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My Thoughts / My Surgical Practice

Support of pregnancy and parental leave for trainees and practicing surgeons

The Association of Women Surgeons (AWS) strongly supports individual family planning decisions through pregnancy, surrogacy, fostering, or adoption. Choosing to have a family does not reflect on one's professional commitment or ability as either a trainee or a practicing surgeon. In fact, having a family may further contribute to physician well-being, feelings of fulfillment, and faculty retention.[1]

In 2021, the AWS Publications committee published an editorial in support of a paid parental leave for surgeons in the United States.[2] To facilitate implementation such policies, we now provide a framework to support surgeons as parents during their training and practice. Further, due to the unique nature and demands of surgical training and practice, we encourage all surgical training programs and departments of surgery to develop and implement their own parental leave policy beyond those provided by the institution's Graduate Medical Education or Human Resources departments.

The recommendations below are for pregnancy, surrogacy, fostering and/or adoption.

This statement does not encompass the important topics of fertility treatments and ova preservation. We do believe that adequate support should be provided to the practicing surgeon and trainee in order to ensure they have adequate time for these treatments and/or any pregnancies.[3]

1. Training

Parental leave terms should be explicitly described in the trainee's contract. The training program should develop a formal parental leave policy based on the practice specific Board of Surgery's leave policy. In addition, the training program should have a handbook or written guidelines for supporting surgical families. The handbook can include some of the considerations listed below in terms of call schedule, support system, parental leave time, etc. The program's policy should be in compliance with ACGME policies on this topic.

The AWS fully supports programs to develop and adopt guideline policy to support surgical families during training.[4] The surgical programs should have a policy to encourage an environment supporting surgical families, pregnancy, and parental leave. A culture of support should be strengthened and mistreatment and bias should not be acceptable to the program.

The trainee is not required to disclose pregnancy status or adoption plans to the program. However, it is recommended that the trainee informs the program director/program leadership of a pregnancy or potential adoption in order to allow for assistance and accommodations during the absence of the trainee. The program director/leadership can not disclose this information except when necessary to facilitate assistance to the trainee and/or to provide reasonable accommodations, or with trainee's permission.

Upon disclosure, a formal meeting with the residency program leadership (Program Director, Associate Program Directors) should be held in order to ensure that the trainee has the necessary support system in place during the process of pregnancy/adoption. Discussion points should include but not be limited to duration of time away, parental leave, rotations, didactics, transition back into residency following parental leave, etc. This group should meet during the process as necessary, and if any significant changes arise. In addition, the program leadership should revise the clinical schedule in order to provide lower acuity rotations for the resident during the later months of pregnancy and upon the resident's return to training, in addition to planning for coverage during the time of parental leave.

Due to the high rate of pregnancy-related complications among surgical trainees and practicing surgeons in the last trimester,[5] consideration for lighter call/rotation schedules should be incorporated in the last trimester of pregnancy. The trainee can help facilitate this process by requesting time off and arranging call/service coverage far in advance. Also, the trainee should be provided with adequate time off for pre-natal or adoption appointments.

AWS supports the American Board of Surgery (ABS) strive to improve the Parental Leave policy. Effective for the 2021–2022 academic year, the ABS provides the option to take at least six weeks away from training for events such as a new child (birth, adoption, or foster care), care for a seriously ill family member, or to grieve the loss of a family member or recover from a serious personal illness. However, these weeks off can lead to diminished vacation time or prolonged training. Further changes should be investigated to help mitigate these consequences.

A uniform Parental Leave policy for trainees across surgical specialties would be essential. While the ABS just extended the policy to at least six weeks, The American Board of Plastic Surgery (ABPS) (Board) has established an optional 12 weeks of Personal Leave that is available to residents in Integrated, Independent and Competency-Based plastic surgery residency training programs. The Personal Leave Policy went into effect beginning with the 2019–2020 academic year. Within orthopedic surgery residency, the American Board of Orthopedic Surgery requires 46 weeks of orthopedic education per year, on average over 5 years. Thus, six weeks per year may be utilized for leave.[6]

Additional provisions should be provided for residents who experience complications of pregnancy/birth or issues with the newborn's health and have exhausted the time off as allowed by the ABS. Trainees should be informed of alternatives, such as the 5 in 6 program or extension of training. Once competency-based assessment is established, provisions for additional time off should be considered and *adjusted if*

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more than one parental leave period is needed during the course of surgical training. In case of pregnancy loss, bereavement time should be provided.

The post-partum period can be a difficult adjustment period. Upon the trainee's initial return, more strenuous rotations, in terms of operative case load and hours, should be avoided so the resident can bond with the newborn and continue to recover physically if necessary. Leading up to or immediately following return from parental leave, the trainee and program leadership should meet to discuss expectations and progress, including case numbers, and clinical re-acclimation, among other topics. The resident should not be expected to make up for missed call upon their return to work. Breastfeeding support should be provided, such as designated times for pumping and accessible locations. For more information, please see the recently published AWS Statement.[7] Ideally, the trainee should have reasonable access to on-site or off-site childcare at an affordable rate. The trainee should feel safe to request accommodations during longer cases to leave the operating room for pumping and/or snack breaks.

While most of these recommendations are directed towards pregnant residents, support for the expecting partner should be provided as well. The non-birthing parent should be allowed adequate time to attend prenatal visits with their partner and provided with parental leave following birth/adoption. Following the birth/adoption of a child, a lower acuity rotation should be considered in order for the trainee to be able to bond with the child.

