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RESIDENCY VS. INDUSTRY: A COMPARATIVE ANALYSIS OF PLASTIC AND RECONSTRUCTIVE SURGERY RESIDENCY BENEFITS WITH NON-MEDICAL HIGH-PRESSURE FIELDS

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ABSTRACT

Introduction: Recent discourse on resident well-being in competitive surgical residency programs, such as plastic and reconstructive surgery (PRS), raises questions about the adequacy of support structures in this context relative to other high-performance professions

Objectives: To quantify these concerns, this study compares wellness-related benefits offered by integrated PRS residency programs to those offered by major consulting, finance, and law firms.

Methods: 51 organizations were reviewed across consulting (n=12), finance (n=14), law (n=10), and integrated PRS residency programs (n=15). Data on paid time off (PTO), parental leave, lactation accommodations, and family planning benefits (including fertility, adoption, and surrogacy support) were collected from institutional websites, human resources personnel, and program-level contracts.

Results: Mean PTO was similar across groups (24.1 ± 1.3 days; $p=0.612$), but unlimited PTO was offered by 75.0% of law firms and 18.2% of consulting firms, compared to none of the PRS programs ($p<0.001$). PRS programs offered significantly less paid primary (7.0 ± 0.9 vs. 17.2 ± 0.9 weeks; $p<0.001$) and non-primary (5.3 ± 1.0 vs. 13.0 ± 1.0 weeks; $p<0.001$) caregiver parental leave than private-sector counterparts. Family planning benefits were provided by 94.4% of private-sector companies but only 53.3% of PRS programs ($p=0.004$). Lactation accommodations were comparable across groups ($p=0.327$).

Conclusions: Integrated PRS residency programs lag peer industries in key support measures, particularly parental leave. As societal emphasis on employee well-being continues to grow, adapting policies from similarly demanding fields, while accounting for the in-person, time-constrained nature of surgical training, presents a challenge for PRS residency program directors.

Key Words: Plastic surgery residency, resident well-being, parental leave, wellness benefits, burnout

BACKGROUND

Burnout, characterized by emotional exhaustion, depersonalization, and a reduced sense of professional efficacy, is a psychological syndrome recognized in the International Classification of Diseases.¹ Among the various theoretical frameworks proposed, the Demand-Resources theory posits that burnout arises when job demands such as work overload, emotional labor, and time pressure consistently exceed the personal or organizational resources available to meet them.¹

² This sustained imbalance leads to cognitive and behavioral dysfunction that undermines employee performance, reduces workforce retention, and compromises institutional outcomes.^{1, 3-7}

In medicine, this phenomenon may manifest as diminished satisfaction with work-life balance among U.S. physicians.⁸ Residents, occupying a liminal space between student and employee, are particularly vulnerable, with qualified access to benefits and workplace protections despite their essential role in patient care.⁹ This vulnerability is amplified in surgical training, where demands on hours and performance expectations are heightened. While the ACGME's 2003 duty hour restrictions demonstrated reductions in medical errors and improvements in patient outcomes,¹⁰ reinforcing the harmful effects of sleep deprivation on clinical decision-making and motor function,¹¹⁻¹⁴ subsequent evaluations have raised doubts about the effectiveness of these reforms in addressing overall resident well-being.¹⁵ These concerns are echoed by a 2020 national study in which 43.2 percent of general surgery residents reported weekly symptoms of burnout.¹⁶

The persistence of burnout in residency, despite efforts to limit duty hours, may reflect the absence of a comprehensive wellness infrastructure. Theoretical frameworks such as social exchange theory and stakeholder theory suggest that investing in employee well-being fosters greater effort, loyalty, and organizational commitment, ultimately enhancing institutional performance.¹⁷⁻²² This concept of reciprocity is supported by empirical research demonstrating higher firm value, increased innovation, and improved financial outcomes in companies with employee-centered policies.²³⁻²⁹ Looking specifically at structured benefits, research shows that higher growth companies tend to have more expansive offerings and that robust family-support benefits promote stronger retention and operational performance.³⁰

Despite this, residency programs do not appear to offer comprehensive support. For example, a 2025 survey found that many plastic surgery residents were unaware of their parental leave policies and that those who required leave often reported feelings of guilt, encountered barriers to workplace lactation, and in some cases used vacation time for postpartum recovery.³¹ However, while such gaps in institutional support have been acknowledged, the wellness resources available to residents have not yet been examined in comparison to peer industries. To evaluate and contextualize the support infrastructure in surgical residency, the present study evaluates the wellness-related benefits offered by PRS residency programs in comparison to those in other demanding professions such as consulting, finance, and law.

