NOTICE: This document contains correspondence generated during peer review and subsequent revisions but before transmittal to production for composition and copyediting:

- Comments from the reviewers and editors (email to author requesting revisions)
- Response from the author (cover letter submitted with revised manuscript)*
- Email correspondence between the editorial office and the authors*

*The corresponding author has opted to make this information publicly available.

Personal or nonessential information may be redacted at the editor’s discretion.

Questions about these materials may be directed to the Obstetrics & Gynecology editorial office: obgyn@greenjournal.org.
RE: Manuscript Number ONG-18-2081

Parenthood and Residency: An Impossible Matchup

Dear Dr. Soffer:

Your manuscript has been reviewed by the Editorial Board and by special expert referees. Although it is judged not acceptable for publication in Obstetrics & Gynecology in its present form, we would be willing to give further consideration to a revised version.

If you wish to consider revising your manuscript, you will first need to study carefully the enclosed reports submitted by the referees and editors. Each point raised requires a response, by either revising your manuscript or making a clear and convincing argument as to why no revision is needed. To facilitate our review, we prefer that the cover letter include the comments made by the reviewers and the editor followed by your response. The revised manuscript should indicate the position of all changes made. We suggest that you use the "track changes" feature in your word processing software to do so (rather than strikethrough or underline formatting).

Your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Dec 20, 2018, we will assume you wish to withdraw the manuscript from further consideration.

REVIEWER COMMENTS:

Reviewer #1: This is a well-written account of the reality of breast pumping for a resident.

A few minor suggestions:

Consider changing the title to reflect the struggle of breast pumping, as "Parenting" seems too broad- maybe along the lines of "The Reality of Breast Pumping as a Resident"

Line 86-87 delete the word "closed" as it redundant

Line 106 should "unmoving" be "unmotivated"?- please edit

Line 114 "did not feel that they..." instead of "like they"

Line 116-118- This seems to be a generalization. Please be more specific in what the literature showed.

Line 127 clarify by adding "while in residency training."

Consider adding some suggestions on how we can be more "breast pump friendly"

Reviewer #2: This personal perspective describes the author's struggles with meeting the demands of a residency program while coping with being a new mother and, specifically, trying to maintain efforts at breastfeeding. The piece is a sincere and eye-opening portrayal of a situation that is growing increasingly common as the proportion of trainees in our field who are women of childbearing age continues to increase. It should serve as a wake-up call to program and hospital administrators who may be unsympathetic or unaware of the challenges faced by women in this predicament. That said, the piece would be more effective if it took a more constructive approach.

Rather than only describing the barriers to breastfeeding and pumping during a busy hospital schedule, perhaps the author could offer some potential solutions, or describe experiences of women who have been able to make this situation work. For example, programs could make sure that there are adequate facilities for residents to pump, or they could assign residents returning from maternity leave to rotations with fewer surgical commitments. A testimonial from a resident who overcame challenges in a different program might be informative.
Also, the author states in line 112 that the difficulties with breastfeeding are "well documented," but there are no references to that effect. Perhaps some background articles would be helpful to compare the author's experience to those in other fields. Potential sources would include Riggins et al "Breastfeeding experiences among physicians," Breastfeed Med 2012 7:151-4; Kacmar et al "Breastfeeding practices of resident physicians in Rhode Island," Med Health RI 2006 89:230-1; Miller et al "Breastfeeding practices among resident physicians," Pediatrics 1996 98:434-7.

Hopefully with some thought and increased acceptance by program administrators, parenthood and residency need not be mutually exclusive. To that end, I would also consider revising the title -- to at least add a question mark to the end!

Reviewer #3: In this manuscript, the author describes her challenges in being a new mother and trying to breastfeed her infant. None of the work challenges outside of being a new mom are surprising as they are typical of anyone who has completed an OB/GYN residency (although arguably the lifestyle has measurably improved given fewer duty hours). The added stress of being a new mom amidst these known work challenges is acknowledged to be very difficult. The author's conclusion to correct this added stress is that, "we owe it to each other and to the future generations to do better." These are nice sentiments but far from an actionable solution. Per Haywood Brown, the OB/GYN residency has to cram "5 pounds of sausage in a 2-pound sack." There is a lot of material to learn and little time to learn it or at least learn to the point that a graduate is prepared for independent practice. This matter is no less clear than the differences in learning the OB vs. the GYN surgery work. The implications of the later are clearly seen in clinical practice where low-volume surgeons have higher costs and great complications relative to higher volume peers (although the association is admittedly messy). The wide-spread use of poorly evidenced and higher cost (that ultimately limit patient access to care) surgical approaches (e.g. the robot) in part reflects these volume and training issues that run into the unavoidable work volume differences across obstetrics and gynecologic surgery. The suggestion to add another year to the residency is not a viable fix given the aforementioned work volume differences even if it could be sorted out who would finance that extra year. There are some really thorny issues here. Clearly, taking a year off to attend to family responsibilities is an option but then who pays for this time?

