Anaesthesia 2024, 79, 706–714 doi:10.1111/anae.16231

Original Article

Successful return to work in anaesthesia after maternity leave: a qualitative study

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Summary

Returning to work after maternity leave poses significant challenges, with potential long-term implications including decreased engagement or attrition of clinicians. Many quantitative studies have identified challenges and supports for women during pregnancy, maternity leave and re-entry to clinical practice. This qualitative study explored the experiences of anaesthetists returning to clinical work after maternity leave, to identify influential factors with the aim of providing a framework to assist planning re-entry. We conducted semi-structured interviews with 15 anaesthetists. Attendees of a re-entry programme were invited to participate, with purposive sampling and snowball recruitment to provide diversity of location and training stage, until data saturation was reached at 13 interviews. Five themes were identified: leave duration; planning re-entry; workplace culture; career impact and emotional impact. Leave duration was influenced by concerns about deskilling, but shorter periods of leave had logistical challenges, including fatigue. Most participants started planning to return to work with few or no formal processes in the workplace. Workplace culture, including support for breastfeeding, was identified as valuable, but variable. Participants also experienced negative attitudes on re-entry, including difficulty accessing permanent work, with potential career impacts. Many participants identified changes to professional and personal identity influencing the experience with emotional sequelae. This research describes factors which may be considered to assist clinicians returning to work after maternity leave and identifies challenges, including negative attitudes, which may pose significant barriers to women practising in anaesthesia and may contribute to lack of female leadership in some workplaces.

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Accepted: 12 December 2023
Keywords: anaesthetists; leadership; maternity leave; re-entry; workplace culture
This article is accompanied by an editorial by Silver et al., *Anaesthesia* 2024; **79**: 675–679.
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Introduction

Re-entry to clinical practice following maternity leave can be a challenging time. Despite the increasing numbers of women in anaesthesia in Australia and Aotearoa New Zealand [1], there are limited data regarding leave patterns and evaluation of support for clinicians and workplaces. Maternity leave is the most common reason for extended leave (> 3 months) [2, 3] and duration varies globally. In the

USA, where maternity leave provisions are less generous [4], women returned to work after 5–12 weeks of leave but would have preferred a minimum of 12 weeks of leave on average [5]. However other surveys from the USA found that 12–20% re-entered the workforce after > 12 months leave [6, 7]. Re-entry after longer periods is likely to be more common in Australia, Aotearoa New Zealand and the UK, where paid leave often exceeds 12 weeks [4], and has been a focus of General Medical Council and NHS workforce planning [3, 8]. In the NHS, 3.7% of women aged < 50 y and who are doctors or dentists are on maternity leave at any point in time. They often return to less than full-time hours, but there is significant variability between organisations [8]. A lack of support for doctors re-entering after maternity leave has been linked with adverse outcomes for both patients and clinicians [9].

Clinicians expect re-entry to be challenging, dissuading some from attempting it [7, 10]. Childbearing can professionally disadvantage women, resulting in decreased earnings and exposure to workplace discrimination [6, 11–13]. Therefore, women returning after maternity leave may encounter significant barriers to career progression. There are broad economic and workforce implications if clinicians do not return [14, 15], or become dissatisfied with work due to poorly managed re-entry [16].

Although surveys of inactive physicians and educators have described barriers to re-entry [7, 17], there are few published qualitative studies examining the experiences of doctors returning from maternity leave and none in critical care specialities. A systematic review of the literature regarding motherhood and medicine identified a gap in the understanding of the experience of re-entry [18]. Qualitative research provides rich data about experiences and is helpful for understanding how processes may be improved [19, 20]. Our study investigated the experiences of anaesthetists in Australia and Aotearoa New Zealand re-entering after maternity leave, aiming to develop recommendations to support re-entry.

Methods

Ethics approval was obtained from the Medical Education Human Ethics Advisory Group at the University of Melbourne. All participants received a plain language statement about the research and provided written consent.

