

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)

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

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

11  
12 This report describes current federal law, institutional requirements of the Accreditation Council  
13 for Graduate Medical Education (ACGME), AMA policies, prevailing trends in US employment,  
14 common medical leave configurations of health care institutions, and training duration  
15 specifications as set forth by the member boards of the American Board of Medical Specialties  
16 (ABMS).

17  
18 Family and Medical Leave Act

19  
20 The Family and Medical Leave Act (FMLA) guarantees to eligible employees a total of 12 weeks  
21 of unpaid leave during a 12-month period for one or more of the following reasons:

- 22  
23 • for the birth and care of the newborn child of the employee;  
24 • for placement with the employee of a son or daughter for adoption or foster care;  
25 • to care for an immediate family member (spouse, child, or parent) with a serious health  
26 condition; or  
27 • to take medical leave when the employee is unable to work because of a serious health  
28 condition.

29  
30 ACGME

31  
32 ACGME Institutional Requirements state that:

33  
34 The sponsoring institution must provide written institutional policies on residents' vacation  
35 and other leaves of absence (with or without pay) to include parental and sick leave; these  
36 policies must comply with applicable laws.

1 The Institutional Requirements also state that:

2  
3 The sponsoring institution must ensure that each program provides its residents with a  
4 written policy in compliance with its program requirements concerning the effect of leaves  
5 of absence, for any reason, on satisfying the criteria for completion of the residency  
6 program as well as information related to access to eligibility for certification by the  
7 relevant certifying board.

8  
9 Although the ACGME's policy does not specifically cover leave for adoption, since FMLA  
10 guarantees leave for adoption, it is likely that institutional policies cover that scenario.  
11 Furthermore, the ACGME stipulates that program candidates (applicants to programs who have  
12 been invited to interview) be informed, in writing or electronic means, of the terms, conditions, and  
13 benefits of their appointment. These terms include "financial support; vacations; parental, sick, or  
14 other leaves of absence; ... hospitalization, health, disability and other insurances provided for the  
15 residents and their families."

16  
17 AMA Policy

18  
19 Existing AMA policy strongly supports maternity, paternity, and adoption leave for residents. In  
20 particular, Policy H-420.987 (AMA Policy Database) states that:

21  
22 The AMA believes that: (1) Residency program directors should review federal law  
23 concerning maternity leave and note that for policies to be in compliance, pregnant residents must  
24 be allowed the same sick leave or disability benefits as other residents who are ill or disabled. (2)  
25 The duration of disability leave should be determined by the pregnant resident's physicians, based  
26 on the individual's condition and needs. (3) All residency programs should develop a written policy  
27 on maternity and paternity leave for residents that addresses: (a) duration of leave allowed before  
28 and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether  
29 provision is made for continuation of insurance benefits during leave, and who pays the premium;  
30 (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f)  
31 how much time must be made up in order to be considered board eligible; (g) whether make-up  
32 time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption;  
33 and (j) leave policy for paternity. (4) Resident numbers and scheduling are encouraged to be  
34 flexible enough to allow for coverage without creating intolerable increases in other residents' work  
35 loads. (5) Residents should be able to return to their training program after disability leave without  
36 loss of training status.

37  
38 AMA Policies H-420.966 and H-420.961 also support family leave for residents, and the clear  
39 delineation of leave policy for residents that incorporate the particulars of the leave, as well as the  
40 consequences on educational requirements.

41  
42 Despite such support for adequate leave for maternity, paternity and adoption, the actual length of  
43 leave taken by a resident may be limited by several factors, including: a) the time allowed by the  
44 employing institution, b) financial hardship resulting from unpaid leave, c) concerns over satisfying  
45 the criteria for training program completion, and d) concerns over eligibility to sit for board exams.

1 U.S. Employment Trends

2  
3 The United States lags behind most other countries in federal legislation guaranteeing paid leave in  
4 connection with childbirth. Out of 173 countries studied by the Institute for Health and Social  
5 Policy, 169 guarantee paid maternity leave (98 offer 14 weeks or more), and 66 guarantee paid  
6 paternity leave (31 offer 14 weeks or more).<sup>1</sup> Some states, however, have Temporary Disability  
7 Insurance (TDI) programs to provide short-term, partial wage replacement to employees who are  
8 temporarily disabled for medical reasons, including pregnancy and childbirth. California, Hawaii,  
9 New Jersey, New York, and Rhode Island have TDI or require employers to offer TDI, as does  
10 Puerto Rico.<sup>2</sup>

