HOD ACTION: Council on Medical Education Report 11 adopted as amended in lieu of Resolution 316 and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 11-A-08

Subject: Family and Medical Leave Act Policies for Residents and Fellows
(Resolution 303, A-07)

Presented by: Richard J.D. Pan, MD, MPH, Chair

Referred to: Reference Committee C
(David M. Lichtman, MD, Chair)

Resolution 303 (A-07), submitted by the Medical Student Section and referred to the Board of Trustees, asked that our American Medical Association:

Study and encourage the Accreditation Council for Graduate Medical Education’s participation in such study of 1) the feasibility of considering guaranteed paid maternity leave for residents of no less than six weeks duration, with the possibility of unpaid maternity leave of an additional six weeks; 2) written leave policies for residents for paternity and adoption; and 3) the effect of such maternity, paternity, and adoption leave policies on residency programs, with report back to the House of Delegates at the 2008 Annual Meeting.

This report describes current federal law, institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME), AMA policies, prevailing trends in US employment, common medical leave configurations of health care institutions, and training duration specifications as set forth by the member boards of the American Board of Medical Specialties (ABMS).

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) guarantees to eligible employees a total of 12 weeks of unpaid leave during a 12-month period for one or more of the following reasons:

- for the birth and care of the newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the employee is unable to work because of a serious health condition.

ACGME

ACGME Institutional Requirements state that:

The sponsoring institution must provide written institutional policies on residents’ vacation and other leaves of absence (with or without pay) to include parental and sick leave; these policies must comply with applicable laws.
The Institutional Requirements also state that:

The sponsoring institution must ensure that each program provides its residents with a written policy in compliance with its program requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program as well as information related to access to eligibility for certification by the relevant certifying board.

Although the ACGME’s policy does not specifically cover leave for adoption, since FMLA guarantees leave for adoption, it is likely that institutional policies cover that scenario. Furthermore, the ACGME stipulates that program candidates (applicants to programs who have been invited to interview) be informed, in writing or electronic means, of the terms, conditions, and benefits of their appointment. These terms include “financial support; vacations; parental, sick, or other leaves of absence; … hospitalization, health, disability and other insurances provided for the residents and their families.”

AMA Policy

Existing AMA policy strongly supports maternity, paternity, and adoption leave for residents. In particular, Policy H-420.987 (AMA Policy Database) states that:

The AMA believes that: (1) Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled. (2) The duration of disability leave should be determined by the pregnant resident's physicians, based on the individual's condition and needs. (3) All residency programs should develop a written policy on maternity and paternity leave for residents that addresses: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption; and (j) leave policy for paternity. (4) Resident numbers and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other residents' work loads. (5) Residents should be able to return to their training program after disability leave without loss of training status.

AMA Policies H-420.966 and H-420.961 also support family leave for residents, and the clear delineation of leave policy for residents that incorporate the particulars of the leave, as well as the consequences on educational requirements.

Despite such support for adequate leave for maternity, paternity and adoption, the actual length of leave taken by a resident may be limited by several factors, including: a) the time allowed by the employing institution, b) financial hardship resulting from unpaid leave, c) concerns over satisfying the criteria for training program completion, and d) concerns over eligibility to sit for board exams.
The United States lags behind most other countries in federal legislation guaranteeing paid leave in connection with childbirth. Out of 173 countries studied by the Institute for Health and Social Policy, 169 guarantee paid maternity leave (98 offer 14 weeks or more), and 66 guarantee paid paternity leave (31 offer 14 weeks or more). Some states, however, have Temporary Disability Insurance (TDI) programs to provide short-term, partial wage replacement to employees who are temporarily disabled for medical reasons, including pregnancy and childbirth. California, Hawaii, New Jersey, New York, and Rhode Island have TDI or require employers to offer TDI, as does Puerto Rico.