Initial recruitment focused on individuals who attended a re-entry course (Critical Care, Resuscitation, Airway Skills: Helping you return to work CRASH®) [21] via an email sent by a co-researcher not involved in the course (KR). This convenience sample was supplemented by snowball recruitment via study participants to identify those who had not attended the CRASH course to ensure a range of geographical locations and career stages, and provide a broader range of experiences and opinions. Inclusion criteria were maternity leave of ≥ 3 months and successful re-entry for > 6 months at more than 0.1 full-time equivalent to public hospital work in Australia or Aotearoa New Zealand. We did not study individuals meeting any of the following criteria: < 3 months maternity leave; < 6 months since re-entry; and returning to a training position supervised by the primary researcher. Successful re-entry was defined as working clinically for > 6 months at the time of the interview.

The interview questions (online Supporting Information Appendix S1) were designed around the principles of phenomenological interviewing and piloted on two participants [22]. Questions were developed following a literature review of re-entry after any leave [2, 7, 10, 11, 14, 17] and from CRASH course participant concerns. Individual interviews were conducted in non-workplace locations, in person or virtually, to allow individuals to elaborate on their experiences and explore sensitive topics [23]. All interviews were conducted by an anaesthetist (KA), who had experienced re-entry after maternity leave and had interview training, to promote participants' discussion of challenging topics [22].

Interviews were audio recorded and transcribed by the first author (KA). Member checking was not employed, consistent with the constructivist ontology underpinning the research question [24]. Interviews continued until no new themes were detected in the data. In line with qualitative research approaches and particularly the notion of reflexivity [19, 20, 25], we recognise the importance of the researcher–participant relationship and its potential effect on the elicitation of data. While the first author/interviewer's direct experience of the topic under investigation was useful as a resource for developing the interview questions and in engaging with and promoting participants' discussion of salient issues, from a reflexivity perspective we appreciate the potential for influencing participants' reflections on the topic. To minimise this risk the two other researchers, who are neither medical practitioners nor involved in the CRASH course, contributed to the literature review and development of interview questions. Further, all three researchers were involved in the data analysis and coding process, including discussion of field notes kept by the interviewer (KA) to balance the perspectives of experience and observation [20].

To encourage multiple perspectives and balance the analysis of the data, the research team met regularly to review the consistency of coding and to establish the

saturation of themes. The researchers independently performed inductive thematic analysis after three interviews using line-by-line coding [23, 25] using NVivo 12 (QSR International, Burlington. MA, USA). The team conducted regular coding meetings during data collection to discuss initial coding, group codes into themes and resolve any disputed codes through discussion and consensus, until no new themes were detected in later interviews. This iterative data analyses process resulted in the final list of themes covering the full data set.

Results

Ninety-five research invitations were sent to participants who had attended previous CRASH courses. Two participants who had not attended the CRASH course were included through snowball recruitment. Nineteen participants were screened but four did not meet the study inclusion criteria (two participants had non-parental leave, one had not taken extended leave and one was a trainee where the primary researcher was supervisor of training). Recruitment continued until no new themes were detected, consistent with the study design. Fifteen participants took part in individual semi-structured interviews of 30–60 min duration.

All participants had experienced at least one re-entry following maternity leave in Australia or Aotearoa New Zealand within the last 4 years. The study participants were median (IQR [range]) age 39 (36–42 [35–49]) y and were located across most states of Australia and in Aotearoa New Zealand. Participants discussed 37 re-entries from periods of leave, the (median (IQR [range]) duration of leave was 8 (6–10 [3–60]) months); 24/37 of the returns were from women taking leave during their training and 13/37 were from established consultants.

All participants had worked clinically for at least 6 months after re-entry. Formal childcare arrangements were used by most, including long-day childcare and nannies. Some had family or partner arrangements as primary care or to supplement this. Whilst robust childcare arrangements and the role of partners are significant influences, our study focuses on the role of the workplace in re-entry rather than this other important area.

Five dominant themes were identified: duration of leave; planning before re-entry; workplace culture; career impact from negative attitudes; and the emotional impact of re-entry.