When I was medical school, residency, fellowship, I often thought, "once I'm done training, then my life will begin." Somewhere toward the end of those training years it dawned on me that my life had already begun and I needed to start living it. I acknowledge most are probably brighter than me and maybe the focus on work-life balance and wellness that is so prominent in GME today reflects more folks making this realization earlier than I did. That said, training is a focused period of one's professional life that requires a lot of attention AND correspondingly the public is paying for this time and there should be some accountability for the spend. Should the populations physicians ultimately serve shoulder the excess costs that come with inadequate training that by some measure reflects the time and structure of that training? As residency inexorably transitions from an apprenticeship to something akin to graduate school, what is the basis of government sponsorship that imposes a duration of training without clear referent to competency? These and related hard questions are just beneath the surface in seeking to do better for future generations.

Incidentally, the new ACGME Common Program Requirements state a lactation space, including a refrigerator, be provided in with proximity appropriate for safe patient care. Graduate medical education is attempting to address the concerns cited in this manuscript but there are limits to how far, within current rule set, these efforts can go.

Reviewer #4: The author describes her personal experience as a resident physician and new mother, focusing on the challenges in incorporating motherhood, and specifically pumping, into her daily routine amidst the demands and time constraints of residency. The author focuses the piece on limitations of residency programs on accommodating new mothers such as herself as they re-enter training postpartum.

Overall, the author effectively demonstrated the multiplicity of demands on her time in the context of an already strained schedule, and relates this information to recent publications on the paucity of efforts to support family leave among residency programs. The author calls for action, however, I think more time could be spent directly relating her experiences to the available literature, or by incorporating suggestions on her perspectives, as a person who has experienced these limitations first hand, on how residencies can better support residents who choose to parent during training. Additionally, I think it would be important to highlight that parenting during residency is a choice that many people make, while others choose to wait until their training is completed. While one can argue the benefits of either approach (i.e. a resident who delays starting medical school until later in life may not have the luxury of waiting), I think it is important to expand the argument as to why residencies should better support parenting during training.
EDITOR COMMENTS:

1. Thank you for your submission to Obstetrics & Gynecology. In addition to the comments from the reviewers above, you are being sent a notated PDF that contains the Editor's specific comments. Please review and consider the comments in this file prior to submitting your revised manuscript. These comments should be included in your point-by-point response cover letter.

***The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.***

- as one of your reviewers noted, your title may not be exactly spot on. While we don't allow titles that ask a question (so adding a question mark here wouldn't work) I wonder if you could make your title suggest some positive steps to make this match up work?

- I chose a mixture of men and women reviewers for your paper and I think you got really good reviews. My comments here are taking their comments into consideration as I try to help you balance their somewhat disparate comments to you. One of them commented in the "comments to the editor" that your paper seems to focus more on negative things about residency in general while being short on recommendations for changes. I had my first baby (now age 34!) when I was a 3rd year resident and I agree with much of what you are writing about. What I'm hoping to do is to provide you some suggestions about ways to make your paper more pro-active--what needs to change to make this work for people. Lines 23-24 seem like complaints or comments that any senior resident would make..."why am I assigned to a case for which I'm holding the uterine manipulator for on rather than actually doing the case?"

Could you re-work this concern to be followed by a suggestion that residents returning from post partum not be assigned to a heavy operative or inpatient clinical rotation and less about what comes across as a complaint about wasting your time in a case where you are primarily providing exposure?

- please substitute "early morning" here.

- Please edit lines 31-36 to be less about the problems of residency in general as these are all common concerns of residents in general and not just residents with newborns. what I don't want is for you to seem whiny--I'm not saying that I think you are but one of your reviewers raised this point in comments to me. Make it objective.

- what is "this" referring to? If its what is outlined in lines 31-38, again it seems like a general concern raised by many residents, not just new parents. Perhaps something like "the learning environment and schedule were stressful before. But now, as a new mother, I found it particularly challenging.

- How about saying something on line 45 like"My clinical assignment when I returned from maternity leave 6.5 weeks after a crash intrapartum cesarean birth was on one of our busiest inpatient surgical services. I book ended my maternity leave with 24 hour shifts 3 days before and after!" This would then reasonably flow into a commentary about returning residents to a less stressful, time consuming rotation.

- I would omit this. Many programs wouldn't have done this.

- Capitalize Facebook. Could you provide the group name?

- Perhaps worth commenting here about how (if that's the case) your advice to your prenatal patients may have changed based on your own experiences.

- spell out minutes

- you have state that your husband was doing the child care. But here you say you have a nanny. Please be consistent and transparent on this point.

- spell out OR

- I hadn't had any food or fluids yet this day.

- despite risking making the attendings uncomfortable?

- spell out A line and IJ line?

