

To leave or not to leave: American Association for the Surgery of Trauma (AAST) panel discussion on personal, parental, and family leave

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SUMMARY

Navigating planned and emergent leave during medical practice is very confusing to most physicians. This is especially challenging to the trauma and acute care surgeon, whose practice is unique due to overnight in-hospital call, alternating coverage of different services, and trauma center's staffing challenges. This is further compounded by a surgical culture that promotes the image of a 'tough' surgeon and forgoing one's personal needs on behalf of patients and colleagues. Frequently, surgeons find themselves having to make a choice at the crossroads of personal and family needs with work obligations: *to leave or not to leave*. Often, surgeons prioritize their professional commitment over personal wellness and family support. Extensive research has been conducted on the topic of maternity leave and inequality towards female surgeons, primarily focused on trainees. The value of paternity leave has been increasingly recognized recently. Consequently, significant policy changes have been implemented to support trainees. Practicing surgeon, however, often lack such policy support, and thus may default to local culture or contractual agreement. A panel session at the American Association for the Surgery of Trauma 2022 annual meeting was held to discuss the current status of planned or unanticipated leave for practicing surgeons. Experiences, perspectives, and propositions for change were discussed, and are presented here.

INTRODUCTION

Trauma and acute care surgeons are inherently aware and familiar with the direct and indirect consequences of emergencies on individuals. Yet, repeatedly, trainees and surgeons are indoctrinated to think that it is a poor performance, or unprofessional, if they take time off for medical or family emergencies.¹ Emergencies present unique hurdles to surgical practice and career. Many surgeons may recall an incident where they, or a colleague, were forced or shamed into working when they were ill or when they needed to be present elsewhere to care for self or family. The lack of supportive leave policies asymmetrically affects employees with serious health conditions, further deepening the inequality and bias in employment. The most frequently studied scenario is maternity leave, specifically during surgical training. The widespread absence of a supportive culture for pregnant surgeons

reflects the long-lasting inequality towards women in medicine. Although significant change has been advocated for and endorsed to support women in medicine, maternity leave policies remain inadequate. Additionally, studies and advocacy efforts have failed to appropriately address paternity leave and its significant value in the healthy development of children and the well-being of families.

To make meaningful progress towards the development of an ideal and universal leave policy, it is important to acknowledge the current deficiencies and opportunities for improvement, in surgical culture, local and federal laws, and leadership support.

AMERICAN ASSOCIATION FOR THE SURGERY OF TRAUMA PANEL DISCUSSION

The American Association for the Surgery of Trauma (AAST) Education Committee held a panel on leave during surgical practice during the September 2022 meeting in Chicago, Illinois. The panel discussion was titled 'To Leave or Not to Leave: Navigating the Needs, Rules, and Risks of Personal, Paternity, Maternity, and Family leave'. It included several trauma and acute care surgeons of different backgrounds, lengths of career, and leadership roles. The objective of the panel was to discuss different types of parental, medical, and family leaves. Maternity and paternity leaves remain the most commonly researched type of leave with a significant on medical career. This was echoed in the personal experiences shared by the participants.

The panel highlighted the paucity of standard policies and guidelines for surgeons who need to take time off during practice. Lessons from these experiences were extremely valuable in promoting supportive attitudes among the participants, their colleagues, and employers. The shared experiences demonstrated the variability among surgeons in attitudes towards medical and family leave and the importance of leadership and collegial support. The panelists emphasized the direct relationship between a supportive culture and established leave policies on one hand and the surgeon's satisfaction, happiness, and productivity on the other. Surgeon leaders on the panel (RDW, BLZ) shared their own experiences as well. They additionally emphasized the importance of the leader to establish a healthy

Box 1 Federal Family and Medical Leave Act (FMLA) eligibility requirements and rules

- ⇒ The employer employs 50 or more employees within a 75-mile radius of the worksite.
- ⇒ The employee must have been employed with the company for at least 12 months before requesting leave.
- ⇒ The employee must have worked at least 1250 hours during the 12 months before the start of FMLA leave.

Planned leave to cover:

- Birth of a child.
 - Care of a newborn child.
 - Adoption.
 - Care of a spouse, child, or parent with a serious health condition.
 - Employees' own serious health condition.
 - Transition of employee or spouse to active duty.
- ⇒ Employers can deny job restoration if employee is among highest paid 10% of all employees.
 - ⇒ Employee must give the employer at least 30 days advance notice of the need to take FMLA leave when he or she knows about the need for the leave in advance.

and supportive *structure* to achieve a meaningful and positive change in *culture*.