2. Practicing surgeons

Parental leave terms should be explicitly described in the practicing surgeon's contract or the institution's leave policy. These terms should include some of the considerations listed below in terms of call schedule, support systems, parental leave time, RVUs adjustments, etc.

The surgeon is not required to disclose pregnancy status or plans for adoption/foster/surrogacy to the employer/hospital. Upon disclosure, a formal meeting with the division chief/chair/supervisor should be held to ensure that sufficient support and accommodations for the practicing surgeon are in place. The pregnancy status or plans for adoption/foster/surrogacy should be kept confidential to the extent possible, or disclosed only with the surgeon's permission.

Adequate time off for prenatal visits or adoption/foster/surrogacy meetings should be provided.

The pregnant practicing surgeon should plan for less strenuous case load/clinics during the third trimester of pregnancy, as data has shown that operating more than 12 hours per week during this time is associated with increased risk of pregnancy complications. Consideration to such data should be taken to reduce rates of complications.[5] In addition, the surgeon should avoid increasing call requirements in the time leading up to delivery to make up for time taken away from clinical duties during parental leave.

The AWS supports at least 12 weeks of **paid** parental leave for all surgeon mothers. The 12 weeks minimum of paid parental leave is recommended by the American Public Health Association and the American Academy of Pediatrics. Other provisions such as short-term disability or donation of sick leave should also be considered in cases where additional leave is necessary and/or FLMA has been exhausted.

The practicing surgeon should not be penalized for lower RVUs during the pregnancy and for the first year after the birth of the child. During the formal meeting with the division chief/chair/supervisor, a productivity and/or compensation adjustment should be discussed and agreement by all parties should be reached. Additionally, academic advancement and promotion should not be negatively impacted by the time off for parental leave. In case of unexpected events, such as complications during pregnancy or birth, another meeting should be held to discuss additional considerations. In case of pregnancy loss, bereavement time should be provided.

Upon return of the practicing surgeon, lower acuity cases and less call could be considered for a period of time mutually acceptable to the surgeon and departmental leadership. The discussion should include potential effect on compensation, if any. The practicing surgeon should not be expected to make up call once they return to work.

Breastfeeding support should be implemented in the schedule, such as designated times for pumping and accessible locations. RVU compensation should be considered for 30 min breaks for pumping. For more information, please see the recently published AWS Statement.[7]

The surgeon should have reasonable access to on-site or off-site childcare.

While most of these recommendations are directed towards pregnant physicians, support for the expecting partner should be provided as well. The non-birthing parent should be allowed time off to be able to go to the prenatal visits. Adequate time off for the partner should be considered for a paid parental leave. Following the birth/adoption of a child, a lower acuity call should be considered in order for the physician to be able to bond with the child.

3. Final thoughts

In summary, the Association of Women Surgeons supports policy that allows for the healthy conception, delivery and adoption of children to surgical trainees and practicing surgeons. Healthy families facilitate surgeons that can participate fully in their careers and care adequately for their surgical patients.

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Declaration of competing interest

The authors report no conflict of interest related to this work.

References

1. Rangel EL, et al. Pregnancy and motherhood during surgical training. *JAMA Surgery*. 2018;153(7):644–652.
2. Slama EM, et al. Paid parental leave for surgeons in the United States. *Am J Surg*. 2021;223(1):218–220.
3. Möller MG, et al. *Time Out! We Must Address Fertility Preservation for Surgical Trainees*. Am J Surg; 2021. Ahead of print.
4. Bamdad MC, Hughes DT, Englesbe M. Safe and supported pregnancy: a call to action for surgery chairs and program directors. *Ann Surg*. 2022;275(1):e1–2.
5. Rangel EL, et al. Incidence of infertility and pregnancy complications in US female surgeons. *JAMA Surg*. 2021;156(10):905–915.
6. Compton J, Hajewski CJ, Pugely AJ. Pregnancy and parental leave during orthopaedic surgery residency. *Iowa Orthop J*. 2021;41(1):19–23.
7. Johnson HM, Torres MB, Tatebe LC, Altieri MS. *Every Ounce Counts: A Call for Comprehensive Support for Breastfeeding Surgeons by the Association of Women Surgeons*. Am J Surg; 2022. Epub ahead of print.

Maria S. Altieri*
Department of Surgery, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA, USA

Aurora Pryor
Department of General Surgery, SUNY Stony Brook, Stony Brook, NY, USA

Madeline B. Torres
Department of General Surgery, Penn State Milton S. Hershey Medical Center, Hershey, PA, USA

Megan E. Miller
Department of Surgery, University Hospitals Cleveland Medical Center, Case Western Reverse University School of Medicine, Cleveland, OH, USA

Mecker G. Möller
Department of Surgery, University of Miami, Miller School of Medicine, Miami, FL, USA

Emilia J. Diego
Department of Surgery, University of Pittsburgh School of Medicine, Pittsburgh, PA, USA

Chantal Reyna
Department of Surgery Crozer Health System, Drexel Hill, PA, USA

the Association for Women Surgeons Publications Committee and the Association for Women Surgeons He For She Committee

* Corresponding author. Department of Surgery Pennsylvania Hospital/ University of Pennsylvania, 800 Walnut St. 20th Floor, Philadelphia, PA, 19107, USA.
E-mail address: Altieri.m@gmail.com (M.S. Altieri).