METHODS

ETHICAL APPROVAL

This study involved analysis of publicly available and institutional policy data only and did not include human subjects, patient data, or identifiable private information. As such, it was deemed exempt from institutional review board oversight and was conducted in accordance with established ethical standards for research.

DATA COLLECTION

A total of 66 major organizations were evaluated across several occupations, including law (n=10), consulting (n=12), finance (n=14), and medical institutions with Plastic and Reconstructive surgery (PRS) residency programs (n=30). Data were obtained through a structured review of institutional websites, press releases, direct communication with human resources departments, and program-level contracts. In cases where integrated PRS residency programs specific contracts were not accessible (n=15), general institutional residency contracts were collected (n=15) since most programs follow the larger institutional guidelines and recommendations.

Data were collected across four categories of wellness-related benefits: paid time off (PTO), parental leave, lactation accommodations, and family planning financial support. PTO was defined as the total number of fully paid days off provided annually. Data were collected on standard vacation days and any fully paid holiday, "personal", "wellness" or "flex" days. Primary caregiver leave referred to fully paid leave provided to the parent assuming the majority of childcare responsibilities, while non-primary caregiver leave referred to fully paid leave provided to the supporting caregiver. Lactation accommodations were defined as the provision of dedicated lactation rooms or private spaces designated for breastfeeding or pumping during work hours. Family planning benefits referred to any employer- or program-sponsored financial support for fertility or family-building services, with maximum financial coverage defined as the highest total dollar amount an organization reported offering toward in-vitro fertilization (IVF), egg preservation, surrogacy, or adoption.

STATISTICAL ANALYSIS

Quantitative data were extracted and standardized for comparison. The primary analysis examined PRS-specific contracts, which was supplemented by a secondary analysis that included both PRS and general residency contracts from programs offering integrated PRS training, in order to support pooled comparisons with the private sector and to estimate baseline benefits. For the purposes of analysis, if a company or residency program listed a range for leave duration or benefit amounts in dollars (for example, based on role, tenure, or training level), the average value was used. Sick leave and professional development days were excluded from the PTO total to maintain consistency across programs, as sick leave was not uniformly reported. Therefore, PTO was limited to clearly defined, fully paid

vacation or personal days to avoid inflating totals for groups with more detailed reporting. Parental leave was analyzed separately for primary and non-primary caregivers. Only fully paid leave was included in both categories; partially paid or unpaid leave, including leave allowable under the Family and Medical Leave Act (FMLA), was excluded from analysis.

Descriptive statistics were reported as means with standard deviations for continuous variables and as frequencies with percentages for categorical variables. One-way analysis of variance (ANOVA) was used to compare continuous variables across sectors, and chi-square or Fisher's exact tests were used for categorical comparisons. Analyses were conducted using two approaches: first, comparing all four sectors individually; and second, comparing residency programs to the combined private-sector group. All analyses were first performed using data from integrated PRS residency programs (n=15). As noted, when PRS-specific contracts were unavailable, general institutional residency contracts (n=15) were included secondarily to support pooled comparisons with private-sector organizations. A follow-up analysis was conducted to confirm that benefit patterns in general residency programs were consistent with those observed in PRS-specific data. All statistical analyses were performed using StataMP 18.0 (StataCorp, College Station, TX). Statistical significance was set a priori at $P < 0.05$.

RESULTS

CROSS-SECTOR COMPARISON: CONSULTING, FINANCE, LAW, AND INTEGRATED PRS RESIDENCY

As shown in Table 1, there were no significant differences in the number of paid vacation days across sectors (mean 23.0 ± 4.6 days; $p = 0.492$). However, unlimited PTO was significantly more common in private-sector organizations, reported by 75.0% of law firms and 18.2% of consulting firms, and absent from all PRS residency programs ($p < 0.001$).

In terms of parental leave, PRS residency programs offered significantly fewer weeks of fully paid leave compared to private-sector peers. For primary caregivers, PRS programs provided a mean of 7.0 ± 0.9 weeks versus 17.4 ± 7.5 , 16.5 ± 3.5 and 17.8 ± 4.8 weeks in consulting, finance and law firms, respectively ($p < 0.001$). Non-primary caregivers received 5.3 ± 1.0 weeks in PRS programs versus 16.1 ± 8.4 , 12.4 ± 4.8 and 10.2 ± 3.0 weeks in consulting, finance and law firms, respectively ($p < 0.001$).

