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Royal College of Paediatrics and Child Health
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Pregnancy Loss and Fertility Issues in the workplace

Purpose:

Included within this document is information relating to reducing risk of adverse outcomes in pregnancy and specifically on miscarriage, threatened miscarriage, recurrent miscarriage, ectopic pregnancy, molar pregnancies and assisted reproductive therapies. These include In vitro Fertilisation (IVF), Intracytoplasmic sperm insemination (ICSI) and Intrauterine insemination (IUI) using a couple's own eggs, own sperm, own embryos, or donor eggs, donor sperm or embryos from a known or unknown donor. It also includes unsuccessful assisted reproductive therapies such as implantation failure, along with stillbirth (in utero and ex utero) and termination of pregnancy.

This document has been produced by resident doctors in training within paediatrics and obstetrics and gynaecology (O&G). This has now been expanded to consider all specialities and has included additional occupational medicine resident input.

We feel well placed to understand the complexities that can arise within the workplace in relation to this subject matter. We aim to help others understand the emotional sensitivity and psychological impact of the subject within the workplace. It may be more emotionally triggering for those experiencing pregnancy loss or fertility problems whilst working within these specialities. The work can involve direct exposure to newborns, babies, infants, or sadly child death, pregnant women or women who are miscarrying which can be particularly challenging and triggering when going through similar adversity. We also recognise that there can be triggers and challenges across all specialties and this should be remembered and considered for any resident doctor or indeed health care professional dealing with these issues. We hope this guide can support resident doctors and managers when faced with these circumstances and promote sensitive and supportive conversations. Vignettes of resident doctors experiences have been included to harness the impact of these traumas on people's lives but also to understand the collective responsibility and importance surrounding this subject.

On 13th March 2024, NHS England[1] released "The National pregnancy and baby loss" people policy framework. This is a big step in the right direction in helping to open up channels of communication and acknowledgement of how traumatic a pregnancy loss can be for so many along with supportive recommendations. NHS staff in England who experience a miscarriage will now receive up to **10 days additional paid leave**.

There is no specific legal protection for those undergoing fertility treatment (or their partners) and infertility itself is not considered a disability under the Equality Act.[2] However, the Equality and Human Rights Commission (EHRC) recommends

that employers handle requests for time off with understanding and care.[3]

This document is intended to provide:

- Best practice for supporting resident doctors after pregnancy loss or during fertility treatment.
- Guidance around time off after pregnancy loss or during fertility treatment.
- Considerations for supported return to work and temporary change in duties if required.
- Signposting to support available locally and from other organisations.

Background

Pregnancy, baby loss and fertility issues are singular journeys, they are not linear and can impact on mental health and wellbeing as well as career progression. Trying for a baby will be the most significant thing in your life when you are in the middle of it even more so when faced with challenges. The idea that we do this in isolation from our working lives is unrealistic. Women and their partners need the confidence that their workplace and work environments can facilitate open supportive conversations whatever the outcome. When a pregnancy doesn't go to plan, this will be an emotionally complex and distressing period in people's lives. It is important to ensure people feel supported and that open dialogues take place in the workplace. Paediatrics and O&G are considered family orientated specialties; therefore, we feel it is important that they lead by example, but of course residents from any specialty may be affected. Many resident doctors will start to consider starting/growing their families during the course of their training. This period is short in relation to the lifetime of a career in the NHS, but one which should be handled appropriately and sensitively. If done well, it will provide individuals with a feeling of support, the space to process, reflect and grieve and an overall sense of feeling valued. Supporting resident doctors should be focused on their individual needs and managed on a case-by-case basis.

A survey undertaken by Fertility Network UK in 2022[4], examined the impact of fertility challenges and treatment. It reported that:

- 58% of women felt concerned that fertility treatment would affect their career prospects.
- 36% felt their career was damaged because of treatment.
- 15% either reduced their hours or left their job.
- 77% disclosed their fertility journey to their employer but only 47% of these said that adjustments were made.
- Only 45% felt they received good support from their employer and only 25% reported the existence of supportive workplace policy (and 19% were not sure whether there was policy).

- In terms of the emotional impact of fertility, 83% of respondents felt sad, frustrated and worried often or all the time as a result of fertility problems and/or treatment.
- 47% experienced feelings of depression often or all the time, and 10% experienced suicidal feelings often or all the time. This report further shines a light on the importance of speaking out about this subject area.