- these seem to be non-sequitur Perhaps "Although my department supports parenting and breastfeeding during our training, I worry that the practicalities of being a resident while breastfeeding are clear to the leadership. I felt that I was without practical support, or support in dealing with my guilt, my fatigue and struggle to be successful in all of my roles. " Again, I'm hoping to steer you to not blame others here but to be constructive. Along in here, from lines 112-118, it would be great to focus on solutions to this dilemma. What can programs/GME programs do to assist residents and fellows returning after from maternity leave to transition back well in light of breastfeeding, fatigue, possible depression, role
challenges?

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:
   1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.
   2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.

3. Submit a completed copy of our revised author agreement form (updated in the January 2018 issue).

Please note:

a) Any material included in your submission that is not original or that you are not able to transfer copyright for must be listed under I.B on the first page of the author agreement form.

b) All authors must disclose any financial involvement that could represent potential conflicts of interest in an attachment to the author agreement form.

c) All authors must indicate their contributions to the submission by checking the applicable boxes on the author agreement form.

d) The role of authorship in Obstetrics & Gynecology is reserved for those individuals who meet the criteria recommended by the International Committee of Medical Journal Editors (ICMJE; http://www.icmje.org):

* Substantial contributions to the conception or design of the work;
OR
the acquisition, analysis, or interpretation of data for the work;
AND
* Drafting the work or revising it critically for important intellectual content;
AND
* Final approval of the version to be published;
AND
* Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

The author agreement form is available online at http://edmgr.ovid.com/ong/accounts/agreementform.pdf. Signed forms should be scanned and uploaded into Editorial Manager with your other manuscript files. Any forms collected after your revision is submitted may be e-mailed to obgyn@greenjournal.org.

3. Standard obstetric and gynecology data definitions have been developed through the reVITALize initiative, which was convened by the American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance. Obstetrics & Gynecology will be transitioning as much as possible to use of the reVITALize definitions, and we encourage authors to familiarize themselves with them. The obstetric data definitions are available at http://links.lww.com/AOG/A515, and the gynecology data definitions are available at http://links.lww.com/AOG/A935.

4. Because of space limitations, it is important that your revised manuscript adhere to the following length restrictions by manuscript type: Personal Perspectives essays should not exceed 12 typed, double-spaced pages (3,000 words). Stated page limits include all numbered pages in a manuscript (i.e., title page, précis, abstract, text, references, tables, boxes, figure legends, and appendixes).

5. Specific rules govern the use of acknowledgments in the journal. Please edit your acknowledgments or provide more information in accordance with the following guidelines:

* All financial support of the study must be acknowledged.
* Any and all manuscript preparation assistance, including but not limited to topic development, data collection, analysis, writing, or editorial assistance, must be disclosed in the acknowledgments. Such acknowledgments must identify the entities that provided and paid for this assistance, whether directly or indirectly.
* All persons who contributed to the work reported in the manuscript, but not sufficiently to be authors, must be acknowledged. Written permission must be obtained from all individuals named in the acknowledgments, as readers may infer their endorsement of the data and conclusions. Please note that your signature on the journal's author agreement form verifies that permission has been obtained from all named persons.
* If all or part of the paper was presented at the Annual Clinical and Scientific Meeting of the American College of Obstetricians and Gynecologists or at any other organizational meeting, that presentation should be noted (include the exact dates and location of the meeting).
6. Provide a short title of no more than 45 characters, including spaces, for use as a running foot.

7. Provide a précis on the second page, for use in the Table of Contents. The précis is a single sentence of no more than 25 words, written in the present tense and stating the conclusion(s) of the report (i.e., the bottom line). The précis should be similar to the abstract’s conclusion. Do not use commercial names, abbreviations, or acronyms in the précis. Please avoid phrases like "This paper presents" or "This case presents."

8. Only standard abbreviations and acronyms are allowed. A selected list is available online at http://edmgr.ovid.com/ong/accounts/abbreviations.pdf. Abbreviations and acronyms cannot be used in the title or précis. Abbreviations and acronyms must be spelled out the first time they are used in the abstract and again in the body of the manuscript.

9. The journal does not use the virgule symbol (/) in sentences with words. Please rephrase your text to avoid using "and/or," or similar constructions throughout the text. You may retain this symbol if you are using it to express data or a measurement.

10. If you choose to revise your manuscript, please submit your revision via Editorial Manager for Obstetrics & Gynecology at http://ong.editorialmanager.com. It is essential that your cover letter list point-by-point the changes made in response to each criticism. Also, please save and submit your manuscript in a word processing format such as Microsoft Word.

If you submit a revision, we will assume that it has been developed in consultation with your co-authors, that each author has given approval to the final form of the revision, and that the agreement form signed by each author and submitted with the initial version remains valid.

Again, your paper will be maintained in active status for 21 days from the date of this letter. If we have not heard from you by Dec 20, 2018, we will assume you wish to withdraw the manuscript from further consideration.

