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Paid parental leave for mothers and fathers can improve physician wellness

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The number of women going into medicine is increasing, and this trend is magnified in pediatrics. In 2017, 46% of U.S. residents and fellows were women compared to 75% of pediatric residents and fellows.

Pediatric training programs, departments and workplaces have the opportunity to be leaders on issues relating to wellness and career satisfaction for female physicians. Parental leave is one such issue.

Despite AAP support for 12 weeks of paid parental leave and statements by AAP Past President Benard P. Dreyer, M.D., FAAP (2016-'17) that six to nine months of leave would be ideal, most female pediatricians take much less time than that. Research by H. J. Talib and colleagues shows that half of pediatricians who were mothers received no paid maternity leave, and 80% wanted a longer leave than what they took. Female pediatricians often cobble together an extended leave by combining vacation time, sick days, disability leaves and unpaid time off, which can lead to burnout and feelings of under-valuation.

Research in high-income countries shows that prolonged paid parental leave is associated with higher rates of exclusive breastfeeding, on-time immunizations and decreases in neonatal mortality. Furthermore, extended paid leaves of about six months are associated with a higher total contribution to household income (Heymann J, et al. *Public Health Rev.* 2017;38:21). This could boost career satisfaction, which overall is lower among female pediatricians than their male colleagues.

Far from being a panacea, paid leaves for female pediatricians come with risks and costs. Women who take leaves have lower peer evaluation scores than those who do not take leave. They can miss out on relative value unit (RVU)-based bonuses. Down the line, academic promotions may be delayed. When parental leave ends, on-service time may be increased to make up for time at home, exacerbating the stress of returning to work. Practice interruptions, including leaves, even have impacted board eligibility status, as in the case of pediatric hospital medicine before the rule was adjusted after a public call to action in 2019.

Workplaces should have equitable parental leave policies for both fathers and mothers. Such policies will help new families stave off stress, decrease resentment toward women who take leaves and will help close gender gaps in pay and promotions.

Policies also should allow parents to return to work gradually and resume responsibilities in a step-wise fashion. For example, new parents might return to academic duties before clinical care, or they may practice in an outpatient setting before returning to inpatient care. Such a transition may ease stress by allowing people to re-engage professionally (something they may be longing to do) while still prioritizing time with their new baby.

To truly embrace the concept of wellness, pediatric workplaces should ask: What small allowances or accommodations can we make for parents that will make them feel valued and supported, even if it means a slight decrease in short-term RVU accrual? Such accommodations will go a long way toward engendering a sense of belonging in a workplace and fighting burnout. For example, lactation-friendly workplaces are a step in the right direction, but they should not supplant sufficiently long paid parental leaves.

Pediatrics can be a beacon to other fields within and outside of medicine by taking the stand that new parents deserve a proper paid leave to recover from childbirth, bond with their baby and support each other through this life-changing event.

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