NATIONAL AND STATE LAWS Family and Medical Leave Act

Hospitals and surgical practices, like other employers in different fields, often base their leave policies on federal and state laws, majority of which fall short of being equitable or providing work and pay guarantees. The basis of these laws is the Family and Medical Leave Act (FMLA) of 1993, which guarantees 12 weeks of protected leave for employees although unpaid and only after meeting several conditions.^{2,3} Despite being introduced in 1984, it did not become law until 1993 due to well-funded opposition resulting in vetoes twice in 1991 and 1992. Prior to this, employees frequently faced a conflict choosing between work responsibilities and family needs. Although FMLA represented a crucial step forward, little has been done to continue to build on it and improve the legislation during the past 30 years. Several strict conditions must be met for employers and employees to apply the benefit which, since inception, continues to limit eligibility³ (Box 1). Surgeons are less likely to qualify due to some of these requirements. Additionally, members of the same household who are employed by the same practice must share a single 12-week protected period. Most importantly, the law does not guarantee financial security and pay. Employees, including many surgeons, might not elect to invoke their right as pay is not guaranteed by their employer beyond what the law mandates.

Recent initiatives and local laws

The implementation limitations led to recent movements to establish federal paid family leave. Unfortunately, the current political environment in the USA prevented the expansion of benefits and rather resulted in significant modifications to the original plan by decreasing the paid leave from 12 weeks to 4 weeks. Eventually, the initiative was slashed completely as a compromise to pass the Build Back Better Act in 2021.⁴ It is evident that laws at the federal level are not sufficient, nor do they provide meaningful relief to employees in need of emergent leave. Fortunately, several states have enacted additional

laws to guarantee family or medical paid leave.^{5,6} Eleven states (Arizona, Colorado, Maine, Maryland, Michigan, Nevada, New Jersey, New Mexico, New York, Rhode Island, and Washington) and the District of Columbia (DC) offer paid family leave with some variability in duration, qualifications, job protection, and compensation mechanisms. Hawaii offers the longest duration of paid leave (26 weeks), whereas DC offers the most funded paid family and medical leave.^{7,8}

SURGICAL CULTURE

The culture of medical practice, and specifically surgical practice, has long fallen short of effectively addressing planned and unanticipated medical and family leave as a vital aspect of the profession. An effective leave policy should ensure protected time off and secure income, be fair and free of bias, and not burden the surgeon with a sense of debt to either employer or colleagues. Therefore, it is of paramount importance that differences in attitude towards medical leave among surgeons, especially among generational groups, are eliminated or changed positively. It was the position of the panel that a universal acceptance and support of the importance of medical leave should become the norm in all practices. One panelist (BKB) stated that, although formal policies did not guide her institutional rights to the type of personal leave that she needed, the culture of adapting to faculty needs at the department was very helpful. Her chair helped institute a plan of gradual return to work in a way that was physically accommodating and ensured a better transition for herself and her partners.

Often surgeons who find themselves in need of medical or family leave are not adequately informed of local and federal laws and policies, let alone individual contractual agreements. Employment contracts' clauses regarding emergencies might not be clear, comprehensive, readily available when in need, or may not exist at all. Only half of top academic medical centers offered paid parental leave (48 of 91)—this was better in private centers than public hospitals.^{9,10} Surgeons, especially groups with historically less power such as women and minorities, feel guilty when taking time off. The need to make up workdays or on-call shifts after unexpected or unplanned leave is a common expectation. Historically, these factors, along with others, have prevented many surgeons from using earned vacation and leave time when needed.

Maternity leave

The surgical culture has frequently favored ignoring personal and family needs and pushed the traditional image of a tough surgeon. A survey of graduating surgeons from University of California conducted between 1989 and 2000 (42 of 71 responded) showed that 38% of men and 67% of women took time off during training for paternity or maternity.¹¹ Among practicing surgeons, however, 12% of men and 64% of women took time off work. Fifty percent reported having a leave policy in place and 11 respondents had a paid policy.¹¹ A more recent survey of 431 surgeons showed that after childbirth, a majority of women took less than 12 weeks off for maternity leave, whereas all men took less than 4 weeks of paternity leave. More interesting, only one-quarter of maternity leaves and one-half of paternity leaves were fully paid.¹² Qualitative statements from participants reflected a desire for a longer leave time for both men and women, separation between leave and need to make up call, as well as separation between leave and promotion or career growth.