Very few US employers offer paid “family leave,” which is defined by the U.S. Department of Labor as paid leave given to an employee to care for a family member, i.e., not a combination of sick leave, vacation, personal leave, or short-term disability. In one survey, only 8 percent of private sector employees had access to paid family leave in 2007, while another survey found 18 percent of employers had a separate, paid maternity leave policy, and 17 percent reported providing paid paternity leave. Among the most “family-friendly” employers, 45 percent offer 1 to 6 weeks paid maternity leave, 35 percent offer 1 to 2 weeks paid paternity leave, and 39 percent offer 1 to 6 weeks of paid adoptive leave.

A review of several surveys of non-federal employers have found a variety of results, ranging from 34.4 percent of employers providing full pay for maternity-related reasons, to 53 percent of mothers receiving at least some replacement pay and 13 percent of fathers receiving some pay, to 12 percent reporting the existence of paid maternity leave. Most leaves taken -- either for family, parental, maternity, paternity, adoptive -- are constructed through employees’ personal paid leave and short-term disability insurance. In fact, it is the requirement of many employers that employees first use one or more of their paid leave benefits before taking unpaid leaves (where this practice is allowed by state law, e.g., California prohibits employers from requiring the use of vacation or sick leave for a maternity leave).

Over 80 percent of health care institutions require employees to use vacation and/or personal time off before taking unpaid leave, and 25 percent require sick days to be used first. Over three-fourths count sick days against the employee’s family and medical leave allotment. The income replacement level provided for employees out on short-term disability can vary, including full pay, full pay for the number of days an employee has accrued in an extended illness bank, a uniform percentage of pay (less than 100%), and a percentage of pay varying by length of service or disability. The majority (62 percent) of health care institutions surveyed provide a percentage of pay less than 100%, the average being 59.3 percent.

Although there have been many studies on pregnancy and residency training (see Finch for a review), few have been conducted recently that include the parameter of whether leave is paid. Gabbe et al. report on the pregnancy outcomes of obstetrics and gynecology residents. Fourteen percent of female obstetrics/gynecology residents reported a pregnancy during training, and 27 percent of male residents reported that their spouse or partner had been pregnant. Over 80 percent of residents reported that maternity leave was paid at their institution; similarly, 49 percent reported paid paternity leave. For three-quarters of residents, paid maternity leave at their institutions was 4 to 8 weeks.
The actual length of leave taken by residents experiencing a pregnancy in their family was not reported. One-quarter of the women who had taken a leave were required to make up the time they missed while out on leave.

The AMA annually surveys all ACGME-accredited residency and fellowship programs for information that is published on the web site, FREIDA Online®. Program directors are asked about the number of days of paid and unpaid leave available for family/medical leave. The table provides the results for paid leave in academic year 2006-2007.

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Twenty-eight percent of programs reported between 1 and 30 days of paid family leave, 5.9% reporting exactly 30 days, or 6 weeks. Nearly nine percent (8.7%) offered 31 to 60 days (6 to 12 weeks), and 4.8% offered more than 12 weeks paid family leave. More than one-third of programs reported that the length of leave is “negotiable,” which is probably true of many more programs. The length of the leave is often the result of what leave is available for the resident to take, i.e., how much vacation and sick leave the resident has (likely to be paid at 100% of salary), and how much time the resident will take of short-term disability (likely paid at less than 100%). Residents, as employees of relatively short tenure, are not likely to have had the opportunity to accrue many sick or vacation days, and due to the time and educational constraints of their training program, are likely not permitted to “carry over” leave time from one program year to the next.

After leave availability, and probably more specifically paid leave availability, the educational requirements of the training program are the next most compelling factor affecting the length of a resident’s parental leave. Jagisi, Tarbell, and Weinstein surveyed the leave policies available from the various member boards of the American Board of Medical Specialties (ABMS). Most boards
allow between 4 and 6 weeks’ absence each academic year before requiring that the resident extend
the length of his/her training in order to make up the time away from the program. Jagsi et al. point
out that not only is there the drawback of making up the time, but there might also be interference
with future employment opportunities for the resident, if the extension approaches the start date of
the resident’s new employment.