Content

1. Pregnancy

(Please note this guide includes advice about pregnancy but recognises the trigger this may cause to its audience)

1.1 Notification of Pregnancy.

Each pregnancy is unique to the individual and telling people you are pregnant can be a daunting prospect even more so if you have experienced loss or had to pursue fertility treatment. Legally you do not need to tell your employer you are pregnant until the end of the **15th week before your due date** (when you are 25 weeks' pregnant) but it is best to tell your employer/HR department along with your ES as soon as you feel comfortable. This is important as the employer has a legal duty to protect the health of pregnant workers and new mothers.[5] You will

need to provide a Mat 1B (maternity certificate) form to your employer, which your midwife (or GP) will provide you with at about your 20th week of pregnancy.

You will need a pregnancy risk assessment, which is the responsibility of the employer and may be assisted by occupational health, where depending on the nature of your work accommodations may be made to your work schedule, including amended duties along with protected time to attend antenatal appointments.

Workplaces' may have a designated person with appropriate experience to support managers in undertaking a risk assessment. Your workplace should have documentation to facilitate and record the assessment. A risk assessment should be performed as soon as practically possible after being informed a resident doctor is pregnant and no later than 3 weeks after the information has been received.

Importantly, the law requires employers to manage the risks to all women they employ of a childbearing age, pregnant workers and new mothers.[5] It is essential to consider all the potential hazards and the likelihood and impact of harm arising, and to identify mitigating actions. There are risks which will be applicable to all staff, but each specialty will have specific hazards, for example surgery, radiology and oncology, as well as those relevant to paediatrics and O&G and these need to be considered appropriately. We have expanded on potential hazards and associated risk in pregnancy in the appendix at the end of this paper.

During risk assessment specific consideration should be given to:

- Physical demands (moving and handling, duration of on call shifts, shift patterns)
- General conditions (lone operating, lone on calls, adequate rest)
- Mental demands of the job

If the risk cannot be controlled or removed, then the department must either:

- Adjust working conditions or hours
- Offer suitable alternative work (on the same terms and conditions, including pay)

If the above is not possible, to suspend the worker on paid leave for as long as is necessary to protect the pregnant worker's health and that of their child. A copy of the formal risk assessment must be returned to the lead employer and/or HR department and any potential or significant changes to working practices highlighted. If the resident doctor changes host trust/hospital during pregnancy then a further risk assessment is required based on the new job, premises, working environment etc. For further information see BMA website.[6]

1.2 Threatened Miscarriage/Pregnancy Loss

- **Who do I tell if I am concerned that I am miscarrying or having a threatened miscarriage**

  This is a very distressing situation to be in, one which should be dealt with sensitively and confidentially. If you are bleeding either on shift or at home and due to work, inform your educational supervisor, on call consultant or staff member you feel most comfortable with as soon as you can. Every effort should be made to remove you from your shift, and alternate cover arranged until you are well enough to return. Your physical and mental wellbeing are of utmost importance and therefore should be prioritised. Please contact your GP, midwife or local early pregnancy assessment unit (EPAU) as soon as possible for further advice and review along with a sick note, pregnancy related absence does not trigger a sickness review and is recorded differently.

- **Am I entitled to time off if I miscarry?**

  Yes you are entitled to statutory bereavement leave for 10 working days as per the NHSE "National pregnancy and baby loss people policy framework".[1] Sometimes you may require prolonged follow up. This is not only a sensitive time, but a stressful one and unique to the individual. Miscarriages can require medical or surgical intervention with secondary complications, this is not be disregarded. Further time off can be reviewed at any time and extended leave discussed with your GP, EPAU and OH along with your ES/manager. Sick leave rules apply and return dates should be discussed in advance, especially if you need more time.

- **Can I discuss amended duties or time off if suspected miscarriage/miscarrying?**

  Yes. Sick leave or compassionate leave applies. It involves a conversation with your team (Consultant, ES and OH). If you suspect you are miscarrying, it is strongly encouraged you do what is right to protect your physical and mental wellbeing. Amended duties should be discussed upon your return to work, when you feel ready.

- **I am finding it hard to see babies and pregnant women, including colleagues, at work.**

  This is completely understandable and can be very distressing. Grief is not linear and can strike at any time, but can be made worse when faced with certain triggers or stimuli in the workplace. Work should be a place of safety and not one in which provokes distress.

