



Contents lists available at ScienceDirect

The American Journal of Surgery

journal homepage: www.elsevier.com/locate/amjsurg

Every ounce counts: A call for comprehensive support for breastfeeding surgeons by the Association of Women Surgeons

Breastfeeding is a vital component of global health. Breastmilk is the optimal nutrition for infants, and breastfeeding confers unparalleled health benefits to women and children including decreased infant mortality and morbidity from infectious diseases, sudden infant death syndrome, necrotizing enterocolitis, leukemia, and chronic illnesses as well as lower rates of maternal breast and ovarian cancers and chronic diseases.¹ Tragically, no country in the world meets minimum standards for breastfeeding established by the Global Breastfeeding Collective, led by the World Health Organization (WHO). The Collective has issued a worldwide call to action for increased support of breastfeeding with a specific aim of increasing rates of exclusive breastfeeding for the first six months of life and continued breastfeeding for up to two years or beyond.² They emphasize that achievement of these metrics depends on financial, political, and social investments including paid parental leave and breastfeeding support in the workplace.

Surgeons face multiple barriers to meeting breastfeeding goals. Compared with the general population, physicians have higher rates of breastfeeding initiation but shorter durations of breastfeeding.³ Physicians in procedural fields such as surgery have particularly low rates of sustained breastfeeding for at least one year postpartum.⁴ Breastfeeding surgeons experience challenges related to inadequate parental leave, lack of access to lactation facilities at work, insufficient time for breast milk expression at work, and suboptimal support from colleagues and leadership. The Association of Women Surgeons (AWS) has co-endorsed⁵ a breastfeeding support policy for medical trainees by the American Academy of Family Physicians.⁶ Now, we wish to extend our call for comprehensive breastfeeding support to include not only surgical trainees but also practicing surgeons.

1. Parental leave

Efforts to establish breastfeeding support for surgeons must begin with strong advocacy for paid parental leave as longer maternity leave is associated with increased duration of breastfeeding.⁷ The American College of Surgeons advocates for family leave of at least six weeks duration for all new parents, and states that the associated decrease in work relative value units (wRVUs) should not be grounds for lower compensation.⁸ However, the United States lacks a paid parental leave mandate and policies vary by training level, subspecialty, and employer.⁹

2. Lactation rooms

The regular expression and storage of milk is crucial for sustained

lactation. Whenever possible, it is optimal for mothers to breastfeed their infants. This may present a challenge for surgeons due to long operations, irregular hours, and the fast-paced environment. The provision of lactation rooms for milk expression (e.g. pumping) is therefore necessary. The location of rooms is of particular importance given the need for privacy as well as proximity to the operating room and patient care areas. Some other considerations for lactation rooms include cleanliness, accessibility, availability, and presence of certain features including a sink, refrigerator, electrical outlet, and table.¹⁰ The Accreditation Council of Graduate Medical Education (ACGME) further recommends that lactation rooms include a computer workstation and phone in order to facilitate continued patient care.¹¹

Utilization of wearable breast pumps in the operating room or other clinical settings is another option for minimizing interruptions in patient care delivery. This practice was recently endorsed by the American Society of Anesthesiologists.¹² Surgeons who are willing and able to use a wearable breast pump should be fully supported in doing so. Theoretical concerns about potential contamination of the sterile field are unsupported by evidence demonstrating the impermeability of surgical gowns and inconsistent with standard operating room policies regarding healthcare providers with stomas or medical devices such as insulin pumps. Restrictive policies that prohibit surgeons from utilizing wearable breast pumps at work do little to aid in the balance of patient care needs and breastfeeding necessities.

3. Time for pumping

There is never a “good” time to stop and pump, thus planning in advance and blocking off time is important. Time accommodations of approximately 30 minutes every 3–4 hours should be implemented into the schedule.⁷ This is simple to arrange for clinic days, didactics, and administrative meetings, but may be more challenging for operative days. In case of longer operations, clear communication with the surgical team is vital and coverage by colleagues may be necessary. As previously mentioned, wearable breast pumps may allow for decreased interruptions in patient care. While use of wearable breast pumps should be supported, this should not be expected nor required as some women are unable to effectively express milk using these pumps or may prefer the privacy of a dedicated lactation room.

4. A culture of support

Beyond the aforementioned requirements and considerations, support from administration, staff, and colleagues is vital. A workplace

<https://doi.org/10.1016/j.amjsurg.2021.12.037>

Received 11 November 2021; Received in revised form 14 December 2021; Accepted 31 December 2021

Available online 5 January 2022

0002-9610/© 2022 Elsevier Inc. All rights reserved.

culture that actively supports breastfeeding must be cultivated, not only for the sakes of the lactating employee and their child, but also for the benefit of medical students and trainees for whom faculty serve as role models. Normalization of addressing biological and personal needs may help to mitigate burnout and counteract negative perceptions of surgery as a field with poor work-life balance.

Institutional commitment to breastfeeding support should be clearly communicated in a written policy. The policy should emphasize the importance of breastfeeding, specify the institution's accommodations for breastfeeding physicians, and delineate clear roles for employees and supervisors. Institutions without policies can rapidly implement one by adopting or modifying existing, published policies¹³ that follow evidence-based public health recommendations and adhere to ACGME requirements for residents and fellows.