11  
12 Very few US employers offer paid “family leave,” which is defined by the U.S. Department of  
13 Labor as paid leave given to an employee to care for a family member, i.e., not a combination of  
14 sick leave, vacation, personal leave, or short-term disability. In one survey, only 8 percent of  
15 private sector employees had access to paid family leave in 2007,<sup>3</sup> while another survey found 18%  
16 of employers had a separate, paid maternity leave policy, and 17% reported providing paid  
17 paternity leave.<sup>4</sup> Among the most “family-friendly” employers, 45% offer 1 to 6 weeks paid  
18 maternity leave, 35% offer 1 to 2 weeks paid paternity leave, and 39% offer 1 to 6 weeks of paid  
19 adoptive leave.<sup>5</sup>

20  
21 A review of several surveys of non-federal employers have found a variety of results, ranging from  
22 34.4% of employers providing full pay for maternity-related reasons, to 53% of mothers receiving  
23 at least some replacement pay and 13% of fathers receiving some pay, to 12% reporting the  
24 existence of paid maternity leave. Most leaves taken -- either for family, parental, maternity,  
25 paternity, adoptive -- are constructed through employees’ personal paid leave and short-term  
26 disability insurance.<sup>6</sup> In fact, it is the requirement of many employers that employees first use one  
27 or more of their paid leave benefits before taking unpaid leaves (where this practice is allowed by  
28 state law, e.g., California prohibits employers from requiring the use of vacation or sick leave for a  
29 maternity leave).<sup>7</sup>

30  
31 Health Care Institutions

32  
33 Over 80% of health care institutions require employees to use vacation and/or personal time off  
34 before taking unpaid leave, and 25% require sick days to be used first. Over three-fourths count  
35 sick days against the employee’s family and medical leave allotment. The income replacement  
36 level provided for employees out on short-term disability can vary, including full pay, full pay for  
37 the number of days an employee has accrued in an extended illness bank, a uniform percentage of  
38 pay (less than 100%), and a percentage of pay varying by length of service or disability. The  
39 majority (62%) of health care institutions surveyed provide a percentage of pay less than 100%, the  
40 average being 59.3%.<sup>7</sup>

41  
42 US Resident Physicians

43  
44 Although there have been many studies on pregnancy and residency training (see Finch for a  
45 review<sup>8</sup>), few have been conducted recently that include the parameter of whether leave is paid.  
46 Gabbe et al. report on the pregnancy outcomes of obstetrics and gynecology residents. Fourteen  
47 percent of female obstetrics/gynecology residents reported a pregnancy during training, and 27% of  
48 male residents reported that their spouse or partner had been pregnant. Over 80% of residents  
49 reported that maternity leave was paid at their institution; similarly, 49% reported paid paternity  
50 leave. For three-quarters of residents, paid maternity leave at their institutions was 4 to 8 weeks.

1 The actual length of leave taken by residents experiencing a pregnancy in their family was not  
 2 reported. One-quarter of the women who had taken a leave were required to make up the time they  
 3 missed while out on leave.<sup>9</sup>

4  
 5 The AMA annually surveys all ACGME-accredited residency and fellowship programs for  
 6 information that is published on the web site, FREIDA Online<sup>®</sup>. Program directors are asked about  
 7 the number of days of paid and unpaid leave available for family/medical leave. The table provides  
 8 the results for paid leave in academic year 2006-2007.

Num. of paid days	Num. and % of programs	
No answer	1141	13.4
0	684	8.0
1-5	72	0.8
6-10	260	3.1
11-15	910	10.7
16-20	298	3.5
21-25	239	3.5
26-30	600	7.1
31-35	131	1.5
36-40	68	0.8
41-45	257	3.0
46-50	22	0.3
51-55	19	0.2
56-60	242	2.8
> 60	406	4.8
Negotiable	2917	34.3
	8502	100.0

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

19  
 20 After leave availability, and probably more specifically paid leave availability, the educational  
 21 requirements of the training program are the next most compelling factor affecting the length of a  
 22 resident’s parental leave. Jagsi, Tarbell, and Weinstein<sup>10</sup> surveyed the leave policies available from  
 23 the various member boards of the American Board of Medical Specialties (ABMS). Most boards

1 allow between 4 and 6 weeks' absence each academic year before requiring that the resident extend  
2 the length of his/her training in order to make up the time away from the program. Jagsi et al. point  
3 out that not only is there the drawback of making up the time, but there might also be interference  
4 with future employment opportunities for the resident, if the extension approaches the start date of  
5 the resident's new employment.