Sincerely,

Nancy C. Chescheir, MD
Editor-in-Chief

2017 IMPACT FACTOR: 4.982
2017 IMPACT FACTOR RANKING: 5th out of 82 ob/gyn journals

In compliance with data protection regulations, please contact the publication office if you would like to have your personal information removed from the database.
December 3, 2018

Nancy C. Chescheir, MD
Editor-in-Chief of Obstetrics and Gynecology

Re: Manuscript Number ONG-18-2081

Title: Parenthood and Residency: An Impossible Mashup

Dear Dr. Chescheir,

Thank you for your email dated November 29, 2018, in which you invited me to submit a revised manuscript for further consideration that addresses the points not only made from the Editorial Board, but also from your personal thoughts regarding the manuscript. I am honored to have received your individual thoughts regarding this piece, and hope that my response to each point raised is satisfactory.

Thank you again for your consideration.

Signed by:

Marti D. Soffer, MD MPH
Reviewer COMMENTS:

Reviewer #1: This is a well-written account of the reality of breast pumping for a resident.

A few minor suggestions:

Consider changing the title to reflect the struggle of breast pumping, as "Parenting" seems too broad- maybe along the lines of "The Reality of Breast Pumping as a Resident"

*Title change has been be made to “Room for improvement: current realities of childbearing in residency”*

Line 86-87 delete the word "closed" as it redundant

*This has been corrected*

Line 106 should "unmoving" be "unmotivated"?- please edit

*This has been corrected*

Line 114 "did not feel that they..." instead of "like they"

*This has been corrected*

Line 116-118- This seems to be a generalization. Please be more specific in what the literature showed.

*This has been flushed out in lines 153-159 where it states: “The obstetrical literature echoed these sentiments when it was shown that program directors, despite a majority having arranged for maternity leave for >1 resident, do not know or do not implement the American College of Obstetricians and Gynecologists (ACOG) recommendations on maternity and family leave for their residents.3 The study found that only 83% and 55% of programs have formal leave policies for childbearing and non-childbearing parents, and found that most programs do not meet ACOG’s recommendations on paid parental leave in residency.”*

Line 127 clarify by adding "while in residency training."

*This has been corrected*

Consider adding some suggestions on how we can be more "breast pump friendly"

*This has been added in lines 198-204 where suggestions for future improvements are described: “Perhaps a system in which women who are pumping can be afforded designated and scheduled times during the day to pump, thereby eliminating the stress and worry about finding a time and location while in the operating room or on the labor floor. Perhaps a designated pumping space
meeting the requirements under the Break Time for Nursing Mothers Law⁴ and the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements⁵ can be created in a more resident-friendly location if the hospital’s space is not conducive to this.”

Reviewer #2: This personal perspective describes the author's struggles with meeting the demands of a residency program while coping with being a new mother and, specifically, trying to maintain efforts at breastfeeding. The piece is a sincere and eye-opening portrayal of a situation that is growing increasingly common as the proportion of trainees in our field who are women of childbearing age continues to increase. It should serve as a wake-up call to program and hospital administrators who may be unsympathetic or unaware of the challenges faced by women in this predicament. That said, the piece would be more effective if it took a more constructive approach.

This point is well received. Changes have been made to make more practical solutions and discussions regarding changes that can be made to improve the situation for other residents. Lines 184-211 reflect this: “My department is supportive of breastfeeding and of maternity leave, but there was no one in the departmental leadership who had a clue what it meant to be a working and lactating resident. No one who could actually support a resident in doing that in a tangible manner. An understanding in the leadership would have been helpful to provide emotional and practical support for me as I made that transition from parent to working parent. I felt supported from other avenues, but it was difficult to juggle the struggles of the workplace on top of breastfeeding, parenting, and the associated guilt. I was fortunate not to have postpartum depression on top of these other challenges, but that would have added an additional amount of strain to an already stretched thin new mother. I do not have all of the answers. And my experience, while shared among others in a similar boat, is only one resident’s perspective. But my experience has shown me how to help those that will continue to come after. Perhaps programs should have an opt-in mentoring model for resident parents, partnering members of the leadership or other faculty to support new parents similar to the mentorship structure for research. Perhaps a system in which women who are pumping can be afforded designated and scheduled times during the day to pump, thereby eliminating the stress and worry about finding a time and location while in the operating room or on the labor floor. Perhaps a designated pumping space meeting the requirements under the Break Time for Nursing Mothers Law⁴ and the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements⁵ can be created in a more resident-friendly location if the hospital’s space is not conducive to this. Perhaps scheduling considerations could be taken such that residents returning to work from maternity leave are initially assigned lighter surgical commitments to enable a sustainable breastfeeding relationship and ensure emotional well-being. Perhaps a forum can be held on a grander scale to discuss the wants of pregnant and breastfeeding residents along with program directors across the country. Many things can be done, and a one size fits all model may not be the solution. However, as more women of childbearing age enter into the field of OBGyn, a discussion to spark change is a good first step.”
Rather than only describing the barriers to breastfeeding and pumping during a busy hospital schedule, perhaps the author could offer some potential solutions, or describe experiences of women who have been able to make this situation work. For example, programs could make sure that there are adequate facilities for residents to pump, or they could assign residents returning from maternity leave to rotations with fewer surgical commitments. A testimonial from a resident who overcame challenges in a different program might be informative.