It is not a surprise that attitudes and culture towards medical and family leave are rooted in surgical training culture. Currently, efforts to establish policies for parental and medical leaves are primarily focused on physicians in training.^{13 14} Perhaps the most unfortunate reporting by surgical trainees finds that one-third did not feel supported by either their colleagues or faculties when they needed to take a parental leave. Another survey of 876 surgery residents showed that 27% of the respondents felt unsupported by their department during pregnancy.¹⁵ The interactions between faculty and trainees have a bidirectional effect on changing attitudes towards medical leave. Implementing policies that support leave among trainees positively changes their faculty's stance regarding personal time off and deepens the support towards colleagues and trainees. Similarly, faculty that demonstrate valuing family and personal well-being to trainees creates a safe environment for the trainees to start a family, take needed time off, and prioritize well-being.^{16 17} The experience of one of the participants in the AAST panel discussion (DLH) demonstrated this trickle-down effect. A mentor advised her to take a longer time off than she had originally planned. Her colleagues felt empowered to do the same afterwards and to advocate for a system-wide policy change resulting in a monumental shift in the culture. Both female and male surgical residents reaped the benefits of this policy. Now as a faculty, she continues to advocate for her trainees and colleagues to be familiar with leave policies and advocate for their own well-being.

The failure to effectively address personal and parental leave is a global issue, especially for surgeons in practice compared with in-training.¹⁸ A global survey conducted in 2020 in 65 countries showed that surgeons do not take adequate time off after the birth or adoption of a child. It also revealed that female medical students are often discouraged from pursuing a career in surgery due to conflicts with family planning. Although an expert committee opinion of the American College of Obstetrics and Gynecology recommends 12 weeks of postpartum care and at least 6 weeks of paid leave,¹⁹ the United Nations recommends at least 18 weeks of paid maternity leave and 6 months of combined leave for both parents.²⁰ Compared with other developed countries, the USA does not have a national policy for paid maternity leave,²¹ and it ranks last in paid parental leave.

Paternal leave

Although pregnancy and newborn care have a greater impact on women, the important role of men in the care of their children and the support of their partners has been progressively recognized. However, paternity leave is significantly short in most countries, and it remains a distant reality in the USA.^{22 23} This ignores the vital and fundamental role of fathers in the care of their spouses and newborn children. The positive impact of paternity leave is evident through strengthening paternal relationships,²⁴ reducing risk of postpartum depression and fostering a stronger relationship with children.²⁵⁻²⁷ Three panelists shared their unique experiences with paternity leave. Of note, they were all relatively junior faculty at the time. None of the surgeons had planned a formal paternity leave initially. Instead, they arranged for a *very* short time off around the birth of their children using unofficial schedule planning. TK expressed immediate regret for not taking a longer time off as his wife struggled with postpartum anxiety. However, his supportive colleagues were quick to rearrange the schedule to accommodate a longer leave without clinical consequences. He could not avoid feeling stuck between his strong belief to be present and supportive to his family and his commitment to work and colleagues. This experience was

enlightening to the vital role of paternity leave for the well-being of himself and his family. DNH's experience involved an unexpected medical condition affecting one of his twins soon after birth. His supportive team also arranged for clinical coverage to allow for additional time off, even though it was relatively short. Yet, he prioritized returning to work early. He attributed his decision to the culture that taking paternity leave would have been 'unusual'. Ten years later, he continues to advocate for a change in the culture—"To phrase it mildly, my wife certainly remembers me being at work during that time period much more than I will ever remember the clinical work that I did." It is important to point out that the experience of DNH impacted TK's attitudes and decisions a decade later. TK was a trainee of DNH at the time of his experience. Although they never talked about it at the time, TK remembered it well when he realized the importance to be fully present to support his new family and thinks it empowered him to approach his colleagues to ask for help. In his reflection on his experience, DNH pointed out the unique personality of a trauma surgeon in regard to taking time off. Trauma surgeons are drawn to this field because they want to help people, even though at times it may result in personal sacrifice. 'In the same spirit, it is also likely that your partners would gladly and without hesitation extend their help to you when you are facing life-changing events. When it is your time, you cannot and should not be afraid to ask for the help you need.'

