Parental Leave for Residents

American College of Physicians*

For the past 2 decades, an increasing number of women have entered medical schools and residency training programs and have joined medical school faculties. At present, women make up 39% of students entering medical school and 28% of residents in accredited residency programs (1), and many of them are choosing to have children during the years of their training.

A recent study (2) of full-time women faculty in departments of medicine found that approximately 50% of the women had their first child and 33% had their second child during medical training. Therefore, training programs must be prepared to respond to the needs of residents before, during, and after pregnancy. However, many programs have not done so, as evidenced by a recent American Medical Association (AMA) survey which reported that fewer than 45% of programs had specific maternity leave policies (3).

Addressing the physiologic and psychologic needs of pregnant residents has important implications for the health of both the mother and infant. Several studies of pregnancy in physicians have indicated that women physicians are at increased risk of adverse outcomes including pre-term labor and pre-term delivery, low birth weight, and abruptio placenta (4-7). Residents seem to be at the most risk, a fact that may be related to demanding work hours and to standing for long periods of time. In addition, psychologic stress appears to be a risk factor for pre-term labor and pre-term delivery (8-11), and the psychologic stress of residency has been documented by numerous studies ("house officer syndrome" [12, 13]). However, no definitive studies have evaluated the effect of psychologic stress during residency on pregnancy.

After delivery, many women must decide when and how to return to work while they continue to meet the needs of their newborn. Child development experts have explored the effects on children of mothers returning to work at various stages. Although data are scarce, most experts strongly suggest that a parent should be the primary care-giver for at least the child's first 4 months (14, 15). Some child care experts recommend substantially longer maternity (paternity) leaves (16). In the context of residency training, however, most women physicians return to work in a relatively short period of time (6 to 8 weeks) (2, 17).

Concerns about spending time with newborn children are, of course, also relevant to men. Fathers are becoming more active participants in the rearing of young children, particularly when both parents are professionals engaged in full-time careers. In addition, 50% to 70% of women physicians are married to physicians (18), and many of these couples may try to work out arrangements that depend heavily on the father for participating in early childrearing. There are approximately 20,000 dual-doctor couples in the United States, with approximately 4000 more each year (19). (Nash DB. The two doctor family: finally some data [Presented paper]. Twenty-Third Annual Research in Medical Education Conference; 1984; Chicago.) In the next generation, 25% of all physicians will be married to other physicians (19). If the trend continues, most young physicians may be either women doctors or married to one (20).

Dual-doctor couples are redefining the challenge to combine medicine, marriage, and motherhood. Women physicians report greater sharing of household chores and parenting responsibilities with their physician husbands than do other women (21). Without a leave policy that includes these fathers, many women residents will not have the flexibility to pursue innovative solutions to integrating home and work. Therefore, the issues surrounding the birth (or adoption) of a child concern both mothers and fathers; such leave is most appropriately called "parental leave." Fathers and their participation in childrearing should not be ignored in the formulation of institutional policy, which should extend to caring for children and other family members. However, concerns about pregnancy and infant care are obviously even more pertinent to the mother; thus, women residents are the focus of this statement.

Although residency programs should be prepared to meet the needs of these new mothers and fathers, doing so creates a challenge. A training program that expects and anticipates pregnancies and incorporates parental leave within its structure will be more likely to support the mental and physical health of all residents and their families, allow flexibility in rotations while maintaining 24-hour patient coverage, reduce resentment among residents, and minimize gender conflict.

This paper should not be construed as encouraging or discouraging pregnancy during residency. All residents should be counseled (either formally or informally) about the additional pressures a pregnancy can

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foster the health of the parent and child. This counseling should be non-directive and non-authoritative. The goal of this paper is to help training programs become better informed and prepared to meet the needs of pregnant residents, fellows, and new parents and, at the same time, to recognize the needs of the institution. The American College of Physicians (ACP), recognizes that no one strategy can apply to all institutions, and urges program directors to work with their residents to develop specific guidelines that meet their needs. This paper provides suggestions for development of institutional strategies and policies to facilitate parental leaves.

**Position 1**

*The American College of Physicians believes that medical institutions should be supportive of residents during pregnancy and postpartum periods and should foster the health of the parent and child.*

**Rationale**

The policies of health care institutions regarding parental leave should serve as models to other professions of appropriate concern for parent and child. The mother's health and perinatal complications are influenced by physical stress and long work hours (4, 22) during pregnancy. Postpartum is a period of recuperation for the mother and a critical time for nurturing the child. Furthermore, the American Academy of Pediatrics, among other medical authorities, strongly endorses breast-feeding of infants during the postpartum period, for both biologic and psychologic reasons. Breast-feeding requires relaxed time with the baby and flexibility. Fostering optimal health outcomes for women and children is an essential goal for medical institutions that should extend to staff as well as patients.

The Pregnancy Discrimination Act (PDA) of 1978 (amending Title VII of the Civil Rights Act of 1964) forbids discrimination against pregnant workers by employers covered by Title VII and mandates that pregnancy be treated like any other disability, allowing pregnant women to be absent from work and to receive whatever benefits the employer offers for medical illness. Because of the finding that discrimination against pregnant workers is impermissible sex discrimination, the PDA requires that women be offered benefits for pregnancy-related medical conditions equal to those provided for other medical conditions, but does not mandate pregnancy coverage in the absence of a general disability plan. The PDA sets a minimum standard for pregnancy benefits; it does not address the broader needs of parenting a young child, needs that go beyond the health of the mother alone. Legislation that would provide job protection for workers needing time off to care for family members is presently under consideration in both the House and Senate. The proposed legislation requires that companies with 50 or more employees (20 or more in the Senate bill) permit 10 weeks of unpaid leave for the care of a newborn or a seriously ill child or parent and continue health care benefits for workers on leave. The ACP agrees that care of ill children and other family members should be considered as leave policies are developed.

