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Resources for pregnant cardiologists, their partners and supervisors

Produced by the British Cardiovascular Society Working Group on: Improving resources and support for cardiology trainees and consultants during pregnancy, fertility treatment, pregnancy loss & parental leave

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SECTION 1 - RADIATION FAQs

1.1 Is it safe to work in the cath lab/EP lab while pregnant?

It is safe for pregnant operators to work in clinical areas using ionising radiation, with the correct use of appropriate radiation protection measures.

X-rays are at the short-wave end of the electromagnetic spectrum and produce high-frequency energy which can ionise atoms and can lead to single or double breaks in the DNA strands of our cells. As a result, exposure to ionising radiation can lead to DNA mutations carrying a risk of radiation-induced cancer and hereditary effects later in life. These effects of ionising radiation are stochastic which means that the probability of occurrence, rather than severity, is determined by the dose. Effective dose is a weighted sum of the doses to the radiosensitive organs and is related to the total radiation detriment and measured in Sieverts (Sv).

We are all exposed to 'background' radiation as part of our daily activities. This background radiation comes from the environment and from outer space. The average background radiation dose in the UK is 2.3mSv [1], however the dose varies throughout the UK with Cornwall averaging a background dose of 7.8mSv. Public Health England in their 2010 report on radiation exposure of the UK population [2] indicated that the average annual dose to cardiologists is 0.12 mSv which is well below the occupational annual dose limit of 20mSv and also well below the annual average background radiation dose.

A case series of 5 operators doing EP or PCI procedures throughout pregnancy found that the abdominal dose was well below the reference limit and in some cases no higher than the background radiation level[3]. Similarly a study at the Mayo clinic found that the dose measured at the abdomen was below the detection limit in 82% of women; the only women to have measurable radiation detected were working in nuclear medicine, general X ray or anaesthetics, not in cardiology [4]. Furthermore, foetal dose has been demonstrated by mathematical modelling and phantom testing to be less than 50% of the dose measured at the abdomen under the lead apron [5].

At these minimal radiation levels there is no measurable increased risk of harm to the foetus. Similarly, the radiation dose received at the abdomen is so low as to have no measurable impact on male or female fertility.

To ensure compliance with The Ionising Radiations Regulations 2017 (IRR17) regulations, your Employer has to risk assess staff who work with ionising radiation in the cath labs. The radiation risk assessment outlines all of the necessary systems of work to ensure that the dose to staff, including pregnant workers and the public is as low as reasonably practicable and well below the annual dose limits.

As for the foetus, the IRR17 regulations require the Employer to take all necessary measures to ensure the that dose to the foetus is as low as reasonably practicable and is unlikely to exceed 1 mSv during the remainder of the pregnancy [6]. The actual dose measured is generally far lower than this. All staff have the right to access their dosimeter readings and you may find it helpful to do this either before a pregnancy (so as to reassure yourself that your abdominal dose is negligible) or during a pregnancy. You can get this information by approaching your local radiation protection supervisor.

1.2 What are the potential risks to the foetus from radiation exposure in pregnancy?

Much of the data on effects of radiation on the foetus comes from animal studies and high exposure situations such as nuclear incidents[7]. Risks in these contexts include teratogenesis, decreased IQ, miscarriage, cataracts and growth restriction, however these issues have not been reported at doses lower than 100mGy[8] which is far higher than would ever be reached by an operator wearing leads.

There is also thought to be an increase in childhood leukaemia risk if the foetus is exposed to radiation[9]. The baseline rate of childhood leukaemia is 2-3/1000. There is a suggestion that this may increase by 1 extra case per 1000 (i.e. to around 4/1000) with a foetal dose of 10mGy, however again this is at much higher dose than is permitted or likely for operators[4]. At the dose limit of 1mSv permitted in the UK there is no measurable increase in risk to the foetus, and it would be exceptionally unusual to get close to this dose limit.

1.3 Are there any special/additional radiation protection measures that I should take in pregnancy?

Your employer needs to assess the risk to you and your baby for the duration of your pregnancy. They need to take all reasonable steps to keep the dose to your baby as low as reasonably practicable. You will also need to follow the Local Rules which outline the steps that you need to take to keep yourself, your baby and others safe whilst working with radiation.