Family planning benefits were also less commonly offered by PRS programs. While 83.3% of consulting firms and 100% of finance and law firms offered at least one form of fertility-related financial support, only 53.3% of PRS programs did so ($p = 0.008$). Lactation accommodations were reported by most organizations, with no significant differences in availability across sectors ($p = 0.117$).

POOLED COMPARISON: PRS RESIDENCY VS. PRIVATE SECTOR

When directly comparing PRS residency programs (n=15) to the pooled private-sector group (consulting, finance, and law; n=36), similar trends persisted (Table 2). Vacation days did not significantly differ (24.1 ± 1.3 vs. 22.5 ± 0.8 days; $p = 0.269$), but unlimited PTO remained significantly exclusive to the private sector (0% vs. 27.3%; $p = 0.041$).

PRS programs continued to offer substantially less paid parental leave: 7.0 ± 0.9 weeks for primary caregivers vs. 17.2 ± 0.9 weeks ($p < 0.001$), and 5.3 ± 1.0 weeks for non-primary caregivers vs. 13.0 ± 1.0 weeks ($p = 0.002$). Only 53.3% of PRS programs offered any fertility benefit compared to 94.4% in the private sector ($p = 0.001$).

POOLED COMPARISON INCLUDING GENERAL RESIDENCY PROGRAMS

While the primary focus of this study was on integrated PRS residency programs, general institutional residency contracts (n=15) were included in the broader residency group (total n=30) to augment the value of pooled comparisons against the private sector (Supplemental Digital Content Tables 1-2). In doing so, patterns remained consistent across both groups, with similarly limited PTO flexibility, reduced paid parental leave, and less comprehensive fertility support compared to private-sector benchmarks. With respect to maximum fertility benefits, private-sector companies still trended higher than the combined residency group, though not statistically significant ($\$50,202.30 \pm 23,540.00$ vs. $\$33,666.70 \pm 26,842.10$; $p = 0.099$).

DISCUSSION

The present analysis demonstrates that integrated PRS residency programs offer more limited family planning benefits and less flexible PTO options than non-medical peer industries such as law, finance, and consulting. Fewer programs provide fertility coverage, and among those that do, maximum allowances are often unclear. Paid parental leave is also significantly shorter. Although the total number of vacation days did not differ significantly, no residency programs offered flexible or unlimited PTO, unlike their private-sector counterparts. Collectively, these findings suggest that surgical training environments lag behind similarly demanding non-medical fields in supporting personal well-being and family-building. While prior studies have relied on survey data to highlight these issues, this is the first to confirm the decreased support through contract-level analysis.

While ostensibly multifactorial, these relative shortfalls in benefit offerings across residency programs are likely reinforced by the culture of medicine. For example, in medicine, many residents feel compelled to project resilience despite personal struggles, reinforcing a culture of stoicism that discourages the use of or advocacy for well-being resources.³² In its most extreme or concentrated form, this culture can perpetuate "malignant" environments characterized by overwork, emotional isolation, and fear of retaliation for raising concerns.⁹ Even in less overtly hostile settings, help-seeking remains stigmatized, undermining the establishment of formal wellness initiatives and

perpetuating psychological risk for burnout.

Beyond cultural taboos, the inherent demands of residency also complicate the provision of benefits compared to corporate environments. Surgical training is physically taxing, time-intensive, and requires consistent in-person participation.^{33, 34} Reduced hours may compromise educational quality and operative exposure,¹⁵ limiting flexibility for remote work or extended leave. Additionally, residents occupy a dual role as both employees and trainees, creating structural challenges in benefit allocation and institutional responsibility. Residency program flexibility is further constrained by accreditation requirements. Historically, the American Board of Plastic Surgery (ABPS) mandated an average of 48 weeks of full-time training per year, effectively capping allowable time off. However, in 2019, in response to growing concerns about wellness, the ABPS implemented a policy allowing residents to take up to three additional months of leave for emergencies or parental care without extending their training.³⁵

Moreover, unlike other comparative professions where advancement may be less structured and more directly tied to the effort the junior associate expends, surgical residents are employees whose employers, the graduate medical education programs (GME), are obligated to prepare them for board eligibility within a defined timeframe. While making partner in other fields may require equal or greater sacrifice to that of a surgical resident, promotion can often be delayed by taking full advantage of benefits, a flexibility that the temporal constraint of residency precludes. This distinction is reinforced by cost constraints whereby many residency programs exceed the federally allotted subsidy for resident education provided by Medicare and must cover the full cost of salaries and benefits. Insofar as reimbursement in healthcare is determined by insurance companies, these expenses cannot be offset by adjusting revenue as easily as in other service-based industries.

