, not housework. If the au pair will be driving, he or she should be added to your auto insurance policy.

Teacher Caregiver

This new model is promoted on the Internet as an “intelligent alternative to nannies and daycare”. (www.teachercare.com) Teacher caregivers are described as child development specialists, and experienced teachers who come to your home and provide care for your child’s daily needs. In light of their enhanced experience, these teachers may be able to develop curricula, and serve as private tutors or home school educators. This option may particularly appeal to families with unique needs (e.g., special needs child, gifted child, foreign adoption, foster child or multiple births).

Out-of-Home Childcare Environments for the Small Child (< age 6)

General categories of out-of-home childcare options include 1) *center based childcare*, a setting that generally serves ages as young as six weeks and may extend through pre-kindergarten age/after school care, and 2) *home-based childcare* setting where a provider cares for one or more children in the provider’s home where the children may be of varying ages, and 3) *limited hour preschool* where a limited, half-day two to five day per week program is offered. Let’s examine some general characteristics of each of these settings.

Center Based Childcare

Center based childcare is generally organized in a classroom type format with similar ages grouped together. Classes have specific child-staff ratios that usually change depending on the age of the child (the younger the child the lower the ratio). Ratios as well as levels of accreditation and licensing vary by region and state. This type of childcare may provide a more ‘school-like’ environment with a defined curriculum. Center-based childcare in a community may be provided by a variety of agencies – independent/private, public, or church based. Hours vary, but full day center based childcare typically caters to traditional daytime working parent schedules that would allow parents to work “9-5”. One may find that drop off can be as early as 7AM and pick-up as late as 6 or 7PM. Many centers have waiting lists, especially for infants less than three months old, so it is best to begin thinking about this during late pregnancy. Remember that in the case of small children, in the first four to six weeks of infancy many parents may find it hard to travel for long periods during the day outside of the home, with or without the infant, as you might typically do when interviewing centers. Hence, exploring centers far in advance may prove to be less stressful. Allow eight to 12 weeks prior to your needed date to find a center. **Advantages:** the cost is typically fixed; you have a sense of your child’s typical daily schedule/curriculum; care providers may have advanced early childhood education/training; it is virtually guaranteed to be open any typical workday; and parents may feel secure regarding the safety of their child given

that multiple caregivers are often present with their child at any given time. **Disadvantages:** staff turnover is common; the hours may be difficult to manage with early or late/evening shifts; lack of individual attention to some of your child's individual needs (such as a specific napping pattern or special dietary needs); the 'sick-out' policy that some centers have may require that your child must be picked up within a short period of time and may not return for a 24-hour or more period after their illness and/or require a doctor's clearance to return.

Home-based childcare

This type of care is typically provided in a person's home that has been converted to meet the needs of several or more children. Licensing varies depending on region and state but typically a home-based child provider is allowed a certain number of children within specific age ranges. One should consider that the age ranges in a home-based childcare setting may be vast – from infant to school aged children that arrive in after school. **Advantages:** can provide a more intimate setting for children; hours may be more flexible; policies and procedures may be more flexible (such as sick-outs). **Disadvantages:** varied curriculum, less sense of oversight.

Limited hour preschool

This care option for young children, less than two years of age is often referred to as a "mother's morning out" program. This type of program may often be anchored at faith-based centers but do not necessarily offer a faith-based curriculum. In general, these programs offer very young children a combination 'playgroup experience' with teaching programs for several hours at a maximum of two to three times per week. As the child gets older, usually more days of the week may be offered with a more focused curriculum depending on age. These types of programs are wonderful opportunities for your child to play with other children and learn routines. At this stage in development, opportunities to build relationships with other adult figures may be an added plus. You should note that depending on the preschool, a work requirement might exist for parents in the so-called 'cooperative' type preschools. **Advantages:** may work very well for children with one-on-one care providers where limited 'playgroup' exposure is desired; low turnover of teachers, low turnover of children. **Disadvantages:** short time period may make it difficult to use as a reliable childcare option.

How do I find Childcare?