If you are already compliant with standard radiation protection measures (summarised below) you will not need to make major changes to your practice. You will need to wear your dosimeter consistently under your lead apron at the waist. You will also need to take care of your lead apron and wear it for all procedures using radiation. You will also need to make sure that the fit is good with no gaps under the armpits, on the sides and around the waist and report to your local Radiation Protection Supervisor if the lead apron is damaged. Clearly these are measures you should already be taking pre-pregnancy. Some centres utilise real-time dosimeter systems which can provide further reassurance.

A small number of operators with higher than average body dose may require adaptations to their workload/personal protection so as to stay under the 1mSv foetal dose constraint. These operators will generally already be aware that their personal doses are above average. Your Radiation Protection Supervisor will let you know what lead equivalence your lead apron should be (e.g. 0.35mm lead) and ensure that the lead fits well throughout pregnancy. Wearing leads that are at least 0.5mm equivalent will stop 98% of scattered radiation versus a 0.25mm lead which stops 96% [10]. Adequate overlap of leads is also necessary to ensure full protection throughout pregnancy as some “0.5mm” leads provide 0.5mm protection when overlapped at the front of a skirt, but only 0.25mm protection when a single layer. Specific 1mm lead equivalent maternity leads or extra abdominal leads are unnecessary and may increase the risk of musculoskeletal injury.

In terms of personal rather than foetal protection, operators can consider wearing leads with a humeral shield (theoretically of benefit but no definitive evidence), or at a minimum make sure there are not large gaps around the arms, to minimise the exposure of metabolically active breast tissue to radiation.

1.4 When should I inform colleagues and radiation protection staff of my pregnancy?

Although not mandatory, it is advisable to report your pregnancy relatively early so that your employer can implement the 1mSv dose limit [1]. It is advisable to speak to your radiation protection supervisor in confidence as soon as possible even if you do not yet feel ready to inform medical staffing or your educational supervisor. If you work with radiation for multiple employers, you will need to inform all of them of your pregnancy, so that they can take all reasonable steps to keep the dose as low as reasonably practicable across all employment. If you are not sure, please speak to your local Radiation Protection Supervisor or your local Radiation Protection Adviser.

1.5 Are there any risks to me if I am still breastfeeding when I return, and should I take additional measures such as humeral shields to mitigate this?

Without a humeral shield, the axillary portion of the breast is potentially exposed to scattered radiation, however there are no direct data on specific risks to breastfeeding operators. It has been suggested that occupational radiation exposure may increase the risk of breast cancer in general, outside the context of breastfeeding [11] . The highest risk however, was in women who had worked with radiation prior to 1940 so well before modern radiation protection measures.

It has also been hypothesised that female interventionalists may be at increased risk of left sided breast cancer [12] although it is difficult to suggest a causal association as the numbers are small. Furthermore other studies do not support a link with radiation exposure [13] and it is not clear whether the incidence of breast cancer in female cardiologists is higher than in the general population [11, 12, 14, 15].

The breast is thought to be more sensitive to radiation in pregnancy and in the first month post partum because of the peripartum proliferation of glandular breast tissue [16, 17]. This risk is unlikely to extend to an operator returning to work still breastfeeding a period of months later, as the changes in the breast tissue are in pregnancy and around the time of delivery rather than ongoing with continued breastfeeding. There is no evidence to suggest that breast milk quantity or supply will be affected by radiation in the cath lab.

In summary there is little difference in risk for operators who are breastfeeding versus those who are not, however female operators may choose to wear a humeral shield irrespective of this so as to minimise their radiation exposure over the course of their careers.

1.6 If I am keen to work in the lab but am having musculoskeletal issues with standard leads is there a requirement to provide me with lightweight leads?

Operators should seek standard radiation protection and a desire for lighter leads must not compromise this protection. If you are having musculoskeletal issues, then you should have a specific occupational health assessment and appropriate recommendations can be made accordingly.

1.7 Should a radiation protection drape be used in all cases in pregnancy?

A radiation protection drape such as the Radpad is a drape that is put on the patient and reduces scatter to the operator however it does not affect abdominal dose under leads and therefore is not specifically required in pregnancy. There is no direct evidence to support a significant reduction in staff body doses by using Radpad drapes when staff wear lead aprons [18].

1.8 What would be considered optimal radiation protection, pregnant or not – should we all be wearing skull caps and shin shields?