*Some of these changes have been made as noted above. A testimonial would be wonderful however I believe that would detract from the personal aspect of this piece.*

Also, the author states in line 112 that the difficulties with breastfeeding are "well documented," but there are no references to that effect. Perhaps some background articles would be helpful to compare the author's experience to those in other fields. Potential sources would include Riggins et al "Breastfeeding experiences among physicians," Breastfeed Med 2012 7:151-4; Kacmar et al "Breastfeeding practices of resident physicians in Rhode Island," Med Health RI 2006 89:230-1; Miller et al "Breastfeeding practices among resident physicians," Pediatrics 1996 98:434-7.

*Thank you for the references. Additional background and references have been added to reflect this in lines 144-149: “It is well documented that motherhood and breastfeeding are difficult in the field of medicine along all stages of training. A report in 2012 showed that “although physician mothers have a high rate of breastfeeding initiation, they face significant obstacles to sustained breastfeeding and have 6-month breastfeeding rates well below Healthy People 2020 goals. Key obstacles include the return, after maternity leave, to the rigorous work schedule of residency or primary care practice, as well as inadequate support for milk expression in the workplace.”*

Hopefully with some thought and increased acceptance by program administrators, parenthood and residency need not be mutually exclusive. To that end, I would also consider revising the title -- to at least add a question mark to the end!

*The author shares this hope as well. And a title change has been made as is reflected from the comments under reviewed #1.*
Reviewer #3: In this manuscript, the author describes her challenges in being a new mother and trying to breastfeed her infant. None of the work challenges outside of being a new mom are surprising as they are typical of anyone who has completed an OB/GYN residency (although arguably the lifestyle has measurably improved given fewer duty hours). The added stress of being a new mom amidst these known work challenges is acknowledged to be very difficult. The author’s conclusion to correct this added stress is that, "we owe it to each other and to the future generations to do better." These are nice sentiments but far from an actionable solution. Per Haywood Brown, the OB/GYN residency has to cram "5 pounds of sausage in a 2-pound sack." There is a lot of material to learn and little time to learn it or at least learn to the point that a graduate is prepared for independent practice. This matter is no less clear than the differences in learning the OB vs. the GYN surgery work. The implications of the later are clearly seen in clinical practice where low-volume surgeons have higher costs and great complications relative to higher volume peers (although the association is admittedly messy). The wide-spread use of poorly evidenced and higher cost (that ultimately limit patient access to care) surgical approaches (e.g. the robot) in part reflects these volume and training issues that run into the unavoidable work volume differences across obstetrics and gynecologic surgery. The suggestion to add another year to the residency is not a viable fix given the aforementioned work volume differences even if it could be sorted out who would finance that extra year. There are some really thorny issues here. Clearly, taking a year off to attend to family responsibilities is an option but then who pays for this time?

When I was medical school, residency, fellowship, I often thought, "once I'm done training, then my life will begin." Somewhere toward the end of those training years it dawned on me that my life had already begun and I needed to start living it. I acknowledge most are probably brighter than me and maybe the focus on work-life balance and wellness that is so prominent in GME today reflects more folks making this realization earlier than I did. That said, training is a focused period of one's professional life that requires a lot of attention AND correspondingly the public is paying for this time and there should be some accountability for the spend. Should the populations physicians ultimately serve shoulder the excess costs that come with inadequate training that by some measure reflects the time and structure of that training? As residency inexorably transitions from an apprenticeship to something akin to graduate school, what is the basis of government sponsorship that imposes a duration of training without clear referent to competency? These and related hard questions are just beneath the surface in seeking to do better for future generations.

Incidentally, the new ACGME Common Program Requirements state a lactation space, including a refrigerator, be provided in with proximity appropriate for safe patient care. Graduate medical education is attempting to address the concerns cited in this manuscript but there are limits to how far, within current rule set, these efforts can go.

These comments and thoughts are much appreciated. This piece is not meant to diminish the rightfully rigorous demands of training in this field, nor to advocate for residents to have more time away from clinical responsibilities as this would only be to the detriment of the women we
serve. It is just meant to advocate for the women we care for as well as the women we both are and work with. Some of these thoughts are reflected in the manuscript on lines 168-183: “Training in this demanding field is rigorous and rightfully so. Residency attempts to cover a vast amount of training in only 4 short years. Further time constraints with added maternity leave are understandably difficult as all residents should be required to spend a sufficient amount of time in the hospital to ensure clinical competency. Surely not every resident will choose to have children at all let alone during this challenging residency, and this is a choice that is and will remain deeply personal and individualized. However, as training is a minimum of eight years, not every resident will have the biological luxury of time and will therefore start their families during their training. As someone who made the decision to have a child while striving toward clinical expertise, becoming a mother has only served to make me a better doctor.