Ultimately, flexibility in your childcare arrangement is probably the biggest marker of success for an Emergency Physician. As previously mentioned, talking to other parents to find out the childcare options in your community is a wonderful first step. That said, what works for one person, may not work for another. If you have never done a childcare search, starting early (twelve weeks prior to your needs) is your best bet. Some resources to find childcare include: word of mouth, local and international (au pair) childcare placement agencies, local newspapers, public advertisements/bulletin boards and local universities and colleges. Of note, if you start too early, you may be required to commit financially even if you are not in need of childcare at that moment. If you are interested in a particular center that you know may have a long waiting list, it might be appropriate to complete an applicant and submit a deposit very early in your pregnancy (amounting to almost one year prior to need). Several recent publications are available to help the harried parent ask the right questions and consider appropriate pearls and pitfalls. (Kittrell HO. *The Nanny World*. Water Hill Press, 1997; Pick DJ, Hadley M. *Am I Hiring the Right Nanny?* Innovative Personnel Strategies, 1998; Douglas A. *The Unofficial Guide to Childcare*, Hungry Minds Inc, 1998; Carlton S, Myers C. *The Nanny Book: the Smart Parents' Guide to Hiring, Firing, and Every Sticky Situation in Between*, Griffin Trade Paperback, 1999.) In addition, the INA publishes an annual directory of nanny training programs, nanny placement agencies and special services; this publication is available for purchase on the Internet. (www.nanny.org/directory)

Local Childcare Agencies

Most major cities have childcare placement agencies or "nanny agencies". Agency directors attempt to assess your needs and commit to finding a match for those needs – for a price, of

course. The agencies specialize in private home placements on a full or part-time basis and offer the convenience of doing initial screening interviews, criminal, financial, driving record and citizenship background checks. The fee structure is quite varied depending on the agency operator and you should ask in detail how each agency charges before agreeing to begin to interview placements. Some agencies charge a flat fee for a placement; others may charge a percentage of the first year's estimated salary. In general, the fees range from \$800 to \$5,000. Most agencies guarantee that they will continue to send applicants for your interview/approval until your needs are met. **Advantages:** For the busy emergency physician, having someone to do all the phone work and background checks for you while you sleep after a night shift is quite comforting. Additionally, the agency may help you clarify your needs and can be a great 'middle-man' for screening of applicants; the agency can send serial applicants with little difficulty if things do not work out with a current placement and when you are seeking help in a hurry. **Disadvantages:** the fee for an agency can be quite high and you may find that the caliber of applicants supplied to you do not match or exceeds someone you may find via word of mouth or local advertising. Recognize however, that if you choose to do your own advertising and screening, that this can be an extremely time-consuming and frustrating process.

The Au Pair System

Reputable international placement agencies should be sought. Look to your colleagues, neighbors and friends for their experiences. A foreign au pair will require a J1 visa. These visas are valid for one year and are only available through authorized government agencies. Placement agencies with a track record of success should handle the visa and international travel arrangements for the au pair. Allow six to eight weeks from the time of application until your au pair arrives. Depending on the country of origin of the au pair, more time may be needed.

Advantages: an agency can work on your behalf to coordinate the au pair; the au pair can add a special element to a family with cultural influence; they are similar to a live-in nanny with respect to hours and may be particularly useful for the emergency physician with variable hours; they are relatively inexpensive compared to live in care. **Disadvantages:** need to make sure the au pair agency that you use is reputable; some might not want live-in type arrangements; might be younger in age and have less childcare experience.

Local ads/newspapers

If you don't mind doing the legwork yourself, placing an advertisement in your local or citywide newspaper may be a cheaper, easier way to find the private, in-home childcare provider that is right for you. Of note, in your ad, you want to be specific regarding your needs. This will help select out applicants who cannot commit to your scheduling needs, starting pay, transportation requirements, language proficiency and the number of references. For the emergency physician, flexibility with hours is very important – the person may need to be at your home as early as 6AM if you have an early shift or late in the evenings. One useful tip to help "screen" calls is to put a call back number in the ad that will go to a voicemail/message service directly. The outgoing greeting should be able to accommodate a long outgoing message. Your outgoing greeting should reiterate all of your criteria and ask for references before calling the person back for an interview (e.g. "If you are calling for the nanny position, please listen closely to the job description and the requirements.... if you are still interested in the position after this message, leave your name, phone number and number of references at the sound of the tone."). After you have called the references and are satisfied, then you should set up a phone interview. Your phone interview questions should be prepared in advance. During the phone interview you should be explicit about your needs while utilizing open-ended questions to gain the most information ("Tell me a little bit about your childcare experience"). You should tell the applicant that they will be submitted to a background check if they choose to apply for the job and should bring a copy of their identification card (license, visa etc.), a copy of their social security card or the number and additional references as required. You should have an idea of what benefits you will offer to applicants and be willing to discuss that in general or specific terms. Top candidates should be interviewed in person. **Advantages:** cheaper than an agency and more direct control of the process. **Disadvantages:** you must dedicate time to do phone interviews, background checks