All operators should wear leads that cover the torso, abdomen and pelvis and thyroid shields. If the radiation risk assessment indicates that additional protection is required, (e.g. lead glasses or shin shields), then your employer will provide you with the additional protective equipment and you, as employee, have a legal duty to wear and take care of the protective equipment.

There is no strong evidence to support a significant reduction in radiation risk when lead caps are used assuming all other protective measures are in place for example, the use of a ceiling suspended lead screen, table lead drapes, lead glasses, thyroid shield and a lead apron[19, 20]. Shin shields can reduce the radiation dose but this does not necessarily translate to a significant reduction in radiation risk[21]. If the doses to the legs of the operator are small, wearing shin shields will not significantly reduce the radiation risk.

Your employer by law must assess the radiation risk for all staff who work with radiation, including pregnant staff. The radiation risk assessment and the Local Rules list the personal protective equipment that employees need to wear when working with radiation. If you have specific questions about protective equipment, speak to your Radiation Protection Supervisor or your Radiation Protection Adviser.

1.9 If I decide I do not want to work with radiation in pregnancy do I have the right to stop doing this type of work, and will it affect my training?

It is safe to work in the cath lab/EP lab in pregnancy provided the right precautions are taken and therefore radiation concerns alone should not be a reason to avoid working in the lab. There are many other potential reasons that may mean an individual cannot work in the lab in pregnancy and these will require a local assessment by occupational health. Where possible, alternative training activities should be offered, but this may not be possible in all settings or subspecialties. It should certainly be possible to make up for lost training opportunities after the pregnancy however in some cases this may require an extension of training. It would usually be expected that unless the pregnant trainee has come off the on call rota, they will come to the cath lab as required for emergency procedures even if otherwise opting out of cath lab based training.

1.10 Who can I speak to (either locally or nationally) for additional advice? Where can I get more information?

Your local radiation protection supervisor and your local radiation protection adviser will be a good source of advice. Some useful weblinks are listed below.

https://rad.womenasone.org

https://doi.org/10.1002/ccd.22877

SECTION 2 - FERTILITY TREATMENT FAQs

Each assisted fertility treatment journey is unique to the individual. These FAQs are to aid the individual to have a constructive dialogue with their colleagues/supervisors, and to ensure that both the individual's wellbeing and the wider service are accounted for. It will be useful for you to check your Employer's Annual Leave, Sickness / Absence, Maternity Leave and special leave policies; to familiarise yourself with your local policies. Also remember that you are not the alone in this process and many will have had experience of this.

2.1 Who should I approach about impending fertility treatment?

It is not mandatory for you to tell anyone. Due to the unpredictable nature of assisted fertility treatment, it is generally a good idea to consider discussing your plans with a few key people including:

- Your educational or clinical supervisor if you are a trainee
- Your line manager. If you need a risk assessment for working whilst pregnant (for example after an embryo transfer) it would usually be your line manager who would do this
- Occupational health – in some organisations you can self-refer, in others it is arranged through your line manager or HR Service.
- Human Resources or Medical HR
- It may be sensible to talk to whoever writes your rota after speaking to some of the above individuals.

2.2 What is involved?

A typical IVF cycle involves attending appointments for consultations, investigations, consent signing, taking injections at specific times and of course egg collection and embryo transfer. One key aspect is that the timings of treatments are subject to last minute changes. You have similar rights as pregnant trainees once embryo transfer has been completed. Clomid and IUI cycles involve similar appointments as above without egg collection and embryo transfer.

2.3 Can I leave at short notice if necessary, for appointments? Do I have to arrange cover for these appointments? What if I am on call?

As best as one can, try to give the relevant people adequate notice of appointments; typically the fertility clinic provides you with a schedule. From this, you may be able to arrange swaps with your colleagues, and your supervisor or rota coordinator might be able to assist in this process. You may also find that your fertility clinic is accommodating of your work schedule and able to have early

morning/late evening appointments. Understandably, as with any medical diagnosis, there may be unexpected appointments that come up at short notice.

By law, you have the right to reasonable time off with full pay to attend pregnancy-related appointments (these may be medical, antenatal or parenting classes). You have this right from the first day of your employment whether you work full time or part time. In order to minimise disruption to the service it is reasonable for employees to try to arrange their appointments outside of working hours wherever possible. However, we recognise it is not always possible to do this, therefore employees must provide as much notice as possible so that cover can be provided.