Theme 1: Leave duration

Participant expectations of re-entry influenced leave duration, and leave duration influenced re-entry. Participants expressed concerns about deskilling with longer breaks but faced challenges in re-entry whilst parenting very young children. Participants who re-entered the workforce quickly described anxiety around commencing childcare, maintaining breastfeeding and the impact of sleep deprivation (online Supporting Information Appendix S2). For example, one participant who re-entered after < 6 months stated:

> *``Had there been workplace flexibility up till the age of one, it would have been a lot easier. I would have probably taken a longer break…a couple of extra months doesn't make any difference to the workplace but would have reduced some of the stress…I can remember how difficult those times were.´´ – Participant 4*

Some chose shorter periods of leave (≤ 6 months) due to training requirements, job availability or deskilling fears. Participants discussed work satisfaction as a significant driver for any re-entry, although those who returned early reported lower job satisfaction initially. Some wanted a longer period of leave but re-entered the workforce earlier because of training or job pressures. Most participants who returned to part-time work would have re-entered full-time if part-time work was unavailable, although may have delayed re-entry or anticipated a lower quality of life.

Participants in late training or early consultancy before leave reported regaining their skill levels quickly, even after > 12 months leave. As one participant who returned after > 3 years stated:

> *``At the end of two or three weeks, I did a night on call…The physical stuff, the intubation and the needling didn't seem really to have deteriorated at all. The cognitive load was very high, but that does decrease reasonably fast, and I was heavily supported.´´ – Participant 12*

Theme 2: Planning re-entry

Planning for re-entry was described universally as being beneficial. Planning was often initiated by the participant and not formalised. Participants found departmental support, a graded return to in-hours and out-of-hours work, and breastfeeding support beneficial. Departmental support ranged from telephone advice to supernumerary rostering. Duration of support was usually short, from 1 day to 6 weeks. Many participants found colleagues who had experienced re-entry themselves an excellent source of support, even when the colleague was not available on site.

Supervised re-entry supported both junior and senior trainees who were returning (online Supporting Information Appendix S3). However, for returning consultants, supervising trainees was only sometimes helpful, other times it was burdensome, particularly when teaching contributed to cognitive load:

> ``*Even at the best of times, when you're not returning to work, [supervising someone] who is not an advanced trainee, or a very good junior trainee is quite challenging [especially in] highly complex lists.*´´ – *Participant 13*

Participants perceived provision of support as onerous for colleagues and sought to minimise the impact of this through planning, including shadowing co-workers before re-entry. However, on reflection, participants believed that allocating a support person had little impact on the overall department clinical workload. In some cases, more than 4 weeks support was required due to the duration of leave, as mandated by the professional documents or governing body requirements, such as the Australia and New Zealand College of Anaesthetists (ANZCA) [26] and Australian Health Practitioners Regulation Agency (AHPRA) [27].

Several participants discussed how a graded return impacted their re-entry experience. A graded return involved fewer hours or a lower acuity case load initially, increasing hours and acuity over time, or delaying resumption of out-of-hours work. Participants described using graded return to reduce the duration of leave, to counter deskilling and reduce re-entry challenges. Participants who undertook a graded return ultimately increased their working hours and returned to similar levels of case acuity as before their leave, finding that their skills and confidence returned quickly. Several preferred to immediately resume complex cases, concerned they would lose sought after lists. Participants reported part-time work improved engagement and job satisfaction.

Case complexity was discussed as a double-edged sword; initially lower acuity was considered helpful by some participants, but low acuity lists in the longer term reduced confidence. Several participants found working fewer hours challenging during career transitions, highlighting the importance of planning and individualising the re-entry process:

> ``*From a clinical point of view, it wasn't very good only working one day a week. . .[it] took me a while to make that transition of the basic trainee to the advanced trainee. . .I remember vividly having a crisis in confidence.*´´ – *Participant 10*

Others believed rostering to low acuity lists occurred because colleagues mistakenly expected them to reduce their scope of practice to meet family needs:

> ``*I had three scope lists in one week once and I was told, ``Well, at least you get to go home on time.´´ . . . I thought there should have been more variability to the lists.*´´ – *Participant 13*

Returning to out-of-hours work, including working for 24 h, at weekends and overnight, was identified frequently as a source of anxiety for participants. They reported concerns around long working hours without protected breaks and undertaking complex cases with fewer staff. Junior consultants were hesitant to express apprehension about returning to out-of-hours work:

> ``*[out-of-hours work] was quite a different challenge . . .I was essentially told, ``If you don't think you can handle it, let me know and I'll arrange something for you.´´ I would have really liked to have said, ``No, I don't think I'm ready to do that,´´ but I didn't. I said, ``No, no, I'll be fine.´´. . .I think that was just a part of being a junior [consultant] wanting to impress.*´´ – *Participant 4*

Several participants delayed return to out-of-hours work for 4–6 weeks after resuming in-hours work, but rostering could not accommodate this for others. Some reported having a supportive colleague attending challenging cases was helpful.