Collectively, these factors help explain the disparity in medical training benefits compared to peer industries. Nevertheless, these constraints do not diminish the urgency of addressing wellness gaps within residency training, particularly in highly competitive specialties such as PRS, where the absence of robust institutional support exacerbates vulnerability to burnout. Insofar as burnout impairs attention, decision-making, and overall performance,¹⁶ and given the profound emotional and interpersonal dimensions of many PRS procedures, resident well-being has critical implications for both patient safety and psychosocial outcomes that should be addressed proactively. To this end, principles from Dynamic Capabilities (DC) theory, which emphasize the need for organizations to reconfigure competencies in response to evolving demands, highlight the importance of embedding institutional support, redesigning curricula, and adopting new technologies in delivering optimal training and outcomes.³⁶⁻³⁸

In this context, support structures to be considered are tangible benefits such as structured parental leave, financial support for fertility treatments, and more flexible vacation policies, as explored in this analysis. Initiatives should also reflect the specific demands of residency training by offering structured mentorship, destigmatized access to mental health services, and formal training in resilience and coping skills as recommended by the ACGME.³⁹ Additional interventions such as mindfulness training, group fitness and recreational programs, peer mentorship, and financial literacy education have also demonstrated positive impacts on resident well-being.⁹

These approaches should be paired with institutional reforms to create more sustainable training environments. Notably, technology adoption offers a pathway to expand resident support without compromising the technical mastery required in demanding surgical specialties like PRS. During the COVID-19 pandemic, advancements in surgical simulation technologies, including virtual and augmented reality, physical simulators, and computer-based platforms, proved critical in maintaining residents' technical skills during periods of limited clinical exposure.⁴⁰⁻⁴⁴ Similarly, curriculum redesign can take inspiration from prior initiatives aimed at increasing flexibility and resilience. For instance, the American Board of Surgery's 2011 approval of flexible rotations, permitting general surgery residents to dedicate up to 12 of their final 36 months to subspecialty training without compromising case minimums or board eligibility, demonstrates that flexibility can be embedded within surgical education without eroding standards.⁴⁵ These models offer a blueprint for modernizing residency structures to better align with the evolving needs of trainees.

While investments in wellness initiatives are undoubtedly valuable to improving residency experiences, the importance of setting clear expectations for prospective residents should also not be overlooked. In an era shaped by social media portrayals, curated lifestyles, and frequent comparisons to careers outside of direct patient care, the responsibilities and demands of surgical training can be misunderstood or misrepresented. Unlike other professions, surgical residency involves high-stakes decision-making and continuous patient care, requiring significant time, emotional labor, and accountability. When trainees enter the field without a clear understanding of these realities, the resulting gap between expectations and lived experience can contribute to disillusionment, highlighting the need for early and accurate communication of training demands.^{46, 47} Moreover, beyond addressing this psychological mismatch, proactively cultivating a realistic understanding of the field's challenges may enhance residents' sense of autonomy, purpose, and intrinsic motivation, which are known to support well-being and reduce burnout.^{48, 49} As such, while wellness programs are essential, helping trainees recognize the intensity of surgical training not as a flaw but as a defining and meaningful feature of the profession may be key to fostering long-term fulfillment and resilience.

Although this study is the first to contextualize PRS residency benefits alongside those of other high demanding professions, offering insight into structural shortcomings and areas for reform, several limitations must be acknowledged. First, the analysis relied heavily on publicly available data and voluntary disclosures, which may underrepresent the full extent of benefits offered. Notably, PRS-specific policy information was often supplemented with general residency contract data. Although discussions with program directors and contract reviews suggest that differences between PRS

residency and general residency benefits typically pertain to paid time off (PTO), this substitution may obscure nuances specific to PRS residents. Second, there is no reliable way to evaluate how institutional culture may deter residents from utilizing benefits that exist formally. Third, inherent differences between residency and corporate employment including work structure, service expectations, and leave constraints, limit the validity of direct comparisons. The benefits found in these firms are not specific for the role or seniority within the firm, and the impact of full utilization of offered benefits on one's promotion within these firms was not established.