2.4 Am I entitled to time off to attend my appointments? Are appointments to be taken as annual leave/sick leave/special leave/time owing?

There is no statutory right to time off for IVF treatment until embryo transfer has taken place. There are usually a range of options open to staff to enable them to attend appointments. However most organisations have local policies in place to support employees and managers to accommodate such appointment.

Managers should not unreasonably refuse requests for additional annual or unpaid leave to attend appointments. In some regions of the UK there is the option of completing a single 4 month block at 80% as a type 3 LTFT trainee (choose to train LTFT as a personal choice that meets their individual professional or lifestyle needs). From August 2022 all cardiology trainees will be able to opt for type 3 LTFT training but total numbers of type 3 may be capped. Alternatively trainees can also apply for type 1 LTFT training.

2.5 Is it reasonable to ask for reduced clinical commitments following an embryo transfer?

As described above, each individual is unique, and this too will be a personal decision. If one chooses to take time off, then this would have to be taken as annual leave.

2.6 What if I experience side effects of the treatment, can I take time off?

Episodes of sickness absence which may occur as a result of the treatment will likely be managed under your local sickness policy and will be recorded as normal sickness absence. The exception to this is upon the implantation of a fertilised embryo, after which any absence will be recorded as pregnancy-related sickness. If the treatment is unsuccessful, any absence will continue to be recorded as pregnancy-related sickness for two weeks after the woman is informed that the implantation was unsuccessful.

2.7 Should partners get time off for fertility treatment appointments?

If your partner is undergoing fertility treatment, then understandably you would wish to be there for support. Additionally, you might be required to attend certain appointments together, e.g. consent, collection and transfer days. There is no statutory right to time off for this purpose however most organisations have local policies in place to support employees and managers. A woman is deemed to be pregnant from the point of implantation and an employee would be entitled to paid time off for antenatal appointments from this point. Partners of pregnant women are entitled to unpaid time off to attend two antenatal appointments.

2.8 Where can I get support?

This process is highly emotional, and it helps to have a supportive team.

- You can access Occupational Health and associated counselling services
- Some Trusts have access to Employee Assistance programmes that have 24/7 counselling services
- Your GP
- If for whatever reason you find the environment that you work unsupportive, raise this with your TPD and your deanery
- All fertility clinics have resident counsellors
- https://fertilitynetworkuk.org/
- For some people, talking to others who have undergone treatment might be helpful, and there are several groups online.

SECTION 3 - PREGNANCY LOSS FAQs

Miscarriages are common; approximately 1 in 4 pregnancies result in pregnancy loss. Going through a miscarriage can often be a lonely process. It is both physically and emotionally challenging, with women experiencing heavy bleeding and severe pain in addition to the mixture of negative emotions which may include sadness, guilt, jealousy, anxiety and loss of hope. These emotions may also be felt by the partner of someone experiencing a miscarriage.

3.1 I, or my partner, have just suffered a miscarriage. What compassionate leave am I entitled to?

In the event of a miscarriage, the usual sickness provisions will apply. You can self-certify for seven days, after which you will need to get a 'fit note' from your GP who can assess how long you may need off work. Sick leave after a miscarriage, ectopic or molar pregnancy is considered 'pregnancy-related' and does not count as a sick leave 'trigger'. Although you may physically be able to return to work, you should also consider your emotional well-being when determining the appropriate time to return. We do not recommend a 'fixed recommended time' to be off work as every person is different and may have different needs and whilst some may need more time, others may require less.

The partner of someone who has suffered pregnancy loss is entitled to compassionate leave although this is up to your employer's discretion. If you feel unable to work, you can request a 'fit' note from the GP. If you have undergone termination of pregnancy (for any reason), you are entitled to sick leave for the procedure and for a period of time after. This should be treated like a miscarriage in terms of sick leave.

Please see https://maternityaction.org.uk/advice/miscarriage-stillbirth-and-neonatal-death-rights-to-time-off-and-pay-for-parents for further information.

3.2 I have just suffered a stillbirth. What compassionate leave am I entitled to?

You are entitled to maternity leave and pay if your baby was delivered at the end of 24th week (or beyond) of pregnancy. If a miscarriage occurs before the end of the 24th week, you are not entitled to maternity benefits but your Trust should offer compassionate leave. If you have medical complications of a miscarriage, the provisions within the sickness policy will apply.