Many participants discussed workplace support for breastfeeding, which influenced the duration of leave and well-being on re-entry. Some described good breastfeeding support, including breaks:

> ``*They were very supportive of breastfeeding pumping breaks. . .the place where I chose to pump was the registrars sleeping room, and occasionally somebody would burst in there. . .It's more embarrassing for them than me.*´´ – *Participant 12*

Other participants had negative experiences with little workplace support:

> ``*There was always. . .guilt in the back of my mind about not wanting to hinder the efficiency of list. . .I would express in the corridor. . ..once a case was on the table, I would sit there with the pump underneath my top with all the men in the room looking over and smirking.*´´ – *Participant 5*

Several participants weaned babies before returning due to a perceived lack of workplace support. Some who

continued to breastfeed after re-entry experienced mastitis requiring treatment including hospital admission thought to be contributed to by poor access to facilities or breaks.

Theme 3: Workplace culture

All participants identified workplace culture as influential on the re-entry experience. This had commonalities with other workplace features, such as departmental role models, but additional features of workplace culture included colleague expectations and attitudes. Role models of successful re-entry were considered beneficial, whereas trailblazing was challenging. Several described a workplace expectation of `hitting the ground running´ (e.g. receiving no orientation to a new workplace or a rapid return to out-of-hours work). Participants reported anxiety on re-entry and concerns about patient safety (online Supporting Information Appendix S4).

Participants who felt perceived as a `burden´ or `troublemaker´ felt anxious about re-entry. In some cases, they eschewed support to appear competent:

> ``*I did not [want to request support] and I'm sure part of it is my personality, but part of it was the institution within which I was training, was that I didn't want to show any weakness.´´ – Participant 5*

In workplaces where few clinicians had returned, some participants were trailblazers and met resistance. In contrast, departmental role models providing practical advice and institutional knowledge were helpful:

> ``*I had people in my department who were interested in this subject. . .Had I not had the [CRASH] course or those casual discussions about return to work. . .it would have been very different.´´ – Participant 1*

Theme 4: Career impact

Many participants described the career impact of negative attitudes towards pregnancy, including job availability/security and career progression. They described attending interviews while pregnant with sufficient clinical expertise but being offered no work or part-time roles. Others described workplaces that hired women of childbearing age on locum contracts until explicit disclosure that childbearing was complete (online Supporting Information Appendix S5).

> ``*During maternity leave, I was actually without a contract, because they didn't renew [the locum contract], because I was pregnant, and I gave birth. To get my next contract I had to re-interview and go through the whole process again. . .I was thinking, surely I won't get a job, because they haven't actually hired a female of childbearing age, and that really upset me.´´ – Participant 8*

Some were discouraged by colleagues from applying to departments where no one had successfully returned following maternity leave. Many were discouraged from applying for full-time work, job sharing and sitting exams while pregnant or after re-entry. In some organisations, participants avoided requesting support, as they perceived this would suggest a lack of competence. For instance, one described whether providing support would be difficult or affect career progression:

> ``*It wouldn't have been a problem so much as what their judgment and views may have been on my performance.´´ – Participant 10*

Theme 5: The emotional impact of returning to work

Several expressed strong emotional reactions discussing re-entry experiences, even years after their return. Moreover, they described re-entry using words such as `worried´, `disaster´, `very challenging´, even if these emotions were short-lived. Even accomplished clinicians found re-entry extremely challenging (online Supporting Information Appendix S6). As one participant described:

> ``*I think it's actually really high functioning women who will find it very hard to say, ``Actually, this is really hard´´. . .to admit that things aren't okay and under their control is not an easy thing to do.´´ – Participant 4*

