AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(I-25)

Introduced by: Women Physicians Section

Subject: Paid Sick Leave and Flexible Work Arrangements for Caregivers of Individuals with Special Needs, Chronic Illness, or Elderly Parents

Referred to: Reference Committee (Assigned by HOD)

Whereas, there is no standardized or universal structure in place for laws related to paid sick leave across the United States[1,2]; and

Whereas, as more than 14 million children in the U.S. have been reported to have special needs, it is essential to expand on sick leave and flexible work arrangements for physician mothers who are also caregivers[3,4]; and

Whereas, in a 2019 JAMA Internal Medicine survey, 45% of physician mothers as caregivers reported being burnout and 40% of physician mothers with reported extra caregiving obligations also identified with having mood and anxiety disorder[5]; and

Whereas, physician mothers with caregiving obligations can reduce higher physician burnout, secondary traumatic stress, and compassion fatigue if their sick child or elderly sick parent receives prompt and timely care[6]; and

Whereas, the American with Disabilities Act (ADA) requires reasonable accommodations for employees with disabilities but does not mandate accommodations for caregivers, therefore accommodation for physician mothers who are also caregivers of child(ren) with special needs, disability, chronic illness or elderly sick parent(s) should be provided[7]; and

Whereas, the Family Medical Leave Act (FMLA) provides at least 12 weeks of unpaid leave for family/medical reasons, it does not mandate paid leave, hence it would be beneficial to provide financial compensation (partial or complete) for employee medical leave which can help to reduce the financial and mental distress of the employee (physician mother)[8,9] and

Whereas, the implementation and addition of backup child-care and elderly-care such as hospital based employer-provided care facilities or community-based respite programs, especially for situations where an elderly or child may be sick or require special in-person assisted care can benefit both the caregiver by reducing work disruptions and stress as well as having necessary support for their child or elderly parent; and

Whereas, provision of well-trained and well-equipped daycare centers that can provide care for children (with special needs or chronic health issues) or elderly parents (with health issues) can improve the work-life balance of physician mothers and reduce caregiver responsibilities; and

Whereas, flexible work arrangements such as flexible work hours, remote telework, or adjusted work schedules can help accommodate physician mothers who are also caregivers and may need to be physically present to attend the needs of their child(ren) (with special needs, disability, or chronic illness) or their elderly sick parent(s)[10,11,12]; therefore be it

RESOLVED, that our American Medical Association that our American Medical Association amend H-420.979, “AMA Statement on Family, Medical, and Safe Leave”, by addition as follows:

Our American Medical Association supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions, caregiving obligations, or reasons related to personal safety. Such policies should provide for reasonable periods of paid or unpaid:

1. Medical leave for the employee, including pregnancy, abortion, and stillbirth.
2. Maternity and paternity leave for the employee.
3. Leave if medically appropriate to care for a member of the employee’s immediate family, i.e., a spouse, children, or elderly parents
4. Leave for adoption or for foster care leading to adoption.
5. Safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking.
6. Flexible work arrangements such as flexible work hours and the ability to work remotely,

Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave; and be it further

RESOLVED, that our AMA supports physician mothers who are caregivers to alleviate physician burnout

Fiscal Note: (Assigned by HOD)

Received: 08/17/2025

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RELEVANT AMA POLICY

H-405.960 Increasing Practice Viability for Physicians Through Increased Employer And Employee Awareness of Protected Leave Policies

Our American Medical Association 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 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 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. Our 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 recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave, and with eligibility beginning at the start of employment without a waiting period.
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, abortion or stillbirth, 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 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. duration of leave allowed after abortion or stillbirth;
   d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
   e. whether leave is paid or unpaid;
   f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) 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. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. 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. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
   d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
   e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
   f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. 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.
10. 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.
11. 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.

12. 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.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. 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 (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.
15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends. [CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24]

H-405.947 Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows

1. Our American Medical Association urges:
    a. medical schools, and the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree.
    b. residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or

fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty.

c. medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

2. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
3. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution’s sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
4. Our AMA supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students, medical trainees, and physician residents and fellows, regardless of gender or gender identity.
5. 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.
6. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. [Res. 309, I-22; Modified: CME Rep. 01, I-23]

H-405.954 Parental Leave

Our American Medical Association encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

1. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
2. Our AMA:
    a. encourages employers to offer and/or expand paid parental leave policies.
    b. encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies.
    c. advocates for improved social and economic support for paid family leave to care for newborns, infants and young children.
    d. advocates for federal tax incentives to support early child care and unpaid child care by extended family members.
3. Our AMA:
    a. encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare.

b. urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare. [Res. 215, I-16; Appended BOT Rep. 11, A-19; Appended: Res. 403, A-22