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Parental Leave in Graduate Medical Education: Recommendations for Reform

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INTRODUCTION

Becoming a new parent during residency or fellowship training is challenging and may adversely affect attainment of professional goals or even guide career specialty choice based on perceived work−life balance.[1] The increase of female medical students in US medical schools to approximately 50% of graduates parallels the increase in pregnancies among females during graduate medical education (GME) training.[2] In one university-based surgery training program, for example, 7% of women gave birth in 1977-1979 and 35% gave birth in 2009.[3] Approximately 40% of GME respondents to a 2013 survey planned to have children during their training.[4]

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The increase in female trainees has challenged GME programs to accommodate the needs of parent trainees while meeting training requirements. Moreover, as GME programs attempt to meet the Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements for trainee well-being, innovative approaches are necessary to meet the needs of parent trainees as well as the training requirements of GME programs.[5] As shown in Table 1, reforming parental leave will have numerous advantages.

In March 2017, the authors of this paper formed the Family Leave Workgroup, each representing the continuum of GME from medical school through fellowship training, including departmental leadership and administration. Although workgroup members are all from internal medicine, the charge was to study the family leave issue broadly in all aspects of GME. This paper comes from the accumulated knowledge from the literature reviewed and the practices studied as well as numerous meetings, reflection, and drafts by the workgroup. Several members of the group also held a workshop on family leave at Academic Internal

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Medicine Week 2018 and incorporated comments and ideas from participant feedback. This article represents the succinct accumulations of the knowledge and ideas obtained by the Family Leave Workgroup.

BACKGROUND

Despite increasingly well-defined parental leave benefits in other industries such as technology and law, there is no standardized approach to parental leave across GME programs. There is also uncertainty and concern about the impact of family leave policies on training outcomes.[4,6] A review of family leave during GME training in 2017 showed the wide range of approaches to leave among training programs. There was a high rate of formal family leave policies for pediatric (90%) and radiology (88%) residency programs as compared with other specialties such as general surgery (67%). Obstetrics and gynecology had the highest proportion of paternity leave policies (69% of programs), although paternity leave was not funded. Policies for same-gender partners were scarce.[6] Authors called for a standardized formal leave policy across GME training for parent-trainees to ensure parity across programs.[6]

The attitudes of GME programs toward parenting range from supportive to unsympathetic.[6,7] Willet et al[8] surveyed 424 residents from 11 different residency programs across 3 academic health centers to better understand gender differences regarding when to have a family. The survey measured 4 issues that trainees perceived as "threats" to their career trajectory: extended training, loss of fellowship positions, pregnancy complications, and interference with career plans.[8] Extension of training was most concerning to female trainees in this study.[8] At a time of growing awareness of the many benefits of gender diversity in the physician workforce and academic medicine, the career progress of women may be adversely impacted by pregnancy-related gender bias, insufficient workplace support, and perceived resentment of pregnancy by peers and faculty during training.[9,10]

PERSPECTIVES VIEWPOINTS

- Women comprise half of graduate medical education (GME) trainees.
- Reforming parental leave in GME will have numerous advantages, including promoting wellness for the parent trainee and the health of the babies.
- Meeting work force needs, ensuring that trainee competency, keeping workload equitable for all trainees, and financing time away are all obstacles.
- Protections like the Family and Medical Leave Act.

Formal parental leave policies benefit the mother as well as the child.[11] Data from the Urban Institute demonstrate multiple positive outcomes when paid leave is offered, including retaining women in the workforce, greater employee satisfaction, and increased retention.[12] Mothers have more time to recover from childbirth, and there is a lower incidence of postpartum depression.[11] Women with paid parental leave are also more likely to breastfeed and to breastfeed longer.[11] The American Academy of Pediatrics supports breastfeeding, noting that breastfed babies have lower rates of infection, asthma, and adolescent and adult obesity. In addition, the rate of sudden infant death syndrome is reduced by over one-third.[13] Benefits of breastfeeding to the mother include earlier return to prepregnancy weight and decreased risk of breast and ovarian cancers.[14]

Parental leave for the nonbirth parent is less well studied, and policies are less standardized across all industries. Adoption or fostering a child requires time for bonding and attachment.[15] In the business world, companies are seeing the benefit of leave for both parents.[16] Paternity leave has been associated with increased father engagement and bonding, improved health for children, shared chores with the mother, improved work−life balance for fathers, and increased employment and pay for mothers.[17] Despite these benefits, paid parental leave for the nonbirth parent in the United States remains inconsistent and unpredictable.