6  
7 Rose et al.<sup>11</sup> also examined leave policies of the different boards. They note that the most  
8 restrictive policies limiting absence from training (for any reason) were of 4 weeks, with no  
9 accumulation from 1 year to another. More liberal policies allowed for program directors'  
10 discretion in determining the length of leave. However, some specialties with these policies, such  
11 as thoracic surgery, have particularly demanding case requirements that in effect limit absence  
12 from the program. Rose et al. further looked at the impact of a 6-week leave of absence on a  
13 resident's ability to enter the board certification examination system. Eight boards require  
14 residents to complete their training by the traditional end of the academic year (i.e., June 30 or so)  
15 of the year in which the exam will be taken, although some of these boards will accept a request for  
16 variance. Three boards will allow a 1-month extension of training (training completed by August  
17 1), 4 boards allow a 2-month extension, and 2 boards have deadlines for training completion of  
18 September 30.

19  
20 Rose et al. point out that the rationale for specifying a certain training deadline as a prerequisite for  
21 examination qualification for a particular year is not stated. Obvious advantages include  
22 motivating the resident to prepare for examinations throughout the residency, and taking the exam  
23 relatively soon after residency completion. However, these advantages are unproven.

#### 24 25 Canadian Resident Physicians

26  
27 Residents in the province of Ontario, Canada, under an agreement between the Professional  
28 Association of Interns and Residents of Ontario (PAIRO) and the Council of Academic Hospitals  
29 of Ontario, have a guaranteed 17-week pregnancy leave, and residents may take up to 37 weeks  
30 following the birth or adoption of a child. These leaves may be extended up to 12 months.  
31 Following the leave, the resident is entitled to return to the program and work for the same period  
32 of the leave in order to complete training. They receive compensation during their leave, although  
33 it may not be full.<sup>12</sup> Certification timing through the Royal College of Physicians and Surgeons of  
34 Canada may be even less flexible than in the United States, in that residents must apply for  
35 assessment of training and credentials (a review of the resident's training) by April 30 of the year  
36 prior to taking the exam for specialties, and by August 31 for subspecialties. However, in Canada  
37 all residents (and fellows) face the same deadlines, regardless of the specialty.<sup>13</sup> A search for  
38 statistics of the frequency and duration of parental leave taken by residents and fellows in Canada  
39 yielded no published data.

#### 40 41 SUMMARY

42  
43 With some effort and possible pay reduction, most residents could probably craft a 6-week paid  
44 parental leave. This will depend upon their institutions' vacation/sick leave and short-term  
45 disability insurance policies as well as whether a resident has used leave already during the year.  
46 However, crafting parental leave is not the same as guaranteeing a 6-week paid leave for all  
47 residents. Furthermore, even a 6-week leave can have a deleterious effect on the resident's  
48 training, requiring a resident in many specialties to make up the time, and possibly delaying board

1 certification by 1 year. A 12-week leave would likely require 1 to 2 months of made-up training  
2 time. This extension would somehow have to be financially compensated, and also could result in  
3 a training program exceeding its ACGME limits on the number of residents in the program.

4  
5 Standardizing the various certifying Boards' policies regarding the length of absence allowed from  
6 training and the timing of graduation required to sit for the certifying examination, could reduce the  
7 stress and disruption to residents who take leave to tend to family concerns. It is also important  
8 that these policies do not create the potential for discriminatory hiring decisions by residency  
9 programs.

10  
11 **RECOMMENDATIONS**

12  
13 The Council of Medical Education, therefore, recommends the following be adopted in lieu of  
14 Resolution 303 (A-07), and the remainder of this report be filed.

- 15  
16 1. That our American Medical Association encourage the Accreditation Council for Graduate  
17 Medical Education to study the feasibility of requiring training institutions to offer paid  
18 FMLA-qualified leave for residents of no less than six weeks' duration, and to permit  
19 unpaid FMLA-qualified leave of an additional six weeks. (Directive to Take Action)  
20  
21 2. That our AMA propose to the American Board of Medical Specialties member boards that  
22 they standardize their policies regarding parental leave, absence from training, and the  
23 timing of entrance into the board certification examination process, so that at a minimum,  
24 all residents are allowed six weeks' absence of training for FMLA-qualified leave per  
25 academic year without disproportionately increasing the length of training, or postponing  
26 certification. (Directive to Take Action)  
27  
28 3. That our AMA oppose requiring residents to serve any more service time than they took in  
29 leave that qualifies under the federal Family and Medical Leave Act. (New HOD Policy)  
30  
31 4. That our AMA convene a group of appropriate interested parties, including the ACGME  
32 and the ABMS, to discuss options for standardization of FMLA-qualified leave policies  
33 that would not disproportionately increase length of training or result in postponement of  
34 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.