Being a patient has shown me how to counsel others more proactively and more compassionately. Being delivered by cesarean section made me better at postoperative counseling both on the obstetric and gynecologic side of my job. Being a working mother has made me more understanding toward my patients as they struggle to make their scheduled appointments or anxiously call with concerns.

Residencies need not prepare for the entire class to have children during their training years, but structural support should be made to support those who do.”

Reviewer #4: The author describes her personal experience as a resident physician and new mother, focusing on the challenges in incorporating motherhood, and specifically pumping, into her daily routine amidst the demands and time constraints of residency. The author focuses the piece on limitations of residency programs on accommodating new mothers such as herself as they re-enter training postpartum.

Overall, the author effectively demonstrated the multiplicity of demands on her time in the context of an already strained schedule, and relates this information to recent publications on the paucity of efforts to support family leave among residency programs. The author calls for action, however, I think more time could be spent directly relating her experiences to the available literature, or by incorporating suggestions on her perspectives, as a person who has experienced these limitations first hand, on how residencies can better support residents who choose to parent during training.

This change has been made as reflected in the comments above in response to the thoughts of reviewer #2.

Additionally, I think it would be important to highlight that parenting during residency is a choice that many people make, while others choose to wait until their training is completed. While one can argue the benefits of either approach (i.e. a resident who delays starting medical
school until later in life may not have the luxury of waiting), I think it is important to expand the argument as to why residencies should better support parenting during training.

Thank you for your comments and thoughts. Some of your thoughts have been incorporated and added to the manuscript accordingly as seen in lines 168-183: “Training in this demanding field is rigorous and rightfully so. Residency attempts to cover a vast amount of training in only 4 short years. Further time constraints with added maternity leave are understandably difficult as all residents should be required to spend a sufficient amount of time in the hospital to ensure clinical competency. Surely not every resident will choose to have children at all let alone during this challenging residency, and this is a choice that is and will remain deeply personal and individualized. However, as training is a minimum of eight years, not every resident will have the biological luxury of time and will therefore start their families during their training. As someone who made the decision to have a child while striving toward clinical expertise, becoming a mother has only served to make me a better doctor.

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Residencies need not prepare for the entire class to have children during their training years, but structural support should be made to support those who do.”
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***The notated PDF is uploaded to this submission's record in Editorial Manager. If you cannot locate the file, contact Randi Zung and she will send it by email - rzung@greenjournal.org.***

- as one of your reviewers noted, your title may not be exactly spot on. While we don't allow titles that ask a question (so adding a question mark here wouldn't work) I wonder if you could make your title suggest some positive steps to make this match up work?

Thank you. As suggested, a title change has been made to “Room for improvement: current realities of childbearing in residency”

- I chose a mixture of men and women reviewers for your paper and I think you got really good reviews. My comments here are taking their comments into consideration as I try to help you balance their somewhat disparate comments to you. One of them commented in the "comments to the editor" that your paper seems to focus more on negative things about residency in general while being short on recommendations for changes. I had my first baby (now age 34!) when I was a 3rd year resident and I agree with much of what you are writing about. What I'm hoping to do is to provide you some suggestions about ways to make your paper more pro-active--what needs to change to make this work for people. Lines 23-24 seem like complaints or comments that any senior resident would make..."why am I assigned to a case for which I'm holding the uterine manipulator for on rather than actually doing the case? "

I thank you for helping in weighing the comments of the reviewers and in making the piece more resonant with a broader audience. And I thank you for the varying editors – I think it only helped to make this better. I do not want to make it sound as if I am complaining – this would only detract from the point of the piece. And I do not wish to make this piece on resident comments but more specifically regarding resident parent challenges. The changes to the specific lines have been made in lines 31-34: “My attending didn’t say anything directly, but it was not well received that I was not present for the positioning and prepping of the patient. After I caught my breath, I scrubbed in for the 4-hour hysterectomy and lymph node dissection.”

Could you re-work this concern to be followed by a suggestion that residents returning from post partum not be assigned to a heavy operative or inpatient clinical rotation and less about what
comes across as a complaint about wasting your time in a case where you are primarily providing exposure?

This point is well taken and changes have been made to reflect this. Lines 53-64 read: “I came back to work 6.5 weeks after a crash cesarean section for fetal bradycardia. And my clinical assignment when I returned was one of the busiest inpatient surgical rotations of residency. I worked a 24 hour shift 3 days before I went into labor, and I worked a 24 hour shift 3 days back from maternity leave. Going back to work is difficult – your body is still adjusting, you are sleep deprived beyond belief, and leaving home that first day is an emotional rollercoaster whether your child is with a family member, a partner, a caregiver, or in daycare. And this was made more difficult by jumping back into the workplace at its busiest, instead of a more gradual readjustment.”