Rose et al.11 also examined leave policies of the different boards. They note that the most
restrictive policies limiting absence from training (for any reason) were of 4 weeks, with no
accumulation from 1 year to another. More liberal policies allowed for program directors’
discretion in determining the length of leave. However, some specialties with these policies, such
as thoracic surgery, have particularly demanding case requirements that in effect limit absence
from the program. Rose et al. further looked at the impact of a 6-week leave of absence on a
resident’s ability to enter the board certification examination system. Eight boards require
residents to complete their training by the traditional end of the academic year (i.e., June 30 or so)
of the year in which the exam will be taken, although some of these boards will accept a request for
variance. Three boards will allow a 1-month extension of training (training completed by August
1), 4 boards allow a 2-month extension, and 2 boards have deadlines for training completion of
September 30.

Rose et al. point out that the rationale for specifying a certain training deadline as a prerequisite for
examination qualification for a particular year is not stated. Obvious advantages include
motivating the resident to prepare for examinations throughout the residency, and taking the exam
relatively soon after residency completion. However, these advantages are unproven.

Residents in the province of Ontario, Canada, under an agreement between the Professional
Association of Interns and Residents of Ontario (PAIRO) and the Council of Academic Hospitals
of Ontario, have a guaranteed 17-week pregnancy leave, and residents may take up to 37 weeks
following the birth or adoption of a child. These leaves may be extended up to 12 months.
Following the leave, the resident is entitled to return to the program and work for the same period
of the leave in order to complete training. They receive compensation during their leave, although
it may not be full.12 Certification timing through the Royal College of Physicians and Surgeons of
Canada may be even less flexible than in the United States, in that residents must apply for
assessment of training and credentials (a review of the resident’s training) by April 30 of the year
prior to taking the exam for specialties, and by August 31 for subspecialties. However, in Canada
all residents (and fellows) face the same deadlines, regardless of the specialty.13 A search for
statistics of the frequency and duration of parental leave taken by residents and fellows in Canada
yielded no published data.

SUMMARY

With some effort and possible pay reduction, most residents could probably craft a 6-week paid
parental leave. This will depend upon their institutions’ vacation/sick leave and short-term
disability insurance policies as well as whether a resident has used leave already during the year.
However, crafting parental leave is not the same as guaranteeing a 6-week paid leave for all
residents. Furthermore, even a 6-week leave can have a deleterious effect on the resident’s
training, requiring a resident in many specialties to make up the time, and possibly delaying board
certification by 1 year. A 12-week leave would likely require 1 to 2 months of made-up training
time. This extension would somehow have to be financially compensated, and also could result in
a training program exceeding its ACGME limits on the number of residents in the program.

Standardizing the various certifying Boards’ policies regarding the length of absence allowed from
training and the timing of graduation required to sit for the certifying examination, could reduce the
stress and disruption to residents who take leave to tend to family concerns. It is also important
that these policies do not create the potential for discriminatory hiring decisions by residency
programs.

RECOMMENDATIONS

The Council of Medical Education, therefore, recommends the following be adopted in lieu of
Resolution 303 (A-07), and the remainder of this report be filed.

1. That our American Medical Association encourage the Accreditation Council for Graduate
   Medical Education to study the feasibility of requiring training institutions to offer paid
   FMLA-qualified leave for residents of no less than six weeks’ duration, and to permit
   unpaid FMLA-qualified leave of an additional six weeks. (Directive to Take Action)

2. That our AMA propose to the American Board of Medical Specialties member boards that
   they standardize their policies regarding parental leave, absence from training, and the
   timing of entrance into the board certification examination process, so that at a minimum,
   all residents are allowed six weeks’ absence of training for FMLA-qualified leave per
   academic year without disproportionately increasing the length of training, or postponing
   certification. (Directive to Take Action)

3. That our AMA oppose requiring residents to serve any more service time than they took in
   leave that qualifies under the federal Family and Medical Leave Act. (New HOD Policy)

4. That our AMA convene a group of appropriate interested parties, including the ACGME
   and the ABMS, to discuss options for standardization of FMLA-qualified leave policies
   that would not disproportionately increase length of training or result in postponement of
   certification. (Directive to Take Action)

Fiscal Note: $1500 to convene a meeting of appropriate parties.

Complete references for this report are available from the Medical Education Group.