Some states have gone further than the PDA by mandating that employers provide family leave or maternity leave and guarantee the employee's reinstatement to his or her job or to a comparable job on return to work. Six states have family or parental leave laws; the amounts of leave allowed range from 24 weeks for state employees in Connecticut to 6 weeks in Minnesota and Wisconsin. Twelve states have maternity leave laws; seven of these do not specify length of leave, but at least 8 weeks is allowed under the others. Twenty other states introduced family or maternity leave bills in 1987 and 1988 (23). Laws that protect a worker's position for a short period of time should be viewed as a floor rather than a ceiling for parental and family rights. Continuation of health benefits and paid leave are important issues that should be considered.

Several medical organizations have guidelines pertinent to parental leave for residents. In 1984, the AMA published a statement on maternity leave for residents (3). This statement included results of a survey of residency program directors on maternity leave and a survey of approximately 550 practicing women physicians on childrearing in the context of their medical careers. The AMA recommended that, "All residency programs should develop a written policy on maternity and paternity leave for residents." They also offered suggestions for the specifics of such policies, encouraging a flexibility in scheduling that would maintain patient coverage without "creating an intolerable increase in other residents' workloads." However, implementing this flexibility can be logistically difficult for many training programs, especially those with relatively small numbers of residents each year.

Individual residency certifying boards have policies that specify how long residents may be absent from their training program. The American Board of Internal Medicine maintains a flexible policy on acceptable reductions in its training requirements for such leaves of absence. The Board allows the program director to use discretion in permitting absences of up to 1 month per year, depending on the individual resident's educational and personal needs. Longer leaves of absence must be justified to the Board.

**Position 2**

*The American College of Physicians urges all residency training programs to develop appropriate and written policies on parental leave.*

**Rationale**

Several recent surveys on pregnancy in residents have provided information about timing of pregnancy, women's and colleagues' attitudes toward pregnancy in housestaff, and residency maternity policies. Most
The duration of leave must be determined by the needs of each family. However, residency programs should develop strategies for parental leave that minimize the resultant burdens on colleagues.

Rationale
The duration of leave must be determined by the woman and her physician and according to the individual's health needs. The American College of Obstetricians and Gynecologists has published guidelines indicating that there is a "window" of disability that begins approximately 2 weeks before delivery and ends 6 weeks postpartum. They state that, "The return to work following delivery is not a decision to be made unrelated to home and job circumstances... although the six to eight week window is a useful rule of thumb in the normal uncomplicated case, it is still necessary to evaluate each pregnant worker individually" (27). Obviously, rules must be flexible when they apply to individuals' biologic and psychologic needs. Additionally, time limits on maternity leave would not be permissible under the PDA if no such limits are set for other employees on disability leave.

The need to provide 24-hour coverage for hospitalized patients necessitates a sufficient core number of residents participating in the night-call system. Although no single strategy can apply to all institutions, the ACP suggests that residency program directors:

1. Modify the rotational schedule to allow for "lighter" months before delivery and on return to work. Rotations with less direct patient care responsibility and less night call give the resident more flexibility and less strenuous work. For example, rotations in subspecialty electives or outpatient clinics can be appropriate for the last month before delivery and on return to work.

2. Clearly notify all residents at the beginning of the year that their schedules may change in order to accommodate events affecting other residents, including illness and pregnancy. If residents are forewarned and reminded that schedules are tentative, they may be more comfortable with changes when they occur. These changes should take into consideration the educational needs of each resident so that those changing their schedules will be less inclined to feel resentment toward the program or the pregnant or ill colleague.

3. Hire qualified replacement physicians on a temporary basis to avoid excessively increasing the workload (particularly night-call) of remaining residents. However, residency programs are under pressure to contain costs, so this strategy should be used judiciously.

4. Consider the options of job sharing or part-time work for residents. These arrangements allow parents to choose to spend more time with children while continuing their careers.

5. Design overall rotation schedules with flexibility in the "elective pool." Because residents on elective are less essential to patient care responsibilities, they can be called on more readily to change their work. If, through flexible scheduling of residents on elective, the initial schedule allows for contingencies that might arise, unexpected needs can be accommodated.

The resident's rights and benefits under a parental leave policy should be concomitant with the resident's responsibility to notify the program quickly of pregnancy. Early notification will facilitate the scheduling changes that will undoubtedly be needed.

A more delicate issue arises in the intern application process. The PDA prohibits any employer from asking...
applicants about their childbearing intentions and expressly forbids making employment decisions on the basis of pregnancy. However, the first year is particularly demanding and the most difficult year in which to accommodate a pregnant resident. The ACP urges all intern applicants to balance personal considerations with the needs and goals of the residency program (especially a smaller one) and to communicate honestly with the program director.

Appendix: Considerations for a Parental Leave Policy

The American College of Physicians recognizes that individual institutions have particular needs and that no policy would be appropriate for all settings. However, minimum elements to include in a policy are as follows:

Guidelines for length of leave allowed before and after delivery

Procedures for requesting leave

Procedures for alteration of leave due to an unanticipated event or complicated delivery

Whether salary is provided during leave

Whether benefits are provided during leave (for example, sick time, vacation time, short-term disability)

Whether time absent needs to be made up in order to fulfill requirements of the American Board of Internal Medicine certification process

If residents are required to make up additional months, whether they will receive benefits and salary during this time

If leave is extended, whether the institution or the individual must pay health insurance premiums

Whether accrual of vacation and sick time continues during parental leave

Whether the policy applies to adoption and to paternity leave

Whether flexible planning (for example, returning to work part-time) is available

References


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