  It can be difficult to advocate for yourself, therefore supported return to work discussions should be had with your TPD, ES, or return to work champion in advance. If you feel they do not understand or support your concerns, seek advice from OH. Work amendments, such as a graded return to work, altered working hours with a supervised return may need to be made for a period of time. Some resident doctors might find being on neonatal units, labour ward,

postnatal wards, baby check clinics, theatres for deliveries and so on, difficult and very triggering. Working alongside pregnant colleagues and patients can also be very triggering and so where possible, flexible working or working from home if practical should be considered and supported for a period of time. This is also supported by NHSE National Pregnancy and Baby loss policy framework.[1]

- **Where can I get support?**

  - Your local miscarriage clinic or local EPAU who can guide you to local support services or resources.
  - Your local hospital/trust will offer staff wellbeing support.
  - Tommys:https://www.tommys.org/baby-loss-support/miscarriage-information-and-support.[7]
  - Miscarriage Association: https://www.miscarriageassociation.org.uk.[8]
  - Consider a pregnancy loss counsellor and seek support from your GP.

1.3 Recurrent Miscarriage

Recurrent miscarriage defined by RCOG Green top guideline[9], is when you have unfortunately experienced three or more first trimester miscarriages. One miscarriage alone is very upsetting and this can be an incredibly distressing time for you, your partner and your family.

- **Am I entitled to time off?**

  Yes. Your local EPAU can offer you a fitnote, as can your GP or other members of the primary care team. OH can also advise you to be off work. This now can be called bereavement leave as opposed to sick leave as per NHS England policy.[1] As per the miscarriage advice above regarding time off, please speak to those who you feel comfortable with. This is a very sensitive and difficult time and unique to the individual. Tests and investigations may be offered; therefore you will need protected time to attend these appointments. Measures should be put in place to support you on your return to work when you feel ready.

- **Where can I find support?**
  Please see reference below for the following:
  Tommys[7,10] Miscarriage Association[8], Sands[11] and Petals[12]

1.4 Termination of Pregnancy

This may be for medical or social reasons. Occasionally, differences in the development of the fetus may be detected and a decision may need to be made about whether or not to continue with the pregnancy. This can be an incredibly difficult decision to make. A lot of the advice above that applies to miscarriage around time off and support applies to termination of pregnancy as well.

Sometimes, you may need to make the decision to terminate the pregnancy due to social reasons, which can be equally as difficult. Most terminations of pregnancy are funded by the NHS but performed outside of acute NHS Trusts by organisations such as British Pregnancy Advisory Service.[13]

- **Am I entitled to time off when I am making this decision**?

Yes, sick leave or compassionate leave applies. This should involve a sensitive conversation between the resident doctor and ES and/or OH. Amended duties should be discussed between you and manager upon your return to work, when you feel ready.

- **Am I entitled to time off following a Termination for medical reasons (TFMR)?**

Yes bereavement leave for pregnancy loss as per NHSE policy[1] applies. The same advice applies about returning to work and amended duties as for miscarriages.

- **Where can I go for support with this decision and to find out more about my options?**
    - Antenatal Results and Choices[14] is a charity that offers impartial information for parents having to make these difficult decisions. This includes a helpline to be able to talk things through with a trained member of staff.
    - Tommys baby loss support [15]
    - Sands[11] have good information about TFMR.
    - Petals[13] also can provide counselling for all types of pregnancy loss.
    - British Pregnancy Advisory Service (BPAS) [10]

1.5 Preterm Birth

Some women may be at higher risk of preterm birth when they are pregnant. In England and Wales in 2022, 7.9% of births were preterm (before 37 weeks' gestation).[16] The majority of preterm births happen without explanation but there are some known risk factors for preterm birth. Those with any of the following risk factors, are likely to be under the care of a preterm birth prevention clinic from the first trimester:

- previous birth before 34 weeks
- previous late miscarriage
- the 'waters' (amniotic sac) have broken before 34 weeks' in a previous pregnancy
- previous surgery to the cervix after an abnormal smear test
- an unusually shaped womb
- women expecting more than 1 baby
- previous caesarean section at full dilatation

Women who are known to be at risk of preterm birth are likely to be understandably anxious during the pregnancy. They may need to attend additional clinic appointments and scans. These appointments will not be taken as sick leave but pregnancy related leave.
Some people will need treatment to reduce their risk of preterm birth and this may include progesterone pessaries or a cervical suture (whereby a stitch is placed in the cervix, usually under spinal anaesthetic). The preterm birth clinic will help guide time needed away from work and amended shift patterns/ duties on an individual basis. This should be supported by the department.