I am at work and I think I am miscarrying. What do I do?

You should speak to your consultant or the consultant on-call as it is unlikely to be appropriate for you to continue working. Advice should be sought from an Early Pregnancy Assessment Unit or A&E if it's an emergency.

3.3 Who do I need to tell after I or my partner has had a miscarriage?

We advise you to speak to your educational supervisor or a trusted colleague who can provide you with support. You should not feel pressured to tell anyone else at your workplace as it is your right to keep this confidential.

3.4 Is there anyone else I can speak to?

There are several people within and outside of your workplace that may be helpful in terms of practical advice or emotional support. These include your training programme director, line manager, clinical lead, occupational health, the NHS Practitioner Health (https://www.practitionerhealth.nhs.uk) and/or your GP.

3.5 Am I required to "pay back" clinics and on-calls for my period of absence?

No. Your employer should fill the shifts as 'bank' or 'locum'.

3.6 I miscarried 4 weeks ago and still struggling at work. Who can I turn to for help?

Returning to work can be hard as there may be things that are 'triggers'. It is worth thinking about this in advance so that you are prepared.

The Miscarriage Association (www.miscarriageassociation.org.uk) is a useful resource which provides support and information for women that have been affected from miscarriage, ectopic pregnancy and molar pregnancy. They also provide online support, support groups and a helpline. The website has a wealth of information including policies and guidance notes for employees, managers, HR and colleagues. If you would like to know more about your rights or specific circumstances regarding stillbirth and neonatal death, please visit https://maternityaction.org.uk

The NHS Practitioner Health (https://www.practitionerhealth.nhs.uk) is a free service for doctors in the U.K. who have concerns regarding impact or function at work related to a mental health concern. It is a specialised confidential service aimed to improve mental well-being of the NHS.

SECTION 4 - HUMAN RESOURCE FAQs

We advise that these FAQs are read in conjunction with your local Trust Maternity Policy and the Gov.uk website Pregnant employees' rights - GOV.UK (www.gov.uk). All of the information below is applicable to all grades of trainee or consultant, regardless of whether they have a temporary or permanent contract. The only exception is agency locum staff.

4.1 If appointments fall during working hours, do I have to make this time up later? Do I have to rearrange on calls in order to attend my appointments?

By law, you have the right to reasonable time off with full pay to attend pregnancy-related appointments (these may be medical, antenatal or parenting classes). You have this right from the first day of your employment whether you work full time or part time. In order to minimise disruption to the service it is reasonable for employees to try to arrange their appointments outside of working hours wherever possible. However, we recognise it is not always possible to do this, therefore employees must provide as much notice as possible so that cover can be provided.

4.2 Who authorises time off and arranges cover if I have an appointment at short notice?

This may differ depending on the managerial arrangement of your service and your Trust but generally it is advised that you speak to your lead consultant (Clinical Supervisor), operational manager or rota co-ordinator/medical HR contact as soon as you are aware of the appointment. Your key contacts are likely to be the same people that you will contact when booking annual leave/advising of sick leave.

4.3 What are the rights of the non-pregnant partner in terms of attending both routine and short notice antenatal/IVF related appointments?

Partners of pregnant women are entitled to unpaid time off to attend two antenatal appointments.

4.4 Do I have to take annual/unpaid/sick leave for antenatal appointments?

No, by law, the individual who is pregnant has the right to reasonable time off with full pay to attend pregnancy related appointments.

4.5 If I cannot do certain procedures due to health concerns during pregnancy do I have to make this time up later?

Most pregnant individuals can continue the full range of duties for the majority of their pregnancy. If you have health concerns relating to your pregnancy that preclude you from undertaking parts of your role you should provide a GP certificate to your line manager. Your employer may also seek

occupational health advice and you must complete a risk assessment. Pregnant trainees unable to do certain procedures may need to catch up on these procedures at a later date according to what is required for competency sign off.

4.6 Who specifically do I have to inform in terms of training, pay, plans to take maternity leave etc?

All employees must tell their employer about their pregnancy at least 15 weeks before the beginning of the week the baby is due. You should first advise your line manager who may be your lead consultant or clinical supervisor. This individual should involve your service operational manager and member of your Trust HR / Medical HR team as soon as possible; the sooner you can advise your employer the sooner that support can be put in place.