Future research should move beyond descriptive policy comparisons to examine how well-being frameworks influence measurable outcomes such as resident performance, job satisfaction, burnout rates, and long-term retention. The degree to which residents are aware of their available benefits also affects the practical relevance of these offerings and warrants further investigation. Comparative analyses between wellness-oriented residency programs and high-performing corporate organizations may help identify scalable strategies that balance institutional limitations with meaningful trainee support. As the surgical field continues to evolve, reimagining residency training with a sustained focus on wellness and structural sustainability will be essential to attracting and retaining the next generation of surgical leaders.

CONCLUSIONS

The present study is the first to compare wellness-related benefits in Plastic and Reconstructive Surgery residency programs with those offered in similarly demanding private-sector fields. Despite offering comparable vacation time, residency programs provided significantly less paid parental leave, lacked flexible or unlimited PTO options, and were less likely to include comprehensive family planning benefits. These findings underscore a structural gap in support for resident well-being and family-building. As burnout continues to challenge both individual performance and institutional sustainability, aligning residency benefits with evolving expectations for work-life integration may attract and enhance the development of the next generation of plastic surgeons.

CONFLICT OF INTEREST:

The authors declare no conflicts of interest related to the content of this manuscript.

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SHORT RUNNING HEAD:

Benefits: PRS Residency vs Industry

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TABLES

Table 1. Benefits Across Evaluated Sectors and Integrated PRS Residency Programs

	Total	Consulti ng	Finance	Law	PRS Residen cy	P- Value
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	
	51 (100.0)	12 (23.5)	14 (27.5)	10 (19.6)	15 (29.4)	
<u>Paid Time Off</u>						
Vacation, days (mean ± SD)†	23.0 ± 4.6	21.1 ± 3.7	22.9 ± 4.1	23.3 ± 5.9	24.1 ± 1.3	0.492
Offers Unlimited PTO	9 (18.8)	2 (18.2)	1 (7.1)	6 (75.0)	0 (0.0)	<0.001*
Primary Caregiver PTO, weeks (mean ± SD)‡	14.5 ± 6.6	17.4 ± 7.5	16.5 ± 3.5	17.8 ± 4.8	7.0 ± 0.9	<0.001*
Nonprimary Caregiver PTO, weeks (mean ± SD)§	11.1 ± 6.6	16.1 ± 8.4	12.4 ± 4.8	10.2 ± 3.0	5.3 ± 1.0	<0.001*
<u>Family Support</u>						
Lactation/Pumping Room Offered						0.117
Yes	43 (84.3)	8 (66.7)	11 (78.6)	10 (100.0)	14 (93.3)	
Not mentioned	8 (15.7)	4 (33.3)	3 (21.4)	0 (0.0)	1 (6.7)	
Offers Planning Benefits (e.g. IVF, adoption services)						0.008*
Yes	42 (82.4)	10 (83.3)	14 (100.0)	10 (100.0)	8 (53.3)	
No	3 (5.9)	0 (0.0)	0 (0.0)	0 (0.0)	3 (20.0)	
Not mentioned	6 (11.8)	2 (16.7)	0 (0.0)	0 (0.0)	4 (26.7)	
*Bold-face values indicate statistical significance, p < 0.05.						
Abbreviations: SD, standard deviation						
† Vacation days were reported for 47/51 programs.						
‡ Primary caregiver paid time off (PTO) data were available for 49/51 programs.						
§ Nonprimary caregiver PTO data were available for 48/51 programs.						