1.6 Complicated pregnancies

There are many intrapartum conditions that can arise in pregnancy. Some of which include:

- Acute fatty liver
- Anaemia
- Antiphospholipid syndrome
- Fetal growth restriction
- Gestational diabetes
- Group B Strep in pregnancy.
- Hyperemesis gravidarum/HELLP syndrome
- Intrauterine infections
- Obstetric Cholestasis
- Placenta previa
- Pre-eclampsia
- Type 1 or 2 diabetes
- Weak cervix

These will require extra care due to the associated risks and will require more frequent appointments, tests, along with close monitoring. The priority is a safe pregnancy. This will be a very anxious time. Please discuss this with your obstetric team, for further guidance. Let your ES know and liaise with OH to discuss work amendments as required. You may be advised a period of bed rest for which this would fall under pregnancy related sick leave.

2. Assisted reproductive treatment

If undergoing fertility treatment to help conceive or sustain a pregnancy, this can be a very stressful time for you and your partner. If you feel able, discuss this with your ES and/or rota coordinator along with OH so they are aware and can support and advise appropriately. Depending on what protocol you are commenced on, downregulation, ovarian stimulation and egg collection can take anywhere from 2 to 6 weeks, this will be a very tentative time, as cycles can get cancelled due to lack of response to treatment or side effects. The frequency of scans and appointments are individual to the person and the clinic where you are having your treatment. Therefore, flexibility is required. Although there is no legal right to time

off work for IVF, employers should treat your IVF appointments and any sickness the same as any other medical appointment or sickness.[17]

If you are having a fresh transfer, the time from egg retrieval to transfer is up to one week, if you are having a frozen transfer there will be a period of time off medications. This will be a time of trepidation as there is no guarantee of an embryo developing. Should an embryo transfer take place, there will be a period of time where the person is on bed rest/amended duties, this will be guided by the clinic. Please ask your fertility consultant for a letter if you experience difficulty protecting this time off. Should a resident doctor require extended time off then a fit note from the GP or other member of the primary care team can be obtained. Once an embryo is transferred, the individual is protected under pregnancy related legislation. You are still protected by law against discrimination relating to pregnancy, as pregnancy is a protected characteristic under the Equality Act 2010[2], for 2 weeks after finding out an embryo transfer was unsuccessful. This can be classed as bereavement leave as per NHSE 2024 policy[1].

If you feel like you require a period of amended duties whilst having IVF, although this will be a matter for the employer and your ES, OH may be able to help advise you. Your fertility consultant will also be able to provide advice. If so, they should write you a letter with these recommendations. This can be particularly relevant after your embryo transfer, where you may feel that not being on call or working long days would benefit you.

- **At work who should I approach about my fertility concerns?**

  Approach someone you have a rapport with, this will ultimately ensure you feel supported. You may find this support with a peer, a ward sister or consultant supervisor. Fertility concerns are not exclusive to health and training and can include financial pressures, relationship strains, logistical challenges and more. Some couples undergo fertility treatment abroad therefore will require open and supportive conversations with managers.

  Having open conversations with your ES should enable you to gain the correct support or be referred to the right support you may need in regard to training and being at work. OH will be able to advise on potential work amendments or change of duties for the employer and/or ES to consider. This may be for a period of weeks or months and discussion can be had at any time throughout the treatment course.

  Further support can be found through your TPD or HoS, particularly if you are seeking an adaptation to your training programme. You may consider time out of training, via going out of programme, again this can be discussed your TPD.

  Health related concerns can be answered by your fertility specialist. Outside of work, most fertility centres provide counselling support as part of the treatment package, but every effort should be made to offer staff psychological support to the resident doctor should they need or want it. This is a very stressful time for

anyone, let alone resident doctors who may be dealing with pregnant women and babies.

- **Protected time for treatment appointments?**

  Treatment and scan appointments should be treated as any medical appointment, it would be usual in the NHS to be given time off to attend these. NHS employees would not be required to take this as annual leave. If possible, let your rota coordinator/ES know as soon as you have a rough timeline of your scan appointments with the appreciation that this process requires flexibility around your cycle and response to treatment. It is reasonable to ask for amended shifts/clinical hours. This is person specific and depends on individual circumstances. For example, you may not wish to work extensive hours post embryo implantation. For the majority it is physically safe to return to work after a period of time off post embryo transfer, this is a decision that is made between you and your fertility team as each case is unique, there are many elements to fertility/IVF and this should be explored on an individual basis. If you feel strongly about reducing shifts, and do not feel supported by the department, please ask for a referral to OH who will be able to provide an objective recommendation to the employer/ES based on your clinical needs.