The Trust maternity policy will provide you with guidance to completing the paperwork including risk assessments and your local HR team will advise you about pay and annual leave. It is also important to advise Health Education England ('The Deanery') so that your training programme can be amended to take into account your maternity leave. If you are about to rotate to another Trust it is also important they are made aware of your pregnancy and maternity leave so that they may make the appropriate arrangements.

4.7 Is the sick leave allowance the same in pregnancy as outside pregnancy? If I have a lot of time off because of hyperemesis does this take me over my sick leave allowance?

Your Trust will record your pregnancy-related absence, but it will be considered separately from other sickness absence. Pregnancy-related absence will not be counted towards any review or trigger points within your organisation's absence policy. Support should also be offered to you. Your sick pay entitlement will be in line with your length of service. If an employee is off work due to a pregnancy-related illness within 4 weeks of the due date, maternity leave begins automatically. This is unless the Trust and the employee agree to delay it for reasons of health and safety for example.

4.8 If I move hospitals part way through a pregnancy how can I ensure my maternity pay is calculated correctly?

We advise you speak to your HR / Medical HR team at your current Trust. Also, please refer to the NHS General Maternity Guidance Document.

4.9 Does spending time outside the NHS (eg on a university contract during a research degree) affect my entitlement to occupational maternity/paternity pay/shared parental leave and pay, in particular if my/my partner's due date is within 12 months of returning to NHS work or within 12 months of starting a university contract? Does holding an honorary NHS contract during this time period change this?"

It depends on the contractual arrangement with your employer as to whether a contract with another organisation counts towards your continuous service. The relationship a Trust has with an academic centre (for example) will vary from region to region. Continuing to hold an honorary contract does not necessarily protect your employment status with the provider. You should speak to your HR team.

4.10 I/my partner are adopting a child, what leave and pay am I entitled to?

The main adopter of the child is entitled to 52 weeks Adoption Leave consisting of 26 weeks Ordinary Adoption Leave (OAL) and 26 weeks Additional Adoption Leave (AAL) regardless of length of service, hours worked or pay, provided that they continue to be employed 14 days before the placement date. Adoption pay will vary depending on length of service with the NHS and your current Trust. Please refer to your Trust's Adoption / Shared Parental Leave Policy for further information.

SECTION 5 - SHARED PARENTAL LEAVE

5.1 What is Shared Parental Leave?

Shared Parental Leave (SPL) is an attempt to distribute time previously allocated to maternity leave between a mother and their partner[22]. You can share up to 50 weeks of leave between partners (and fathers/partners can take 2 weeks statutory paternity leave in addition).

5.2 Who can take Shared Parental Leave?

SPL can be taken by a mother, adopter or partner sharing responsibility for raising a child at the time of its birth and providing the mother is eligible for statutory maternity or adoption pay/leave (or maternity allowance)[23]. There are further eligibility criteria available online[23, 24].

5.3 What pay can I expect during Shared Parental Leave?

Previously the terms of junior doctors' contracts meant moving to SPL usually meant lower combined income between a mother and her partner, placing a financial disincentive against parents choosing this option. In April 2019, however, shared parental pay in England was enhanced to the same levels as occupational maternity and adoption pay [25], aiming to maximise uptake of SPL. Unfortunately, renegotiated terms have yet to be agreed on consultant and SAS doctor contracts. Full details of remuneration would depend on the mother and partner's exact employment, but for doctors is six weeks' full pay, 18 weeks' half pay plus any statutory shared parental pay, 13 weeks' statutory shared parental pay, and 13 weeks' unpaid leave [23].

5.4 What advantages are there to Shared Parental Leave over maternity leave?

SPL allows leave to be requested in non-continuous blocks (unlike maternity leave) which may provide greater flexibility for mothers. Additionally, there are 20 Shared Parental Leave In Touch (SPLIT) days available to those on SPL (compared to 10 equivalent days on maternity leave) [23]. SPL also allows greater involvement in caring duties from partners during the early years of a child's life – either simultaneous with a maternity leave or (if also on SPL) to allow alternating blocks of work and care between partners.

There are many reasons to choose SPL for mothers, partners and their children, and it can result it flexible and rewarding parenting experiences for all involved, but early contact with employers and human resources departments for both parents is strongly recommended.

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