Table 1 Rationale for Reform

1. Promote wellness for trainees
2. Retention of a more diverse workforce
3. Achieve consistency across specialties
4. Reduce the impact on family needs
5. Align priorities with that of other countries and businesses
6. Encourage trainees to focus on their educational outcomes
7. Align training with competency-based measures

CURRENT RULES, REGULATIONS AND PAYMENT

United States Government Laws

GME programs must follow the US federal government laws about parental leave.[6] The Amendment of Title VII of the Civil Rights Act of 1964 prohibits discrimination against women affected by pregnancy or related conditions. The Americans with Disabilities Act prohibits discrimination against people with disabilities. Women who are temporarily unable to perform their jobs due to a medical condition related to pregnancy or childbirth are similar to any other

temporarily disabled person.[18-20] In addition, Title IX protects trainees from gender discrimination in any educational program that receives federal funding, including GME training programs.[21]

FMLA

The Family and Medical Leave Act (FMLA) enables eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons.[22] The issue of whether a resident is a "student" or an "employee" was argued at the level of the Supreme Court in 2011, with the court ruling that residents are employees,[23] which means that residents are protected under FMLA. Eligibility for FMLA coverage, however, requires that the employee be employed for 12 months and have worked at least 1250 hours during the 12 months prior to the start of FMLA leave.[22] Due to the transition from medical student to residency or residency to fellowship, FMLA statutes may therefore not cover GME trainees in their first year of training.

ACGME

ACGME is a private, not-for-profit organization that sets standards for US GME programs and their institutions by employing best practices, research, and advancements across the continuum of Medical education. ACGME standards require time and competency-based metrics before trainees can complete their residency or fellowship-training program. One component of the ACGME Next Accreditation System was developed in part to align education of residents and fellows with 21st century medical care and to demonstrate that trainees are competent to practice independently.[24] The Next Accreditation System has 9 metrics that are submitted by GME programs to the ACGME each year. One of the metrics (milestones) takes observable knowledge, behaviors, and skills to show the trainee's skill on a trajectory. Tools have been developed to help with these assessments.[25] Early data on the impact of the milestones shows that they successfully measure GME outcomes.[26,27] The ACGME Clinical Learning Environment Review monitors fatigue management and wellness.[28]

American Board of Medical Specialties

The American Board of Medical Specialties (ABMS) works with 24 specialty member boards to certify physicians in more than 150 specialties and subspecialties. The training requirements for ABMS board eligibility are based, in part, on the duration of training.[29]

ABMS works with the American Board of Internal Medicine (ABIM), which allows up to 4 weeks per academic year for time away from training, including vacation, illness, parental, or family leave. Training must be extended to make up any absences exceeding 1 month per year of training. ABIM also recognizes that delays or interruptions may occur during training such that the required training cannot be completed in the standard time. In those cases, if the training program director and clinical competency committee attest to ABIM that the trainee has achieved competence in the final year of training with a deficit of <1 month, extended training may not be required.[30]

Salary Continuation During Family Leave

There is no standard across GME programs to ensure that compensation is continued for trainees during a parental leave of absence. Statistics are not readily available on the prevalence of unpaid leave specific to GME programs. FMLA provides job protection during a leave of absence, but does not govern pay benefits that vary depending on state and institutional policies. Currently, only 4 states (Calif, NJ, RI, and NY) and the District of Columbia offer paid FMLA.[12,31] Continued compensation during a trainee absence frequently derives from accrued sick and vacation time. In some cases, short-term disability benefits may be activated.