Participants described transitioning from supervised to supervisory roles around the time of return as particularly challenging:

> ``*Because I think when you're a consultant you're ultimately responsible. Whereas, when you're a registrar . . . I always felt like there was someone else that could come and assist me, like I wasn't just on my own, I suppose I was prepared to take on a bit more risk. Maybe that was the difference. Whereas, as a consultant, I'm the sort of ultimate person that's supposed to be able to step in and save the day.´´ – Participant 2*

Discussion

Participants experienced both supportive and challenging workplace factors influencing re-entry to the workplace following maternity leave. Themes were very consistent,

Figure 1 A framework to facilitate planning re-entry to the workplace after maternity leave.

despite variation in career stage and geographical location. Supportive factors included engagement between the clinician and workplaces to plan re-entry; rostering considerations; and breastfeeding arrangements. Challenges included negative attitudes towards re-entry. A graded return was considered desirable and particularly improved the experience of early (< 6 months leave) re-entry. The key features of successful re-entry, as identified by our study and other key literature [5, 11, 14, 18, 28] provide a framework for planning re-entry (Fig. 1), including areas where workplaces can increase support depending on the individual clinician's needs. For example, a graded return with gradually increasing hours and telephone support for out-of-hours work, was considered beneficial but rarely explicitly discussed before return. Short-term investment from departments providing flexibility of caseload and minimising unplanned overtime may pay off with increased engagement over a long career.

Explicit recognition of the capacity, capability and credibility of women is critical for career progression [28] and may help to address negative attitudes to re-entry. This may range from recognition that confidence is affected in re-entry [9] but competence is likely to be maintained [3], through to offering non-clinical opportunities to build a career, which may be paternalistically withheld from women during and after maternity leave [11]. While breastfeeding spaces and job security are legislated [29], participants did not consistently experience these in practice. This framework may provide guidance for departments and individuals in planning re-entry and inform studies evaluating factors that may contribute to clinician attrition, particularly of women.

Previous studies have reported a perception by colleagues that women become disengaged with clinical practice following childbearing [11], which is in contrast to the motivations reported by women themselves [18]. Our study found that women did not want to `burden´ departments or be considered `trouble´ because of re-entry requirements, instead choosing to seek informal systems to manage low confidence. This had emotional impacts, exacerbated by the personal and professional identity challenges experienced at re-entry. Greater clarity for women regarding clinical support, availability of lactation facilities, rostering allowances and escalation strategies may enable women to have greater confidence and reduce challenges on re-entry.

Clinicians in this study reported that they required support for relatively short periods to successfully re-enter even after lengthy maternity leave. This is an important finding, as some did not seek support because of a perceived impact on the workplace, and participants reported taking shorter periods of leave to reduce the `burden´ of support. A rapid return to practice for clinicians who had > 12 months leave may reflect the ANZCA recommended level of support [26]. Other options to support the re-entry process include `Keep In Touch´ days available in Australia [30], Aotearoa New Zealand [31] and the UK [32]; these allow practitioners to work as supernumerary staff for a day at a time during leave. Workplace orientation is required by Australian National Safety and Quality Health Service Standards (Action 1.19) [33], but this did not occur for several participants.

Some participants experienced explicitly negative attitudes regarding re-entry, consistent with data from the general Australian population, which suggests that both men and women experience discrimination and negative attitudes around childbearing and re-entry [29]. Similarly, our research showed that anaesthetists experienced strong emotional impact from negative re-entry experiences. Several participants experienced overt health issues which they attributed to these challenges, including admission to hospital for mastitis. This is consistent with evidence suggesting that restricted access to breastfeeding facilities can decrease clinician well-being [34]. Furthermore, practitioner well-being as a contributor to excellent clinical performance has been systematically reviewed [35], indicating that failure to provide a supportive environment for re-entry may directly affect patient outcomes.

Discouragement from colleagues around applying for jobs or sitting exams while childbearing limits the career progression of women, increasing the burden on those attempting to return. While our research specifically explored the experience of women who had successful re-entered, a recent Australian study found that cumulative negative workplace experiences and lack of support following maternity leave can contribute to women leaving surgical training [36].