etc. (Note: this is often hard to juggle if you do not have anyone to care for your child while you undergo this process) and be willing to “break bad news” to applicants that you do not choose to hire them. Additionally, throughout the process, you will be their primary employer and will not have an intermediary, as you would with an agency.

Background Checks

As previously emphasized, the first stage of screening is the telephone interview and reference check. Your instincts are your best tool in choosing the right nanny. You should talk with the references in detail about the individual and have a sharp ear for clues that sound like the reference could be fraudulent (a friend or neighbor). If you are uncomfortable and you can't resolve what it's about, it's probably best not to hire that person. The Internet is a great place to start with background checks, as there are companies that specialize in background checks for nannies (e.g., 4nannies.com). You will need the name, social security number, date of birth and current address. If you wish to check the driving record you will also need the driver's license number and the state that issued the license. A basic background check will determine if the social security number is legitimate and if it belongs to your applicant. Also, you may see where your subject has lived for the last seven to 15 years (which may be used in helping establish the stability of your applicant) and you may run a criminal records check that may identify any aliases or other names that your applicant uses. For an additional fee, some companies can perform a sexual offender registry search.

Arranging a Contract for In-Home Care

Contracts can be verbal or written, but they should be mutually understood. To enhance the understanding of the employer/employee relationship, the INA and other childcare and legal organizations contributed to a document, entitled the “INA Nanny and Family Agreement”. This tool is designed to solidify and enhance the partnership between the childcare provider and parents. It helps both parties understand the childcare arrangements and responsibilities, salary and benefits, work hours, vacation and sick time, and additional *perks*. It is available on the Internet for \$50. (www.nanny.org)

Back-Up Arrangements and other Pearls

Even the best-laid plans can go awry. Just as with airway management, the prepared emergency physician will need to have a contingency plan in the event of illness, injury or ill fit. With prior discussion and mutual agreement, emergency nanny services or nanny sharing may be an option. Be open with your colleagues and neighbors and have a back-up plan in place. It is wise to maintain an up-to-date list of daycare programs that allow “as needed drop off” for emergency childcare.

Remember that the first fit is not always the best fit. Changing childcare providers/settings is probably one of the most underestimated anxiety provoking experiences that moms will face. After you have searched diligently with all of your heart and soul for a wonderful arrangement for your child, it can be heartbreaking when things don't work out. Don't be afraid to change childcare arrangements just because you think that you 1) will never find someone else that will do ... 2) that your child will not love anyone else as much as “Jane” and vice-versa or that 3) that worked so well for “Sally” so it must also work for me (and my child). It is common for families to ‘try-on’ multiple arrangements until they find the one that fits right. Remind yourself as you go through the search that you are a ‘great mom’/‘great family’ or you wouldn't be so stressed about finding the best arrangement. That said, your child can feel your anxiety regarding childcare arrangements, so whatever you choose to go with, go forth confidently, watchfully and support the care provider in being the best caregiver for your child that they can be.

Summary

There are many traditional methods of in-home and out of home childcare and recently, more modern “shared” arrangements. In your absence, while you work or sleep, the most important surrogate for you is someone who can provide safe, responsible, nurturing care to your children. Allow plenty of time to explore all of these options and opportunities.

Resource List

www.localdaycare.com; National Association of Family Child Care (NAFCC). www.nafcc.org ; National Association for the Education of Young Children www.naeyc.org. The US Department of State offers information on the au pair programme in the USA.
http://exchanges.state.gov/education/jexchanges/private/aupair_brochure.htm