Table 2. Benefits in Integrated PRS Residency versus Private Sector Companies

	PRS Residency	Consulting, Finance, & Law	P-Value
	No. (%)	No. (%)	
	15 (29.4)	36 (70.6)	
<u>Paid Time Off</u>			
Vacation, days (mean ± SD)	24.1 ± 1.3	22.5 ± 0.8	0.269
Unlimited PTO	0 (0.0)	9 (27.3)	0.041*
Primary Caregiver PTO, weeks (mean ± SD)	7.0 ± 0.9	17.2 ± 0.9	<0.001*
Nonprimary Caregiver PTO, weeks (mean ± SD)	5.3 ± 1.0	13.0 ± 1.0	0.002*
<u>Family Support</u>			
Lactation/Pumping Rooms			0.117
<i>Yes</i>	14 (93.3)	29 (80.6)	
<i>Not mentioned</i>	1 (6.7)	7 (19.4)	
Offers Planning Benefits (IVF, adoption, etc)			0.001*
<i>Yes</i>	8 (53.3)	34 (94.4)	
<i>No</i>	3 (20.0)	0 (0.0)	
<i>Not mentioned</i>	4 (26.7)	2 (5.6)	

Supplemental Digital Content, Table 1. Benefits Across Evaluated Sectors and Medical Residency Programs.

	Total	Consulting	Finance	Law	Residency (PRS + General)	P-Value
	No. (%)					
	66 (100.0)	12 (18.2)	14 (21.2)	10 (15.6)	30 (45.5)	
<u>Paid Time Off</u>						
Vacation, days (mean ± SD)†	23.0 ± 4.9	21.1 ± 3.7	22.9 ± 4.1	23.3 ± 5.9	23.6 ± 5.4	0.612
Offers Unlimited PTO	9 (14.3)	2 (18.2)	1 (7.1)	6 (75.0)	0 (0.0)	< 0.001 *
Primary Caregiver PTO, weeks (mean ± SD)‡	12.8 ± 6.8	17.4 ± 7.5	16.5 ± 3.5	17.8 ± 4.8	6.8 ± 3.0	< 0.001 *
Nonprimary Caregiver PTO, weeks (mean ± SD)§	10.3 ± 6.2	16.1 ± 8.4	12.4 ± 4.8	10.2 ± 3.0	6.0 ± 2.8	< 0.001 *
<u>Family Support</u>						
Lactation/Pumping Room Offered						0.110
<i>Yes</i>	56 (84.9)	8 (66.7)	11 (78.6)	10 (100.0)	27 (90.0)	
<i>Not mentioned</i>	10 (15.2)	4 (33.3)	3 (21.4)	0 (0.0)	3 (10.0)	
Offers Planning Benefits (e.g. IVF, adoption services)						0.060
<i>Yes</i>	53 (80.3)	10 (83.3)	14 (100.0)	10 (100.0)	19 (69.3)	
<i>No</i>	3 (4.6)	0 (0.0)	0 (0.0)	0 (0.0)	3 (10.0)	
<i>Not mentioned</i>	10 (15.2)	2 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)	
Maximum Benefit, \$ (mean ± SD)¶	45401.6 ± 25263.4	40833.3 ± 29734.9	59383.3 ± 22625.3	46428.6 ± 17008.4	33666.7 ± 26842.1	0.179
*Bold-face values indicate statistical significance, p < 0.05.						
Abbreviations: SD, standard deviation						
† Vacation days were reported for 59/66 programs.						
‡ Primary caregiver paid time off (PTO) data were available for 62/66 programs.						
§ Nonprimary caregiver PTO data were available for 59/66 programs.						
¶ Maximum financial benefits were reported by 31/66 programs.						

Supplemental Digital Content, Table 2. Benefits in Residency versus Private Sector Companies

	Residency (ALL)	Consulting, Finance, & Law	P-Value
	No. (%)	No. (%)	
	30 (45.5)	36 (54.6)	
Paid Time Off			
Vacation, days (mean ± SD)	23.6 ± 5.4	22.5 ± 0.8	0.384
Unlimited PTO	0 (0.0)	9 (27.3)	0.002*
Primary Caregiver PTO, weeks (mean ± SD)	6.8 ± 3.0	17.2 ± 0.9	<0.001*
Nonprimary Caregiver PTO, weeks (mean ± SD)	6.0 ± 2.8	13.0 ± 1.0	<0.001*
Family Support			
Lactation/Pumping Rooms			0.327
<i>Yes</i>	27 (90.0)	29 (80.6)	
<i>Not mentioned</i>	3 (10.0)	7 (19.4)	
Offers Planning Benefits (IVF, adoption, etc)			0.004*
<i>Yes</i>	19 (69.3)	34 (94.4)	
<i>No</i>	3 (10.0)	0 (0.0)	
<i>Not mentioned</i>	0 (0.0)	2 (5.6)	
Maximum Benefit, \$ (mean ± SD)	33666.7 ± 26842.1	50202.3 ± 23540.0	0.099