American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

POLICY STATEMENT

Parental Leave for Residents and Pediatric Training Programs

SECTION ON MEDICAL STUDENTS, RESIDENTS, AND FELLOWSHIP TRAINEES and COMMITTEE ON EARLY CHILDHOOD

KEY WORDS

Family and Medical Leave Act, FMLA, parental leave, residency program

ABBREVIATIONS

AAP—American Academy of Pediatrics
ABP—American Board of Pediatrics
ACGME—Accreditation Council for Graduate Medical Education
FMLA—Family and Medical Leave Act

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abstract

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The American Academy of Pediatrics (AAP) is committed to the development of rational, equitable, and effective parental leave policies that are sensitive to the needs of pediatric residents, families, and developing infants and that enable parents to spend adequate and good-quality time with their young children. It is important for each residency program to have a policy for parental leave that is written, that is accessible to residents, and that clearly delineates program practices regarding parental leave. At a minimum, a parental leave policy for residents and fellows should conform legally with the Family Medical Leave Act as well as with respective state laws and should meet institutional requirements of the Accreditation Council for Graduate Medical Education for accredited programs. Policies should be well formulated and communicated in a culturally sensitive manner. The AAP advocates for extension of benefits consistent with the Family Medical Leave Act to all residents and interns beginning at the time that pediatric residency training begins. The AAP recommends that regardless of gender, residents who become parents should be guaranteed 6 to 8 weeks, at a minimum, of parental leave with pay after the infant's birth. In addition, in conformance with federal law, the resident should be allowed to extend the leave time when necessary by using paid vacation time or leave without pay. Coparenting, adopting, or fostering of a child should entitle the resident, regardless of gender, to the same amount of paid leave (6–8 weeks) as a person who takes maternity/paternity leave. Flexibility, creativity, and advanced planning are necessary to arrange schedules that optimize resident education and experience, cultivate equity in sharing workloads, and protect pregnant residents from overly strenuous work experiences at critical times of their pregnancies. *Pediatrics* 2013;131:387–390

INTRODUCTION

The Family and Medical Leave Act (FMLA) of 1993 requires employers to grant workers up to 12 weeks of annual unpaid leave for a family member's serious illness. It also specifies that parents be allowed this same amount of leave for the birth or adoption of a child.[1] This federal legislation regarding maternity leave significantly affects residency training programs because approximately one-half of women who enter the field of medicine give birth to their first child during their residency training.[2] This impact is growing, as the percentage of women graduating from medical school has been consistently increasing over the years, from 9.2% in 1970 to 48.8% in 2009.[3] Specific to pediatrics, 53.3% of pediatricians in 2006 were women and that percentage had increased to 69% by 2009.[3,4]

As an advocate for children and their families, the American Academy of Pediatrics (AAP) supported the passage of the FMLA and is concerned with the need to ensure healthy outcomes for pediatricians and their families. The AAP is committed to the development of rational, equitable, and effective parental leave policies that are sensitive to the needs of pediatric residents, families, and developing infants and that enable parents to spend adequate and good-quality time with their young children. Parent–infant attachment is of paramount importance in the first weeks of life, and protected time at home fosters the development of healthy relationships and practices, such as breastfeeding.[5]

A position statement on parental leave for residents by the American College of Physicians in 1989 noted the increasing number of residents having children and raised concerns about both the health outcomes of the children and the emotional outcomes of the parents.[6] The American Medical Association subsequently adopted a policy that supports maternity, paternity, and adoption leave for residents and recommends that programs develop a detailed written policy regarding leave for residents.[7] All accredited residency training programs are required by the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) to provide written policies on residents' vacations and other leaves of absence (with or without pay), including parental and sick leave, and these policies must comply with applicable laws, such as the FMLA.[8] By 2006, 90% of pediatric residency program directors surveyed reported that they have a parental leave policy in place for their program. The mean leave time allowed without having to make up the time was 3 weeks, with a range of maternity leave reported from 0 to 12 weeks.[9]

It is important for each residency program to have a policy for parental leave that is written, that is accessible to residents, and that clearly delineates program practices regarding parental leave. Lack of such a policy forces residents to rely on departmental policies, which are often unclear or not as relevant to a resident in training. Lack of clarity regarding leave practices can lead to anxiety for the resident expecting a child, and the resident often faces resentment from colleagues for the extra work they must do in the resident's prolonged absence. Without a clear, written policy outlining expectations for the program and for the resident who is expecting a child, advance planning is not as likely to occur, and unplanned absences can adversely affect the work schedules of peers. Morale problems among residency groups may be exacerbated by surprise or sudden strategies that are used to replace or to cover absent residents, and inconsistencies in departmental policies within and among programs can cause discord. In addition, from a patient-care standpoint, conflicts regarding the balance of work and personal life among residents and faculty members are associated with increased reports of stress and burnout,[10,11] which can be linked to increased rates of medical errors.[12,13]

Although each program must develop its own methods to provide appropriate coverage for anticipated or unanticipated parental leave, certain basic guidelines should apply. At a minimum, a parental leave policy for residents and fellows should conform legally with the FMLA as well as respective state laws and should meet Institutional Requirements of the ACGME for accredited programs. Policies should be well formulated and communicated in a culturally sensitive manner.