Additionally, lines 204-207 read: “Perhaps scheduling considerations could be taken such that residents returning to work from maternity leave are initially assigned lighter surgical commitments to enable a sustainable breastfeeding relationship and ensure emotional well-being.”

- please substitute "early morning" here.

This change has been made.

- Please edit lines 31-36 to be less about the problems of residency in general as these are all common concerns of residents in general and not just residents with newborns. what I don't want is for you to seem whiny--I'm not saying that I think you are but one of your reviewers raised this point in comments to me. Make it objective.

- what is "this" referring to? If its what is outlined in lines 31-38, again it seems like a general concern raised by many residents, not just new parents. Perhaps something like "the learning environment and schedule were stressful before.. But now, as a new mother, I found it particularly challenging. Of course.

Changes in response to the two comments above have been made as reflected in lines 39-52: “The schedule was not foreign. The daily resident schedule began with a 4am wakeup, quickly eating breakfast while reading up on the overnight events of my patients. Then there were early morning prerounds and furious note writing followed by group rounds and checklists for each complicated patient. This was followed by didactic lectures on various topics and patients at hand. And then it was 8am – time for back to back surgeries or endless laboring patients while fielding consults and trying to man the floor of admitted patients with ongoing and evolving events throughout the day. The candy drawer on our patient floor was the bright spot in every day, not to mention the only source of calories. And bathroom breaks became obsolete as water was a luxury unafforded.
The learning environment and fast paced schedule were stressful but manageable now having spent three years adjusting to this new reality. But as a new mother, it became infinitely more challenging.

I wanted to keep a description of the typical residency schedule as I think it paints a picture of what is known yet what is already challenging, which is highlighted later during the discussion of the additional time commitment needed for pumping.

- How about saying something on line 45 like "My clinical assignment when I returned from maternity leave 6.5 weeks after a crash intrapartum cesarean birth was on one of our busiest inpatient surgical services. I book ended my maternity leave with 24 hour shifts 3 days before and after!." This would then reasonably flow into a commentary about returning residents to a less stressful, time consuming rotation.

The paragraph in question has been changed. The lines 53-70 now read: “I came back to work 6.5 weeks after a crash cesarean section for fetal bradycardia. And my clinical assignment when I returned was one of the busiest inpatient surgical rotations of residency. I worked a 24 hour shift 3 days before I went into labor, and I worked a 24 hour shift 3 days back from maternity leave. Going back to work is difficult – your body is still adjusting, you are sleep deprived beyond belief, and leaving home that first day is an emotional rollercoaster whether your child is with a family member, a partner, a caregiver, or in daycare. And this was made more difficult by jumping back into the workplace at its busiest, instead of a more gradual readjustment. The same held for call. In the first 6 weeks back to work, I was scheduled to work 84 hours of weekend call. And that would mean my husband was scheduled for 84 hours of single parenting, plus the hours of parenting spent with her while I tried to sleep. I both understood that my coresidents wanted some well deserved weekends off and also wanted to pay them back for my leave, but to pay it all back in those first 6 weeks did not feel like a sustainable model for a new working resident parent.”

- I would omit this. Many programs wouldn't have done this.

I have omitted the portion regarding the half a week “gift” from the department, but I think the portion about the large amount of call is needed. I have added some comments to make it more salient and constructive instead of complaining as read on lines 65-70: “In the first 6 weeks back to work, I was scheduled to work 84 hours of weekend call. And that would mean my husband was scheduled for 84 hours of single parenting, plus the hours of parenting spent with her while I tried to sleep. I both understood that my coresidents wanted some well deserved weekends off and also wanted to pay them back for my leave, but to pay it all back in those first 6 weeks did not feel like a sustainable model for a new working resident parent”.

- Capitalize Facebook. Could you provide the group name?

The capitalization has been done. I have added the name of the group on line 88, “Dr. Milk” - I just wanted to ask the group admin for permission prior to doing so.
Perhaps worth commenting here about how (if that's the case) your advice to your prenatal patients may have changed based on your own experiences. 

This has been changed and lines 90-95 reflect this: “Now, I ask detailed questions regarding breastfeeding and can troubleshoot problems with patients regarding latching, hands on expression, nipple trauma and healing, milk storage, and feeding and pumping schedules. I can commiserate about how terrible mastitis is, and I can write pointed letters to employers regarding lactation accommodations. Prior to doing it myself, I knew nothing about breastfeeding. And I knew even less about pumping.”

- spell out minutes

This has been changed

- you have state that your husband was doing the child care. But here you say you have a nanny. Please be consistent and transparent on this point.

Of course. I have a nanny Mon-Fri during the daytime. My husband is there every morning, nighttime, and the weekends. I have tried to make this more transparent as seen on Lines 110-112 read: “I had previously thought that I’d be able to pump in a dedicated space, use my time to eat, chart, and maybe check in with my nanny during the week or my husband on the weekends to see how my child was doing.”

- spell out OR

This has been changed

- I hadn't had any food or fluids yet this day.