Funding

The financial implications of trainee leaves of absence on individual programs and institutions vary by funding source. The most significant sources of GME funding include the Center for Medicare and Medicaid Services, and the Veterans Health Administration.[31,32] These funding sources do not provide additional resources if a trainee is required to extend training. For example, the Veterans Administration disbursement agreement restricts reimbursement for sick leave that can be used for family leave to a maximum of 15 days per academic year of training.[32]

CHALLENGES TO PROVIDING A UNIFIED POLICY

Implementing a standardized parental leave policy across all GME programs is challenging (Table 2). Funding for the leave, workforce needs, funding for extended training, and meeting educational goals are some of the most important challenges. Small programs and programs with more women trainees face greater difficulty meeting clinical demands when trainees take maternity leave. Parental leave could also have implications for the trainee and the programs beyond residency. For example, resident physicians who have chosen subspecialty training but need to extend internal medicine training will need to start fellowships beyond the date of their peers. Internal medicine has proposed a standard that prevents the trainee from leaving the internal medicine program too soon. There is no policy that prevents the resident from starting a fellowship later than the rest of the fellowship class.[33] Finally,

Table 2 Challenges with a Uniform Family Leave Policy

1. Regulatory rules
   a. FMLA is based on time at the location
   b. Certifying examination based on time
2. Funding
   a. No funding to pay for maternity leave
   b. No funding to cover extra trainees who may overlap to make up for time
   c. Different payers
   d. Issues different based on the size and the nature of the program
3. Workforce issues
   a. Coverage for trainees that are out on leave
   b. Issues that are more difficult for small programs
4. Timing
   a. Asynchrony between completing a residency program in internal medicine and moving to on to a fellowship program for trainees that need to make up training
5. Stigma
   a. Cultural issues that may be difficult to change
6. Education
   a. Ensuring education outcomes are met for trainees who take family leave
   b. Validating competencies among those who take leave and those who do not

FMLA = Family Medical Leave Act.

there is the added challenge of meeting all the needs for a trainee and a program if the trainee has more than one leave during the training cycle. Recognizing that physical recovery from childbirth can be significant and circumstances vary, policies need to be flexible enough to accommodate individual trainee needs while balancing the practical challenges of workforce needs, attainment of competencies, and financial support.

RECOMMENDATIONS

As educators, we have an obligation to ensure adequate leave for our parent trainees. Accomplishing it will require overcoming many challenges and addressing the competing needs of multiple stakeholders. Meeting work force needs, ensuring trainee competency, keeping workload equitable for all trainees, and financing time away are all obstacles that must be overcome. After indepth research and reflection, we suggest 3 practical goals that can be readily implemented (Table 3).

First, **we recommend a paid 6-week leave maternity leave (8 weeks to account for caesarean birth) that is separate from vacation or sick leave**. We acknowledge that absent new funding sources for GME, paid leave may incur an additional expense. Programs should evaluate their core curriculum and create innovative opportunities for individualized learning plans for trainees. Program directors should work with the trainee to optimize the schedule during the pregnancy and when they return to work. The educational goals, workforce needs of the program, and clinical competencies of the individual can be accomplished within a more flexible framework.

Second, **we recommend that trainees be eligible for FMLA-type protections regardless of how long the trainee has been at the institution**. The federal law, which requires minimum time for the employee to be at a job before FMLA applies, limits its application in GME because many trainees transition from one institution to another. We recommend that trainees be eligible for FMLA-type protections regardless of how long the trainee has been at the institution.

Third, **we recommend that institutions provide parental leave for the nonbirth parent.** We recognize that parental leave is important for all GME trainees and should be offered to all GME trainees. Due to lack of standardization across industries and limited studies in GME training, we do not recommend a specific amount of leave or propose that it be paid or nonpaid leave.

The Family Leave Workgroup acknowledges that further change requires representation from the various stakeholders, including but not limited to ACGME, ABIM, Association of American Medical Colleges, and health systems. It is paramount that ACGME

Table 3 Recommendations

1. A unified policy of 6-week paid maternity leave* for all women across GME
2. The option to voluntarily apply the 12-week FMLA standard for all trainees regardless of duration of employment at their current institution
3. Institutions should recommend paternity leave and by extension, leave for the second parent

FMLA = Family Medical Leave Act; GME = graduate medical education.
*Eight weeks for mothers who have had a caesarean section.

establish a standardized parental leave policy to foster the work and education of trainees while promoting compassion and wellness. A standardized parental leave policy would foster the work, education, and well-being of all trainees. Recommendations set forth in this article require the assistance of the various stakeholders within GME. We believe that a formal and consistent parental leave policy during GME training will benefit the entire medical community.

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