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What's Best? Parental Leave and Pediatric Training

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In a recently released issue of *Pediatrics*, trainee physician Dr. Erin Bruney and attending colleague Dr. Sakina Sojar share the lead author's experiences of becoming a mother during residency, and Dr. Judy Schaechter, President and CEO of the American Board of Pediatrics (ABP), and colleagues comment on the challenges and questions raised with respect to training (10.1542/peds.2022-057775). Maternity and paternity leaves are a highly personal and sensitive issue, yet are also a policy matter in the public domain; the well-written essays of Drs. Bruney and Sojar, as well as of Dr. Schaechter and colleagues (10.1542/peds.2022-059827), beautifully embody the tension between these two arenas.

Dr. Bruney's postpartum experience was complicated both by postpartum pre-eclampsia and then by postpartum depression. Hypertensive disorders of pregnancy affect up to 1 in 7 mothers[1] and postpartum depression affects up to 1 in 8 mothers, with higher rates of depression among those delivering preterm and with other risk factors.[2,3] Both conditions are medically and psychologically stressful, with short- and long-term complications possible for the mother, child, and for their vulnerable, critically important and growing relationship.[4,5] In addition to sharing key lessons learned for pediatricians, Dr. Bruney asks for additional support for trainee mothers from the ABP. Dr. Schaechter and colleagues respond graciously and sincerely with acknowledgement of the stressful challenges Dr. Bruney faced. They recommit the ABP to improving recognition and treatment of postpartum depression, and appropriately remind us that the ABP is responsible to the public for safe and excellent training of pediatricians. They also note the recent incremental but meaningful changes to ABP parental leave policy that exceed Accreditation Council for

Graduate Medical Education/American Board of Medical Specialties (ACGME/ABMS) requirements by increasing leave to 8 weeks and (potentially) decreasing training to 31 months.[6]

How can we reconcile these differing views of the work of the ABP and its support for trainees with the postpartum experiences of residents such as Dr. Bruney? Dr. Bruney's challenges were *extraordinary*, in that she faced a trifecta of postpartum preeclampsia, postpartum depression, and a return to rigorous work conditions, yet her experience is *ordinary*, in that so many mothers (including trainees) face such stressful return to work circumstances across the US .[7] The lens for parental leave in the US is, in my view, terribly flawed. Of 193 countries in the United Nations, only a small number (New Guinea, Suriname, a few South Pacific Islands, and the US) do not have paid parental leave; the US is the only high-income country without paid maternity leave.[8] The United Nations Children's Fund (UNICEF) recommends at least 6 months of paid maternity leave, citing evidence that this is the optimal way to ensure healthy growth and development for infants until they reach 6 months of age or even older with subsequent transition to high-quality non-parental child care and ongoing workplace lactation support.[9] This 6 month leave would allow a parent this important extended special time to establish a foundational relationship with their young child, making it less stressful for them to return to work. The extensive evidence cited in this UNICEF brief relates to direct benefits for infant and maternal health, prevention of family violence, and economic benefits for families and society.[10] In the US, there is currently a widespread expectation that all new parents can leap back into the workplace within 6-8 weeks of having a new baby, and that this "multi-tasking" is a manageable demand; in fact, evidence cited in the UNICEF brief suggests this may not be optimal. I believe we need a new national discourse about parental leave that re-focuses on how UNICEF's global evidence-based recommendations can be implemented in the US.

With respect to what can be done in the short-term to better support trainees who have a baby during residency or fellowship, we should encourage trainees (as per ACGME/ABMS policy) to take full advantage, or as much advantage as they believe is right for their family, of the extended parental leave permitted by the ABP, which is up to 2 years for residents and up to 1 year for fellows without the need to petition for credit from prior training on re-entry.[11] I strongly encourage the ABP to remove just one of its caveats on parental leave, which effectively makes leave up to the Program Director, not the trainee: "The total amount of leave time offered to the trainee is at the discretion of the Institution."[11] This approach, while respectful of scheduling needs, co-trainees' stress, and hospital needs, does not align with respect for trainees' self-determination and reproductive choices. Given this revision to the ABP's thoughtful and precise policies, and with more flexibility in-program directors and the residency programs they oversee, becoming a fully trained and competent pediatrician would not need to conflict with caring for oneself and one's family.

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