Personal words from resident doctors who underwent fertility treatment

"I hope my journey highlights some of the weight individuals carry whilst undertaking IVF whilst also trying to multitask a demanding job and training post"

"*I am in a same sex relationship and we now have two beautiful children. My wife and I had very different reactions to the same hormones but I was left feeling low in mood, which is very abnormal for me. Long days were 15+ hours on a good day. I was working full time.*"

"*I didn't really know who to professionally turn to. I desperately wanted to do fewer hours but also wanted to keep it all together. I am ultimately very positive about our journey and feel very lucky, but it was a difficult year and I wish I had had more bandwidth, words and psychological + training support to have had an easier time.* "

3. Still birth and Neonatal death

- **Am I entitled to time off?**

Yes, if you have had a stillbirth (which is currently classed as a pregnancy loss at or after 24 weeks' gestation) or if you have a neonatal death, you are also entitled to full maternity leave. This may not be enough time, and you may want an extension. You should discuss this with your TPD and HoS, along with seeing your GP. Come the time, if you feel you can return to work, or want to return to work, plans should

be put in place with your TPD and ES to design a return to work plan. A supervised return with amended duties and amended hours should be supported. You may need to consider the location of the hospital, the department due to potential triggers in the workplace. Please see the guidance previously discussed under section 1.2

Both partners are entitled to 2 weeks of parental bereavement leave for any stillbirth or death of a child under the age of 18 years, including neonatal deaths, further time off is sick leave which should be supported. This is in addition to any maternity, paternity or parental leave you have taken. Parents are eligible for this from their first day with their employer, with no minimum length of service required. This leave can be taken as a 2 week block, or as separate 1 week blocks, and must be taken within 56 weeks of the stillbirth or death of the child.

Personal words from a resident doctor who experienced still birth:

'*After my baby died at the end of a normal pregnancy, I knew I would not be able to continue my paediatric training if I had to return to my neonatal post. My HoS was very supportive and allowed a supernumerary post in a paediatric ED with good support, which allowed me time to grieve and recover. I am now a successful paediatric emergency medicine resident doctor, but I am sure I would have left paediatrics were it not for this crucial intervention at this formative time in my training.* '

4. Support for partners

We must not forget our colleagues whose partners may be the ones experiencing issues we have highlighted within this document. Support for partners must also be equally acknowledged in the same way as those going through pregnancy loss or fertility issues. Partners as per the NHSE pregnancy loss policy[1] are entitled to five days statutory bereavement leave, and the same advice applies for miscarriage should further time off be required.[18]

5. Returning to work

Returning to work can be particularly difficult for doctors and partners in Paediatrics and O&G after a pregnancy loss. Resident doctors may not feel able to advocate for themselves for the work modifications that will most support them on their return to work. It is vital that the ES or your local SuppoRTT champion, discusses all possible modifications with the individual and liaises with the appropriate TPD, college tutor and rota coordinator on their behalf to ensure that any agreed modifications are adopted alongside discussions with OH.

Options that should be considered to support their return to work include:

- Not scheduling the resident doctor to cover areas they have identified as potentially being particularly difficult to work in e.g. theatres for deliveries, neonatal units, postnatal wards, NIPE clinics, Early Pregnancy units or Labour Ward
- A flexible and phased return to work
- Enhanced supervision sessions
- Taking into consideration home working for a period of time, where practical

The individual may experience exacerbations of the grief and trauma associated with their pregnancy loss at unpredictable times in the future. It is important that supervisors plan regular meetings, be guided by the individual, respect their wishes and signpost to staff psychology services who have experience with dealing with workplace triggers. Consideration of a further period of time off in the future may be required.

6. Further resources

- Doctors can access free & confidential psychological or mental health support 24/7 via the following services:

  - The NHS Frontline service for all NHS staff: Call 0300 131 7000 (between 7am-11pm) or Text 'FRONTLINE' to 85258 (24hrs/day)
  - NHS Bereavement & Loss Helpline for NHS staff: Call 0300 303 4434 (between 7am-11pm)
  - The BMA's 24/7 counselling service for all doctors (including non BMA members): Call 0330 123 1245 or visit the BMA
  - The Samaritans: Call 116 123 or visit Samaritans
  - The Practitioner Support Programme's crisis line: Text NHSPH to 85258 or visit https://www.practitionerhealth.nhs.uk/

- **Supporting doctors/colleagues**

Included below are some broad consensus guidelines from the Miscarriage Association[8] about how to support those experiencing a pregnancy loss:

1. *Acknowledge the loss*
   - Do not underestimate how important it is to simply say 'I'm sorry'.
   - Do not try to cheer the person up or diminish the importance of the loss with statements like:
     - 'At least this shows you can get pregnant'
     - 'At least it was early on'
     - 'I'm sure it will be different next time'
     - "At least you have another child"

- *Reassurance*

  - Resident doctors need to know that they won't be judged or discriminated against for taking time off.
  - Resident doctors need to know that the information will be confidential, unless they give you permission to share it with colleagues.

