SOCCA Recommendations for Parental Leave and Lactation[*,†]

1. Employers of critical care anesthesiologists should have explicit written policies that support and define parental leave and lactation support.
    a. These policies should include statements on birth, adoption, surrogacy and care of a sick family member.
    b. Type of leave, payment schedule, insurance coverage, incentive pay if applicable and duration should be specified.
    c. Institutional parental leave policies should not be more restrictive than applicable federal and state laws.
    d. Lactation accommodations should include private space and reasonable time including patient care assistance if needed.
2. SOCCA encourages parental leave should be paid time away from work and not require use of vacation or sick days, however, it is ultimately the responsibility of the employer to inform employees on all policies regarding parental leave.
3. SOCCA discourages from the 'front-loading' or 'back-loading' of calls to compensate for missed calls during parental leave.
4. The critical care physician has the responsibility to notify their employer of changes to personal or family status as soon as reasonable.
5. Critical care physicians should be offered maternity leave of at least 6 weeks (vaginal delivery) or 8 weeks (Cesarean delivery) and paternity leave of at least 6 weeks with the option to extend the leave.
    a. Parents should have the option to break up the leave time over a period of 6 months with flexible scheduling for child care associated needs.
6. Critical care physicians with lactation needs, should be reasonably accommodated with private space and adequate time for pumping.

Background:

The Society of Critical Care Anesthesiologists (SOCCA) recognizes the invaluable contributions made by intensivists who also have familial duties. The training and diligence required to obtain and maintain a career in critical care anesthesiology is formidable. Additionally, the daily work of critical care practice involves an innate stressful environment. As such, SOCCA wishes to recommend a guide for paid time off for intensivists who have children either by pregnancy, adoption or surrogacy. Furthermore, lactation needs should be addressed with adequate space and time allotments. The following recommendations are set forth to protect employment and to honor healthy and fulfilling home lives. SOCCA believes that the promotion of work-life balance will benefit departments, hospitals and patients in numerous ways by retaining high quality critical care anesthesiologists who feel dedicated to their workplace.

[*] All in concordance with the ASA Statement on Personal Leave[2]

[†] Since the document has neither been presented to nor approved by either the American Society of Anesthesiologists (ASA) Board of Directors or House of Delegates, it is not an official or approved statement or policy of the ASA. Variances from the recommendations contained in the document may be acceptable based on the judgment of the responsible anesthesiologist.

Other Medical Society Statements on Family Leave:

Parental leave is linked to health benefits for both children and parents.[1] As a precedent, the American Society of Anesthesiologists endorsed a recommendation stating that physician anesthesiologists and anesthesiology residents/fellows should be offered maternity leave of at least 6 weeks (vaginal delivery) or 8 weeks (Cesarean delivery) and paternity leave of at least 6 weeks with the option to extend the leave. Physician anesthesiologists and anesthesiology residents/fellows who become parents outside of pregnancy (such as via adoption or surrogacy) should be extended the same benefits.[2] The American Academy of Pediatrics endorses 12 weeks of paid family leave based on scientific benefit to the child. The American College of Surgeons (ACS), The American College of Obstetricians and Gynecologists (ACOG), The American College of Physicians (ACP) all endorse paid parental leave for all workers that includes maintenance of full benefits and 100% of pay for at least 6 weeks.

Evidence of Need:

Recent surveys of women in anesthesiology have provided evidence for the need to understand and offer support for child bearing physicians. One survey of 1827 women anesthesiologists, demonstrated that approximately 1 in 10 would counsel a student against a career in anesthesiology due to obstacles pertaining to motherhood, and this was associated with altering one's timing and number of children due to job demands.[3] In another survey study in respondents identifying as female (n=519), half of respondents (51%) felt that the number of children they had, or did not have, was due in part to career choice.[4] Over a third of respondents worked in institutions that did not provide any form of maternity leave excepting the use of sick and/or vacation days in order to receive pay following the birth of a child (35%).

Lactation spaces were only suitable to 1/3 of respondents. Many women identified that breastfeeding options were limited by lack of time, space and other inconveniences. Breast milk feeding has been linked to numerous health benefits in children such as stronger immune systems, fewer infections, lower rates of infant mortality, lower incidences of ADHD and obesity.[5,6] Additionally, parents who breast milk feed have up to six times less absenteeism from work.[6] Furthermore, federal law requires employers to provide reasonable break time for an employee to express breast milk for her child for one year after the child's birth each time such employee has need to express the milk (Section 7 of the FLSA). Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk. ACGME has recently added similar requirements for residents who are need of lactation spaces, with the addition of refrigeration storage and helpful additions of a computer and phone for work-related purposes.[7]

As for work life balance, the survey[3] found that 60% of female anesthesiologists reported that they were responsible for the majority of household duties and that work-life balance was less than ideal for 45%. Notably, 42% of respondents limited roles at work or went part-time due solely to demands of home life. Overwhelmingly, participants felt that women in medicine need to work harder than men in medicine to achieve similar goals (90%). This finding may be attributed to the stress and obligations associated with child bearing, lactation and home responsibilities.

However, these data could represent discrimination in medicine as identified by another on-line survey.[8] Of 5782 respondents, 66% reported experiencing female gender discrimination and 36% reported maternal discrimination. Of those reporting maternal discrimination, 90% reported

discrimination based on pregnancy or maternity leave, and 48% reported discrimination based on breastfeeding. Notably when broken down by medical specialty, anesthesiology ranked highest as the specialty for physicians to experience maternal discrimination.