Importantly, surgeons should not be financially disincentivized from pumping due to concerns about productivity and reimbursement. The University of California San Francisco (UCSF) is a leader in this arena, with a program that credits breastfeeding clinicians with wRVUs for scheduled lactation time accommodations.¹⁴ In brief, employees are entitled to one "Lactation Hold" per half-day of clinic, which protects a 30-min block of time for breastfeeding or pumping and is reimbursed at 1.5 wRVUs. This model should be adopted by all health care systems.

5. Final thoughts

Surgeons represent a vulnerable population at risk of failing to meet breastfeeding goals. Paid parental leave, lactation facility and time accommodations, and support from colleagues and supervisors is therefore imperative. In addition to structural factors impeding wellness for breastfeeding women, there is a long history of martyrdom within surgery that exacerbates poor health and burnout. We advocate fiercely for our breastfeeding patients. We need to just as passionately advocate for ourselves.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

1. Stuebe A. The risks of not breastfeeding for mothers and infants. *Rev Obstet Gynecol*. 2009;2(4):222–231.
2. Global Breastfeeding Collective. A call to action. <https://www.globalbreastfeedingcollective.org/media/481/file/A%20global%20breastfeeding%20call%20to%20action.pdf>. Accessed August 12, 2021.
3. Sattari M, Levine D, Serwint JR. Physician mothers: an unlikely high risk group-call for action. *Breastfeed Med*. Feb 2010;5(1):35–39. <https://doi.org/10.1089/bfm.2008.0132>.
4. Melnitchouk N, Scully RE, Davids JS. Barriers to breastfeeding for US physicians who are mothers. *JAMA Intern Med*. Aug 01 2018;178(8):1130–1132. <https://doi.org/10.1001/jamainternmed.2018.0320>.

5. AWS. Statement on supporting surgical trainees who are breastfeeding. Updated June 26 <https://www.womensurgeons.org/news/514650/AWS-Statement-on-Supporting-Surgical-Trainees-Who-Are-Breastfeeding.htm>; 2020. Accessed October 3, 2021.
6. AAFP. American Academy of family physicians. Breastfeeding and lactation for medical trainees. <https://www.aafp.org/about/policies/all/breastfeeding-lactation-medical-trainees.html>. Accessed October 3, 2021.
7. Marinelli KA, Moren K, Taylor JS. Breastfeeding support for mothers in workplace employment or educational settings: summary statement. *Breastfeed Med*. Feb 2013; 8(1):137–142. <https://doi.org/10.1089/bfm.2013.9999>.
8. ACS. American College of Surgeons. Revised statement on the importance of workplace accommodations for pregnancy, parental leave, and lactation support for practicing surgeons. <https://bulletin.facs.org/2021/08/revised-statement-on-the-importance-of-workplace-accommodations-for-pregnancy-parental-leave-and-lactation-support-for-practicing-surgeons/>. Accessed October 3, 2021.
9. Slama EM, Johnson HM, Yu YR, Sumra H, Altieri MS. Paid parental leave for surgeons in the United States. *Am J Surg*. Aug 17 2021. <https://doi.org/10.1016/j.amjsurg.2021.08.016>.
10. American Institute of Architects. Best Practice. Chapter 10.05 Design Phases. Recommendations for designing lactation/wellness rooms. <https://www.aia.org/best-practices/17116-recommendations-for-designing-lactationwelln>. Accessed October 3, 2021.
11. ACGME. Accreditation Council for graduate medical education (ACGME) common program requirements (residency), effective July 1, 2020 <https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency2021.pdf>; Updated February 3, 2020. Accessed October 3, 2021.
12. American Society of Anesthesiologists. Statement on lactation among anesthesia clinicians. <https://www.asahq.org/standards-and-guidelines/statement-on-lactation-among-anesthesia-clinicians>. Accessed December 10, 2021.
13. Johnson HM, Walsh DS. Crafting an evidence-based, accreditation Council of graduate medical education-compliant lactation policy for residents and fellows. *Breastfeed Med*. 01 2020;15(1):49–55. <https://doi.org/10.1089/bfm.2019.0201>.
14. Porter KK, Arleo EK, Spalluto LB, McGinty G, Hess CP. A lactation credit model to support breastfeeding in radiology: the new gold standard to support "liquid gold." *Clin Imag*. Jun 29 2021;80:16–18. <https://doi.org/10.1016/j.clinimag.2021.06.026>.

Helen M. Johnson*

Department of Surgery, East Carolina University Brody School of Medicine,
600 Moye Boulevard, Greenville, NC, USA

Madeline B. Torres

Department of Surgery, Penn State Health Milton S. Hershey Medical
Center, 500 University Ave MC H149, Hershey, PA, 17033, USA
E-mail address: mtorres2@pennstatehealth.psu.edu.

Leah C. Tatebe

Department of Trauma and Burn, Cook County Health, 1950, West Polk
Street, Chicago, IL, USA
E-mail address: leah.tatebe@cookcountyhhs.org.

Maria S. Altieri

Department of Surgery, East Carolina University Brody School of Medicine,
600 Moye Boulevard, Greenville, NC, USA
E-mail address: altierim19@ecu.edu.

from the Publications Committee of the Association of Women Surgeons

* Corresponding author.

E-mail address: johnsonhe15@ecu.edu (H.M. Johnson).