AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 5
(I-26)

Introduced by: Matthew D. Gold, MD

Subject: Mitigating the Burden of Staff Medical Leave on Medical Practices

Referred to: OMSS Reference Committee
(, MD, Chair)

Whereas, the American Medical Association (AMA) focuses practice sustainability around reducing administrative burdens, fixing payment models, and improving physician well-being. Key focus area include streamlining prior authorizations, optimizing digital workflows, and fostering viable private practice environments; and

Whereas, healthcare organizations rank second among industries for Family Medical Leave Act (FMLA) usage, with roughly 39 percent of healthcare employees having an open FMLA leave case at any given time during the year. Overall national absence rates for healthcare support occupations hover around 4.3 percent on a day-to-day basis. Across all U.S. industries, roughly 15 percent of total eligible employees actually take leave for a qualifying FMLA reason annually, meaning healthcare experiences more than double that utilization rate[1,2,3]; and

Whereas, specific comparative percentage figures for FMLA absenteeism broken down strictly between small medical practices and large hospital networks are not officially published by the government or industry tracking bodies. Overall data shows, however, that healthcare organizations experience an FMLA utilization rate of roughly 39 percent of their workforce having an open leave at some point during a year, but eligibility and rates shift dramatically based on organizational scale[1,2,3]; and

Whereas, state-level family leave mandates, growing in number, often cover small practices excluded from the federal FMLA, which only applies to private employers with 50 or more workers. Key aspects of these laws include lower employee thresholds, state-managed insurance funding, and varying employer tax exemptions. Federal FMLA and state family leave laws increase the frequency and duration of employee absences, particularly in small businesses. Specific data isolating small medical practices remain sparse, however, and general small business findings show mixed impacts on operations[4]; and

Whereas, many cited prior studies were done some years ago; and

Whereas, smaller practices not covered by FMLA may grow to become so; and

Whereas, there are many workforce factors that impact on a healthcare business. To start, however, the direct cost of parental leave is the salary continuation during the absence, plus any temporary coverage you need. For a 10-person company offering eight weeks at full pay to one employee, the cost is approximately $12,000 to $20,000, depending on salary. Spread across a team of 10, that is $1,200 to $2,000 per person per year in expected exposure[5,6]; and

Whereas, the American Medical Association advocates for robust parental and medical leave policies while encouraging flexible work arrangements and study of the impacts on diverse

medical practices, however current policy does not focus on small business operations; rather official AMA policy centers on physician wellness, resident leave allowances, and patient health outcomes[7]; therefore be it

RESOLVED, that our American Medical Association advocate for, or work with other stakeholders to sponsor, an updated study of the impact of the Family Medical Leave Act in states with, and those without, paid family leave acts on independent medical practices of different sizes, with an emphasis on small practices, as well as other medical care models, including financial, patient-access-to-care, and staff burnout factors (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 8/3/2026

REFERENCES

1. Human Capital Institute, Benefits and Compensation, HR Management & Compliance: FMLA Absences Up, Some Industries Hit Harder Than Others By Daniel Cafaro Jul 19, 2013
2. Turnozo, "Employee No-Show Stats: 3.2% Absence Rate," updated June 10, 2026.https://turnozo.com/blog/employee-no-show-statistics
3. Brown, S., Herr, J., Roy, R., Klerman, J.A. (2020). Abt Associates. *Employee and Worksite Perspectives of the FMLA: Employee Leave-Taking Patterns*. Chief Evaluation Office, U.S. Department of Labor.
4. “Massachusetts law about parental, family and medical leave” https://www.mass.gov/info-details/massachusetts-law-about-parental-family-and-medical-leave#paid-family-medical-leave-pfml
5. “Parental Leave for Small Businesses: What the Law Requires and What You Should Offer” https://www.talentforge360.com/resources/parental-leave-small-business Last updated May 2026
6. “Does FMLA Apply to Small Businesses? Understanding the Rules” https://absenceplus.com/does-fmla-apply-to-small-businesses-understanding-the-rules/
7. Increasing Practice Viability for Physicians Through Increased Employer and Employee Awareness of Protected Leave Policies H-405.960 (Year Last Modified: 2025); Parental Leave H-405.954 (Year Last Modified: 2022)

RELEVANT AMA POLICY

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

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.
21. Our AMA supports policies that provide physician employees with paid leave for routine prenatal care or any medical care related to pregnancy in addition to other existing forms of leave.

Citation: CCB/CLRPS 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; Appended: Res. 306, I-25

Paid Sick Leave and Flexible Work Arrangements for Physicians who are Caregivers H-420.979

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. Parental leave for the employee.
3. Leave if medically appropriate to care for a member of the employee's family, i.e., a spouse, children, or other individual for whom the employee is the primary caregiver.
4. Leave for adoption or 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, without creating intolerable increases in the workloads of other physicians and students.

Such periods of leave may differ with respect to each of the foregoing classifications and may vary by 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.

Citation: BOT Rep. A, A-88; Reaffirmed: Suset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22; Appended: Res. 413, A-23; Modified: Res. 424, A-23; Modified: Speakers Rep. 02, I-24; Modified: Res. 305, I-25

Parental Leave H-405.954

1. 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.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. 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.
4. 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.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of our American Medical Association:

1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise their medical judgment as to what information or treatment is in the best interest of the patient.
2. working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship.
3. to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications.
4. to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients

Citation: Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13; Reaffirmed: CEJA Rep. 05, A-23; Modified: Speakers Rep. 02, I-24

Paid Sick Leave H-440.823

1. Our American Medical Association recognizes the public health benefits of paid sick leave and other discretionary paid time off.
2. Our AMA supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.
3. Our AMA supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.
4. Our AMA advocates for federal and state policies that guarantee employee access to protected paid sick leave without unduly burdening small businesses.

Citation: CMS Rep. 03, A-16; Reaffirmed: BOT Rep. 11, A-19; Modified: Res. 214, A-24