Participants in our study successfully returned to clinical work, yet many still found re-entry extremely challenging. This is concerning, as evidence suggests that some competent physicians perceive re-entry as too challenging to attempt [7, 10]. In addition to developing pathways to enable women to pursue career progression [28], our study identifies a critical transition for many women, during which increased supports can be provided in the short term. Failure to engage women returning after maternity leave may promote attrition or delayed career advancement, leading to a lack of female role models [28] who could provide valuable guidance to other women.

These challenges may have career-long implications for women. Returning to lower acuity lists long term may result in significant skill deterioration, and a lack of job security and non-clinical time also contribute to career stagnation [28, 37]. When re-entry coincided with other role transitions, the impact on the confidence of participants in this study was magnified.

Our findings have significant implications for planning successful re-entry following maternity leave. While effective re-entry plans must be individualised to clinician preference and workplace dynamics, there are many commonalities that can form part of any plan following maternity leave (Fig. 1). Our study demonstrated that negative attitudes about re-entry from maternity leave persist, which may prevent women from engaging in clinical or non-clinical work and result in career stagnation. Substantially more commitment must occur to challenge and change these attitudes. Even small workplace investment in facilitating re-entry following maternity leave is likely to produce significant gains for clinician well-being. While the proposed framework is broad, and not all items will be achievable for all departments, we hope that it will serve as a visual prompt to discussing a return to work. Organisations may be able to adapt it to create a local resource to support women returning to work in anaesthesia or other disciplines.

Our study identified consistent themes among anaesthetists re-entering after maternity leave in Australia and Aotearoa New Zealand. The degree to which these findings apply to clinicians from other specialities or countries is unclear and should be explored through further research. The influence of sociocultural diversity was not explicitly explored in this study. Examining the experience

of under-represented groups in medicine at critical career inflections, such as re-entry, is an important area for further research.

There are some other considerations which should be taken into account in future work. In this study, participants who experienced more than one re-entry during training following maternity leave may have had more detailed recall of the most recent re-entry, which was often during late training or early consultancy. As a result, recollection of the challenges experienced during early training may have been selective. Most of the participants had undertaken the CRASH course, indicating high motivation for successful re-entry. Nonetheless, many of the CRASH participants had previous unsupported re-entry to the workforce and thus had a range of experiences on which to draw. It is, however, possible that women re-entering without the support offered by CRASH may experience greater difficulties and our study might under-represent the difficulties of re-entry. There may also be under-representation of women who experienced few or no difficulties in returning to work, who did not utilise CRASH and were not recruited to this study.

Returning to work is a significant time in a woman's career, with the potential for long-term career impact. This study found several key factors affecting the experience and potentially the success of the re-entry process, namely the duration of leave; prior planning of leave; nature of expected duties on return (graded return and out-of-hours work); and quality of departmental support. Our proposed framework may assist workplaces and clinicians working together to achieve optimal re-entry, identifying key areas for supporting clinicians.

Providing such support requires short-term investment from workplaces, with potential for significant improvements in well-being. More women successfully returning to work promotes positive culture change, countering the negative attitudes which can cause significant emotional distress and career stagnation. Specific measures promoting the re-entry process for female clinicians include the formal implementation of support structures which consider the specific needs of women re-entering following a career break. Noting and celebrating the successes must occur alongside meaningful and practical workplace changes. Several strategies emerged from this study that suggest key areas and practices which can contribute to a more supportive working environment for women at this critical career juncture, thereby improving well-being for clinicians, increasing patient safety, and promoting staff retention and diversity in the clinical workplace.

Acknowledgements

Associate Professor R. O'Brien served as a scientific advisor and critically reviewed the proposal. The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to potential to compromise the privacy of the participants. KA convenes The CRASH Course but has no financial interest in the course. No external funding or other competing interests declared.

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Supporting Information

Additional supporting information may be found online via the journal website.

Appendix S1. Interview questions.

Appendix S2. Leave duration.

Appendix S3. Planning re-entry.

Appendix S4. Workplace culture.

Appendix S5. Career impact.

Appendix S6. The emotional impact of returning to work.