SUMMARY OF RECOMMENDATIONS

FMLA

Federal law requires that employees be eligible for FMLA benefits after they have been employed for 12 months, which means that, during the first year of pediatric residency training, "interns" (eg, postgraduate year 1 trainees) would not be eligible for the FMLA. The AAP advocates for extension of benefits consistent with FMLA to all residents and interns beginning at the time that pediatric residency training begins, which would give a resident or intern 3 months per year of leave without pay and mandates that health insurance benefits be continued by the employer during this time. The AAP advocates for the same coverage for fellows at the beginning of training.

Parental Leave

The duration of maternity leave, both before and after the infant's birth, should be determined in conjunction with the pregnant resident and her physician and should be based on her condition and needs and on the condition of the child. The AAP recommends that regardless of gender, the resident who becomes a parent should be guaranteed 6 to 8 weeks, at a minimum, of parental leave with pay after the infant's birth. In addition, in conformance with federal law, the resident should be allowed to extend the leave time when necessary by using paid vacation time or leave without pay. The resident who is a new parent but not the primary caregiver is also entitled to parental leave. For these residents, program directors may require that parental leave in excess of 2 weeks draw on unused vacation time followed by leave without pay. It is preferable, however, to protect and preserve vacation, sick leave, and time scheduled for elective rotations. Parents in nontraditional families should receive the same leave as parents in traditional families.

Adoption and Foster Care Leave

Adoption or fostering of a child should entitle the resident, regardless of gender, to the same amount of paid leave (6–8 weeks) as a person who takes maternity leave. Extensions should be allowed as leave without pay.

Work Conditions During Pregnancy

Attention should be paid to tailoring resident work schedules during pregnancy to the medical and emotional needs of the pregnant resident while maintaining an emphasis on professional responsibilities. Increases in adverse pregnancy outcomes have been observed with strenuous working conditions.[14] Specifically, increases in pregnancy complications, such as preterm labor, pre-eclampsia, and fetal growth restriction, have been associated with strenuous working conditions during residency training.[15–17] Flexibility, creativity, and advanced planning are necessary to arrange schedules that optimize resident education and experience, cultivate equity in sharing workloads, and protect pregnant residents from overly strenuous work experiences at critical times of their pregnancy.

Training Status and Makeup Time

The duration of training in an accredited program required by the American Board of Pediatrics (ABP) is 36 months, with 33 months of clinical training required (allowing for vacation, illness, and parental leave). Residents who take maternity, paternity, or adoption leave should, therefore, have no loss in training status if their total leave from training has not been more than 3 months. Total absences in excess of 3 months require a written explanation and justification by the program director and would present unique salary complications requiring case-by-case resolution. The program director, therefore, plays an essential role in the certification process, but the Credentials Committee of the ABP must review the circumstances and approve the extended leave. Makeup time for an absence beyond 3 months is indicated to meet the training requirements for board certification. The topic of leave and makeup time for residents in combined training programs (eg, internal medicine and pediatrics) is more complicated and is beyond the scope of this policy statement; the ABP Web site offers more information on this topic (https://www.abp.org/abpwebsite/publicat/certboi.pdf).

Issues Regarding Staffing and Scheduling

Each program should determine the most satisfactory and cost-effective approach to providing appropriate coverage during parental leave. Residency program staffing levels should be flexible enough to allow for coverage without creating an intolerable burden on the other residents. Some programs might rely on physician assistants and/or advanced practice nurses to provide intermittent coverage for residents in these cases. Programs could consider offering incentives or otherwise recognizing those residents who take on additional work for a resident on leave (realizing additional work cannot exceed work-hour limitations). Each residency program should attempt to anticipate the number of residents who will take parental leave to project staffing needs and to prepare annual program budgets. To accomplish this effectively, residents should be professional and responsible and should notify the program director of anticipated leave far in advance, whenever possible. Such notification should be a requirement written into program policy. Programs should consider incorporating training regarding these professional challenges when planning residency curriculum.

Other Issues

Programs need to develop specific written policies for providing family medical leave for residents to permit them to be at home to care for an ill child, spouse, life partner, or parent.

Flexibility of staffing and scheduling issues are affected by current and future limitations that the ACGME places on the number of hours each resident is allowed to work per day or per week. Work hours are limited for the sake of patient safety; such policies do, however, limit the ability of other residents to take on the workload of residents who are on leave and limit the degree to which program directors can allow flexibility for residents to make up leave time. Decisions regarding leave time and makeup time, therefore, must not negatively affect patient safety and must be in accordance with ACGME work-hour requirements.

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