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Pediatricians Advocating Breastfeeding: Let's Start with Supporting our Fellow Pediatricians First

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Physician mothers have some of the highest rates of breastfeeding initiation; however, their rates of continuation of breastfeeding to 12 months of age drop substantially from 97% to 34%.[1] Major barriers include difficulty finding time and a place to express their milk while at work, competing demands from work and family, as well as perceived lack of employer support.[1,2] Less than one-third of physician mothers are able to reach their personal breastfeeding goal, with more than one-half stating that they would have breastfed longer if their "job had been more supportive."[3] Insufficient opportunities to express milk can not only lead to a physician mother not meeting her own lactation goals, but also to blocked ducts, mastitis, decreased milk supply, feelings of inadequacy, stress, and burnout.[4] Several factors are specific to early cessation of lactation in physician mothers, including the shame and stigma around breastfeeding[4] and taking breaks from patient care, teaching, and even research to express milk during working hours.[2] This is especially a problem for fields where physician mothers are involved with operating room and procedural duties.[5] Furthermore, physicians often work in teams and taking a break may affect other team members, or the work cannot continue without the physician (eg, operating rooms or procedural spaces). Unfortunately, anecdotes of physician mothers being suboptimally supported in lactation in the workplace are not uncommon, even in pediatrics. Although many behaviors around expressing milk in the workplace are "tolerated" by employers, these behaviors are not explicitly protected as rights of the employee by many institutions. The Affordable Care Act[6] mandates that employers provide lactating mothers with "reasonable break time and a private space to express breast milk," however, these accommodations are minimal and many employers, including hospital systems, have not extended their policies or cultures to increase support for their lactating employees.

Pediatricians are the natural leaders to champion and support lactating mothers both in our clinical care and in the workplace. Pediatricians are educated on the importance of breastfeeding; many of us have worked hard to support the mothers of our patients in achieving their breastfeeding goals, with these efforts even extending into baby-friendly hospital initiatives. Pediatricians support their colleagues and trainees when returning from maternity leave, often adapting their schedules or covering for a "pump break." Our workforce in pediatrics, being majority female, most of whom complete training or work during their childbearing years, necessitates this. A natural next step should be to formalize the support that many departments, supervisors, and individuals are already providing unofficially, through the creation of formalized policies that demonstrate support and promotion of breastfeeding.

The benefits of supporting breastfeeding physicians extend beyond the benefits to their infants and include the well-being of the physician mother. This in turn results in improved patient care and contributions to overall workplace wellness. Physicians who have successfully provided breast milk to their infants are more likely to support continued breastfeeding in their patients.[1] There are also benefits to the employer. Mothers who feel supported in breastfeeding by their employer have fewer sick days (both from better health of the mother but also the immune benefits to the infant), more productivity, and less burnout.[7] Physician mothers experience a double burden of guilt surrounding breastfeeding. Patient care demands and not wanting to "let the team down" make taking breaks difficult. The difficulty of finding time to express milk in the workplace leads to skipped "pump breaks," which can in turn lead to inadequate milk supply. A workplace culture of support for breastfeeding should decrease this guilt and shame, and instead empower physician mothers to take the time they need to express their milk.

This burden felt by practicing physicians is felt by our trainees to an even greater extent. Students, residents, and fellows are particularly vulnerable given that they have less control over their schedules, work longer hours, and are away from their infants for longer stretches of time. Special considerations for promoting breastfeeding and pumping in these vulnerable trainees is critical.[2] Supervisors need to think about scheduling and actively helping trainees to identify break times. It is often difficult for a trainee to advocate for herself because of the hierarchy of medicine, and discomfort in discussing breastfeeding with senior faculty. Having a straightforward policy, and an informational handout on the facts about returning to work, can prevent discrimination and educate returning physician mothers as well as supervisors.

As part of a larger Diversity, Equity, and Inclusion initiative at the University of Michigan, the Department of Pediatrics created a gender issues focused committee. One of the efforts of this committee has been to support lactation within the Department. The committee collected University policies, state and federal laws, and worked to identify the needs

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of breastfeeding mothers, particularly those of physician mothers, in our system. The committee then created a policy to support lactating individuals as well as a handout to help supervisors and colleagues support lactating women in the healthcare setting (**Supplemental material**; available at www.jpeds.com).

At the University of Michigan, the Department of Pediatric has adopted this policy and urges other departments and institutions to do the same. Prior work[8] has shown that only 10% of pediatric training programs have policies to support lactating residents; it is unknown how many programs have policies for nontrainees. Although these practices are probably already accepted by many departments, we would argue that their formalization through a policy is imperative to promote a culture of acceptance and encouragement of breastfeeding. Highlights of a departmental lactation policy should include the following. **A dedicated time to express milk.** Protections and provisions should be made to set aside blocks of time for milk expression. One example is dedicating a 15-minute period out of every 4-hour block spent in clinical duties, including clinic, floor work, and procedural work. For trainees who often have midday educational activities, they should not need to choose between milk expression and their education. **A dedicated place to express milk.** Provisions should be made to allow lactating individuals access to a private, clean, nonbathroom location to express milk. This may be a lactation room, call room, or office. Ideally, a busy physician should have access to a room with a phone and computer to continue working if she so chooses, although this should not be an expectation. **A dedicated place to store milk.** Human milk is not a biohazard, and is considered a food product; therefore, lactating individuals should be supported in storing their milk in areas where employee food may also be stored. **An open culture of communication around lactation.** Support for program directors, supervisors, and colleagues in engaging in a dialogue around lactation is essential to help this need be addressed, especially for trainees.

In summary, the support and encouragement provided to breastfeeding physicians has improved over the last several decades, however, there is still a long way to go. Pediatric leadership can further this effort in their hospitals, departments, and offices by adopting policies and cultures of acceptance and encouragement for breastfeeding. ■

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