Furthermore, previous authors have coined the term “medical pipeline theory” reflecting a dwindling percentage of women physicians advancing academically. For example, in anesthesiology, this “pipeline theory” has been demonstrated in that women represent 34% of anesthesia residents, 37% of full time anesthesia faculty, but only 18% of full professors and 11.5% of anesthesiology department chairs.[9,10] Surprisingly, in 116 years since inception of the American Society of Anesthesiologists began, only four women have made it up the ranks to president.[11] However, the “pipeline theory” has recently been refuted to reflect that there may be institutional bias instead of a leaky “pipeline”.[12] In other words, the cause of these areas of underrepresentation is not that there is an insufficient number of women, but that there is a process involving implicit or unconscious bias leading to gender disparities in medicine.

Institutional and financial benefits associated with Parental Leave Policies:

When analyzing outcomes associated with maternity and paternity leave practices, evidence demonstrates that departments and institutions benefit from parental policies. Not only financially, but also academically. The ‘Top 12 U.S. Medical Schools’ ranked both by funding by the National Institutes of Health and academic ranking by the *US News & World Report* all have childbearing leave policies with salary support.[13] The mean length of full salary support was 8.6 weeks (range 6-16). Similarly, 53% of academic surgery departments at top-ranked academic centers offer some form of paid parental leave to faculty surgeons.[14] In fact, the higher the ranking, the more likely the institution offered paid parental leave. It is unclear if institutions that implement parental policies attract top talent or if parental policies improve faculty morale and productivity leading to higher rankings. Either way, these policies advance departments.

Currently, there is an on-going shortage of intensivist in the United States.[15] There is extensive evidence that intensivist presence is associated with decreased mortality rates for critically ill patients.[16,17] While intensivists bring experience and expertise in the care of critically ill patients that non-intensivist physicians do not possess, they also bring leadership skills which lead to improved team performance. This in turn, may also lead to improved multidisciplinary team job satisfaction and encourage the retention of ICU nurses, respiratory therapists, ICU pharmacists and other critical team members. Indeed, there is robust evidence that maintenance of ICU team atmosphere is a key component in the provision of high-quality critical care to patients of increasing complexity and with increasingly diverse needs.[18]

Retention of highly trained workers is important for departmental finances. For an organization, the cost of physician burnout can range from $500,000 to more than $1 million per doctor. This estimate includes recruitment, sign-on bonuses, lost billings and onboarding costs for replacement physicians.[19]

References:

1. Heymann J, Raub A, Earle A. Creating and using new data sources to analyze the relationship between social policy and global health: the case of maternal leave. *Public Health Rep*. 2011;126 Suppl 3:127-134.
2. ASA Statement on Personal Leave. https://www.asahq.org/standards-and-practice-parameters/statement-on-personal-leave. Accessed October 7, 2020.
3. Kraus M, Dexter M, Patel P, et al. *Anesth Analg*. 2020 May;130(5):1296-1302.
4. Flynn B, Stiles K, Fritzel A, et al. Analysis of factors affecting women anesthesiologists. *Anesthesia: Essays and Researches*. 2020. Online ahead of print.
5. Lichtman-Sadot S, Bell N. Child health in elementary school following California Family Leave Program. *J Policy Anal Manage*. 2017;36:790-827.
6. https://my.clevelandclinic.org/health/articles/15274-the-benefits-of-breastfeeding-for-baby--for-mom. Accessed October 7, 2020.
7. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf. Accessed October 14, 2020.
8. Adesoye T, Mangurian C, Choo E, et al. Perceived discrimination experienced by physician mothers and desired workplace changes. *JAMA Intern Med*. 2017;177:1033-6.
9. American Medical Association Physician characteristics and distribution in the U.S. Chicago. 2016.
10. Miller J, Chuba E, Deiner S, DeMaria S, Jr., Katz D. Trends in authorship in anesthesiology journals. *Anesth Analg*. 2019 Jul;129(1):306-310.
11. https://www.asahq.org/about-asa/governance-and-committees/past-presidents. Accessed October 7, 2020.
12. Silver JK, Poorman JA, Reilly JM, et al. Assessment of women physicians among authors of perspective-type articles published in high-impact pediatric journals. *JAMA Netw Open*. 2018;1:e180802.
13. Riano NS, Linos E, Accurso EC, et al. Paid Family and Childbearing Leave Policies at Top US Medical Schools. *JAMA*. 2018;319(6):611-614.
14. Itum DS, Oltmann SC, Choti MA, Piper HG. Access to Paid Parental Leave for Academic Surgeons. *J Surg Res*. 2019;233:144-148.
15. Halpern N. Pastores S, Oropello J, Kvetan V. Critical Care Medicine in the United States: Addressing the Intensivist Shortage and Image of the Specialty. *Crit Care Med* 2013; 41:2754–2761.
16. Wilcox ME, Chong CA, Niven DJ, Rubenfeld GD, Rowan KM, Wunsch H, Fan E. Do intensivist staffing patterns influence hospital mortality following ICU admission? A systematic review and meta-analyses. *Crit Care Med*. 2013 Oct; 41(10):2253-74.
17. Benoit M, Bagshaw S, Norris C, et al. Postoperative Complications and Outcomes Associated With a Transition to 24/7 Intensivist Management of Cardiac Surgery Patients. *Crit Care Med* 2017;45:993-1000.
18. Donavan A, Aldrich J, Gross A, et al. Interprofessional Care and Teamwork in the ICU. *Crit Care Med*. 2018 Jun;46(6):980-990.
19. https://www.ama-assn.org/practice-management/physician-health/how-much-physician-burnout-costing-your-organization. Accessed October 7, 2020.