- *Listen*
  - Ask if the resident doctor wants to talk about their loss – they may not want to do so right away but ensure they are aware when and how they can contact you.
  - Even if you have experienced a pregnancy loss yourself, be careful of sharing your own experiences – everyone will respond very differently, and it is important that resident doctors do not feel they should be responding in a certain way.
  - We suggest that you make a plan with the resident doctor on how and when they would like you to 'touch base' during their leave.
  - Take the lead from the resident doctor in terms of what language to use – some will prefer to use 'pregnancy', others 'baby' and some resident doctors may have given their baby a name.

- *Consider triggers*
  - Are there colleagues at a similar point in pregnancy?
  - Has anyone fallen pregnant during their leave?
  - Remember, people may need more support around the time of their period after a pregnancy loss.
  - Later in the year, people may experience an exacerbation of their grief, or reaction around the anticipated due date of their baby.
  - Consider a supported return to work in conjunction with a return to work champion or manager

7. Appendix:

Workplace hazards when trying to conceive and in pregnancy

As discussed in section 1.1 different roles and areas of work will pose different workplace hazards and it is important to be aware of these. Risks can be posed to those trying to conceive as well as during pregnancy. Below is further information to consider and discuss directly with the person conducting your risk assessment, as to methods of mitigating the risks to as low as reasonably practicable. Further advice can also be sought from your relevant Occupational Health department if required.

Some pre-conception risks to consider, include:

- Cytotoxic drugs – in long term exposure these drugs can potentially cause damage to the genetics of the sperm and egg, as well as other fertility side

effects. There is no known threshold limit to cause these effects and therefore guidance is provided by the HSE for precautions for the safe handling of cytotoxic drugs. [19,20]

Some risks which may be applicable to all staff when pregnant, include:

- Slips, trips and falls
- Manual handling – in general employers should reduce very heavy physical activities and lifting for pregnant workers where possible and particularly during the later stages of pregnancy. [21]
- Prolonged standing – where possible pregnant workers are advised to regularly change their position and should reduce standing for longer than three hours where possible, particularly in late pregnancy. [21]
- Working hours/shift work – in general there is a wide range of research around the effects of nights and shift work on pregnancy. There is insufficient evidence to restrict all women from such work and therefore it is recommended that this is reviewed on a case by case basis, depending on the pregnancy and the type of work undertaken. [21]
- Exposure to biological agents such as rubella, varicella (chickenpox) and measles – can pose a risk at varying gestations of pregnancy. It is important to know your immunity status and to inform Occupational Health and your midwife if an occupational exposure is thought to have occurred, so appropriate risk assessment and follow up can occur.

Specific risks that may depend on specialty and working environment, include:

- Anaesthetic gases – some anaesthetic gases e.g inhalation gases, have some evidence for adverse pregnancy outcomes when associated with long term, high levels of exposure. If exposure is low, infrequent or well controlled then minimal risk is likely to occur. Areas such as paediatric anaesthetic rooms or recovery may have increased levels of anaesthetic gas exposure, therefore, a discussion with department is likely to be helpful in assessing this risk.[22]
- Ionising Radiation - significant exposure can harm a fetus, especially in the first 8 weeks or breastfed infants (depending on how a mother is exposed). When pregnant the acceptable does of exposure to radiation is lower than pre-pregnancy, however, with correct safety precaution the dose that you and the fetus is exposed to is likely to be considerably less than the acceptable dose. A discussion with your line manager is recommended to identify the risk and implement measures to mitigate the risk. Further details around this can be found in the HSE document, Working Safely with Ionising Radiation.[23]

- Exposure to cytotoxic – certain tasks when working with cytotoxic medication can be more of a risk to workers than others, with the gestational period of greatest risk being in the first trimester. In general, caution is advised where possible to avoid exposure and where continued exposure is to occur; the use of PPE and adherence to standard handling precautions is advised. Specific workplace risk assessments should be undertaken to review exposure and controls implemented to minimise the risk to as low as reasonably practicable.[23]

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