This has been changed

- despite risking making the attendings uncomfortable?

This has been changed

- spell out A line and IJ line?

This has been changed

- these seem to be non-sequitur Perhaps ”Although my department supports parenting and breastfeeding during our training, I worry that the practicalities of being a resident while breastfeeding are clear to the leadership. I felt that I was without practical support, or support in dealing with my guilt, my fatigue and struggle to be successful in all of my roles. " Again, I'm hoping to steer you to not blame others here but to be constructive. Along in here, from lines 112-118, it would be great to focus on solutions to this dilemma. What can programs/GME
programs do to assist residents and fellows returning after from maternity leave to transition back well in light of breastfeeding, fatigue, possible depression, role challenges?

With respect to this comment I have changed the flow of the last portion of the piece and have incorporated suggestions for improvement and actionable steps that programs can take. Lines 185-212: “My department is supportive of breastfeeding and of maternity leave, but there was no one in the departmental leadership who had a clue what it meant to be a working and lactating resident. No one who could actually support a resident in doing that in a tangible manner. An understanding in the leadership would have been helpful to provide emotional and practical support for me as I made that transition from parent to working parent. I felt supported from other avenues, but it was difficult to juggle the struggles of the workplace on top of breastfeeding, parenting, and the associated guilt. I was fortunate not to have postpartum depression on top of these other challenges, but that would have added an additional amount of strain to an already stretched thin new mother. I do not have all of the answers. And my experience, while shared among others in a similar boat, is only one resident’s perspective. But my experience has shown me how to help those that will continue to come after. Perhaps programs should have an opt-in mentoring model for resident parents, partnering members of the leadership or other faculty to support new parents similar to the mentorship structure for research. Perhaps a system in which women who are pumping can be afforded designated and scheduled times during the day to pump, thereby eliminating the stress and worry about finding a time and location while in the operating room or on the labor floor. Perhaps a designated pumping space meeting the requirements under the Break Time for Nursing Mothers Law and the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements can be created in a more resident-friendly location if the hospital’s space is not conducive to this. Perhaps scheduling considerations could be taken such that residents returning to work from maternity leave are initially assigned lighter surgical commitments to enable a sustainable breastfeeding relationship and ensure emotional well-being. Perhaps a forum can be held on a grander scale to discuss the wants of pregnant and breastfeeding residents along with program directors across the country. Many things can be done, and a one size fits all model may not be the solution. However, as more women of childbearing age enter into the field of OBGyn, a discussion to spark change is a good first step.”

2. The Editors of Obstetrics & Gynecology are seeking to increase transparency around its peer-review process, in line with efforts to do so in international biomedical peer review publishing. If your article is accepted, we will be posting this revision letter as supplemental digital content to the published article online. Additionally, unless you choose to opt out, we will also be including your point-by-point response to the revision letter, as well as subsequent author queries. If you opt out of including your response, only the revision letter will be posted. Please reply to this letter with one of two responses:

1. OPT-IN: Yes, please publish my response letter and subsequent email correspondence related to author queries.

Opt in
2. OPT-OUT: No, please do not publish my response letter and subsequent email correspondence related to author queries.
Hi Randi

Thank you for your email and the revisions. Attached are my revisions.

In response to the items you have listed:

1. I have reviewed the changes and made sure they were correct. I also made some additional small changes myself as noted
2. I agree - the title edit it great
3. In response to this change, I have added the listed reference along with the AJOG article that is referenced in the original manuscript. I think that the AJOG article is discussing the knowledge of program directors regarding this policy, so I felt it appropriate to reference them both. The reference section has been updated accordingly.

Thank you again for the consideration and the time.
Marti

On Thu, Dec 13, 2018 at 2:26 PM Randi Zung <RZung@greenjournal.org> wrote:

Dear Dr. Soffer:

Your revised manuscript is being reviewed by the Editors. Before a final decision can be made, we need you to address the following queries. Please make the requested changes to the latest version of your manuscript that is attached to this email. Please track your changes and leave the ones made by the Editorial Office. Please also note your responses to the author queries in your email message back to me.

1. General: The Editor has made edits to the manuscript using track changes. Please review them to make sure they are correct.

2. Title: I have reversed the title and subtitle, since “Current Realities…” is really what your piece is about.

3. Reference 3: Reference 15 in this article cites this reference:

The American College of Obstetricians and Gynecologists. Statement of Policy:
Your article states, “…the American College of Obstetricians and Gynecologists (ACOG) recommendations on maternity and family leave for their residents.” Should the ACOG Statement of Policy be cited instead of the AJOG reference?

To facilitate the review process, we would appreciate receiving a response by December 17.

Best,

Randi Zung

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Randi Zung (Ms.)
Editorial Administrator | Obstetrics & Gynecology
American College of Obstetricians and Gynecologists
409 12th Street, SW
Washington, DC 20024-2188
http://www.greenjournal.org

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Marti D. Soffer, MD MPH