ORGANIZATIONAL SUPPORT AND INITIATIVES

Surgeons have the privilege of being supported by well-established and influential societies and organizations. The American Board of Surgery (ABS) and the Accreditation Council for Graduate Medical Education (ACGME) recently acknowledged the need to support surgical trainees and provided guidelines to allow necessary leave time without impacting the ability to qualify for board certification.^{28 29} The ACGME recommends that institutions establish policies that grant trainees with a 6-week fully paid medical, parental, or caregiver leave for residents and fellows. The ABS maintains admissibility to certification examinations while allowing for 4 weeks off during first 3 years of residency and 4 additional weeks in last 2 years. These additional weeks are independent of the 4 non-clinical weeks that are allowed annually. They further confirm commitment to implement such policies without fear of negative consequences. Both the ABS and ACGME regulate policies during training and for the purpose of certification. Therefore, these guidelines do not extend to the practicing surgeon. The American College of Surgeons (ACS) released a statement in 2016 (revised in 2021) on the importance of institutional policies to support maternity and parental leave and provide lactation support.³⁰ This statement strongly encourages clear contractual language for a paid, protected parental leave for 6–8 weeks without financial penalties. It also recommends accommodating call and operative schedules during the third trimester and establishing an accessible setup for lactating mothers. Despite the progressive recommendations, the ACS, as a non-governing body, does not have the ability to make these recommendations mandatory or provide a mechanism to enforce such policies. The statement also extensively covers parental leave and postpartum needs of women in surgery, but does not provide guidance for other medical or caregiver leaves or addresses best practices around emergency leaves. Similarly, several other professional organizations, such as the Association of

Women Surgeons³¹ and Eastern Associations for the Surgeon of Trauma,³² play an instrumental role in raising awareness and advocacy. These efforts should be unified to attain the desired positive impact.

LEADERSHIP ROLE

One study in Japan attributed the negative attitudes towards paternity leave to pluralistic ignorance. This occurs when individuals of a group of people erroneously think others in the group disagree with their views or attitudes, when in reality most if not all share the same views and attitudes towards an issue.³³ This concept similarly applies to attitudes towards family and medical leaves in the surgical community. Individually, each surgeon expresses support to parental and medical leave, but simultaneously, and mistakenly, thinks most other surgeons have opposite views. As a result, they elect not to seek the needed leave or appropriate duration of time off.

To correct the pluralistic ignorance, deeper and more open discussions need to take place locally and nationally. On the panel, RDW and BLZ emphasized that leaders at the division and department levels have a responsibility to build a healthy and supportive environment to only normalize taking time off appropriately, but also to encourage policies and structures to support this goal. One way to normalize time off for paid leave is to include contractual clauses covering paid leave policies during the recruitment process. RDW shared how establishing a divisional policy for backup surgeon activation and call-in when the on-call surgeon is operating eliminated the stigma around asking for help or stepping in when colleagues are in need. This resulted in more flexibility and cross-coverage in the setting of an emergent leave. BLZ emphasized that the compensation model should reflect the team effort required in Acute Care Surgery divisions, a group-based compensation model with an overall target and a benchmarked compensation if more supportive of a team-based concept. Another example at a different institution was a division-specific change to create the schedule as a group activity instead of being assigned. The redesign was fully supported by the leadership. This allowed for the surgeons to openly share plans, availability, and attitudes. The new process allowed for the elimination of the pluralistic ignorance among the team members and flexible rearrangements of clinical duties when emergent events occur. For TK, this approach was vital to create an environment where he could take the needed leave and simultaneously feel supported by his colleagues.

CONCLUSION

The path to secure equitable family and medical leaves for surgeons remains rugged. Existing laws and policies, although reflecting a significant progress, remain insufficient to meet the needs of practicing surgeons in times of emergency. In the meantime, a change in the culture and mindset of practicing surgeons is paramount. Such a change cannot occur without a complete acceptance and support from local and national leaders in surgery. Hospitals, chairs, and division chiefs must recognize the importance of clear and accessible leave policies locally. Colleagues should provide unconditional support to their partners in need and realize that a healthy team relies on healthy individuals, physically and mentally. Finally, professional organizations such as the AAST must collaborate and continue to provide

Box 2 American Association for the Surgery of Trauma panel's summary of recommendations

- ⇒ Hospital leadership should enact policies for all parental and extended personal or medical leave in alignment with institutional, state, and national laws.
- ⇒ Division and department leadership should develop contingency plans for clinical coverage that can be activated in the event of an unplanned or planned prolonged absence.
- ⇒ Research should be pursued to determine the national and state norms for all types of leave, barriers to successful implementation of national and hospital policy and barriers to creation of standard policy; and evaluate the differences between use and non-use among all medical and surgical specialties.
- ⇒ Professional societies should promote all forms of leave by creating and providing standard policies, fostering educational sessions and leadership training, and actively advocating at the state and national levels for protected leave legislation.

a platform for open and honest conversations to establish gold standards for fair, equitable, and practical medical and family leave (Box 2).

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