AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-22)

Introduced by: Illinois

Subject: Parental Leave and Planning Resources for Medical Students

Referred to: Reference Committee C

Whereas, The number of women enrolled as first year medical students has recently risen to the majority of 51.6% in 2018[1]; and

Whereas, The average age of matriculated first year medical students is 24[2]; the average amount of time specialized physicians spend in post high school training is 14 years[3], and the average age of mothers at first birth in the United States is 26.8 years[4]; and

Whereas, 9.2% of medical students are parents by graduation[5], and thus it is essential to address the potential of pregnancy and parenthood during the course of medical education; and

Whereas, The rate of attrition for premedical females who ultimately attend medical school is significantly higher than expected due to social factors including policies regarding parental leave, which influence students to opt for a more accommodative career[6]; and

Whereas, The perceived higher compatibility of maintaining a family life with a career as a physician assistant rather than a physician has led to an increase in female physician assistant students at a rate higher than the rate of increase of female medical students[7]; and

Whereas, A survey of students from the South Dakota Sanford School of Medicine shows that medical students of all genders largely want schools to provide “clear, well-defined guidelines, scheduling flexibility and administrators who are approachable and understanding of their individual circumstances” regarding pregnancy and parenthood[5]; and

Whereas, Amongst the barriers that have been identified by female faculty physicians that prevent the advancement of qualified women in academic medicine are workplace policies that do not allow for women to maintain a balanced lifestyle in fear of not advancing in their careers[8]; and

Whereas, A survey across 11 academic medical institutions of residents in internal medicine, family practice, pediatrics, medicine–pediatrics, surgery, and obstetrics–gynecology, found that women residents were more likely than their male counterparts to intentionally postpone pregnancy because of perceived threats to their careers[9]; and

Whereas, Though there is limited research on medical student family planning, research focusing on residents and physicians, summarized above, suggests that early-career professionals of all genders express a desire for well-defined guidelines and policies promoting work-life harmony without effects on career opportunities. It is reasonable to assume that the opinions of residents, in conjunction with the data from South Dakota Sanford School of Medicine, can be extrapolated to medical students; and

Whereas, The Family and Medical Leave Act (FMLA) requires qualifying employers to give up to 12 weeks of unpaid leave to bond with a newborn or newly adopted child and the ability to apply other paid leave time towards FMLA-protected parental leave[10]; and

Whereas, The FMLA does not have protections for students, and thus schools are not required by law to accommodate parental leave[10]; and

Whereas, Current AMA, LCME and COCA policy does not require medical schools to help medical students in family planning or lay out clear policy addressing how assignments and/or classes can be made up in a way that would be amenable to family planning, and thus many schools do not provide resources outside of individual consultation; and

Whereas, The average proportion of medical students who are parents nearly triples between matriculation (3.0%)[11] and graduation (8.9%)[12]; and

Whereas, Medical students from every medical school have anecdotally expressed difficulties regarding family planning in medical school; and

Whereas, A majority of female physicians surveyed have regrets about family planning decisions and career decision-making, and if given the chance would have made decisions such as attempting conception earlier (28.6%), choosing a different specialty (17.1%), or using cryopreservation to extend fertility (7%)[13]; and

Whereas, 68.2% of medical students whose first pregnancy was in medical school and 88.6% of those whose first pregnancies occurred in training perceived substantial workplace support, indicating a lack of policy and support at medical schools comparative to residency training programs[14]; and

Whereas, It is unrealistic and inappropriate to expect trainees to delay childbearing or to forgo spending critical time with their infants, indicating the necessity of alternative solutions to improve family leave in undergraduate medical education; and

Whereas, There is little to no literature on medical students who are fathers, but they should also be allowed to spend critical time with their newborns; and

Whereas, A study addressing, “the common personal and professional challenges that medical students who are also parents face during their undergraduate medical education” found that by addressing the following: lack of career advisory and support networks for parents/expecting parents, unaccommodating schedules requiring formal leaves of absence, and childcare facilitated by the institution and challenges of breastfeeding support, medical schools can support the health and promote the education of their students[15]; and

Whereas, Students who take leaves for family planning may be negatively impacted during their training and the residency application process due to the opinions of faculty evaluators regarding leave, and residency programs’ negative perception of gaps in medical training[16]; and

Whereas, There are clear burdens and stress on medical students, particularly female medical students, and medical school administrators do not counsel and provide trainees with clear information about the impact of childbearing and family leave on coursework; and

Whereas, Medical educators should have established resources and policies that are as accommodating as possible; and

Whereas, Requesting information is often a barrier to access of knowledge, and this information is not freely and publicly available to students; therefore be it

RESOLVED, That our American Medical Association encourage medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area (New HOD Policy); and be it further

RESOLVED, That our AMA encourage medical schools to give students a minimum of 6 weeks of parental leave without academic or disciplinary penalties that would delay anticipated graduation based on time of matriculation (New HOD Policy); and be it further

RESOLVED, That our AMA encourage that medical schools formulate, and make readily available, plans for each year of schooling such that parental leave may be flexibly incorporated into the curriculum (New HOD Policy); and be it further

RESOLVED, That our AMA urge medical schools to adopt policy that will prevent parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) from discriminating against students who take family/parental leave (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for medical schools to make resources and policies regarding family leave and parenthood transparent and openly accessible to prospective and current students. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (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; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may

be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14