Multispecialty Resident Perspectives on Parental Leave Policies

Christin Giordano McAuliffe, MD
Kristy L. Rialon, MD
Dustin M. Hipp, MD, MBA
Kate B. Krucoff, MD

The United States is the only industrialized nation without guaranteed paid parental leave for employees.[1] Additionally, there is no federal law guaranteeing comprehensive workplace accommodations for pregnant employees. In the midst of shifting societal and generational norms regarding work-life integration and parental roles, increasing attention has been given to developing national policies that protect pregnant employees on the job and encourage employees of all genders to be at home with new children. This emerging perspective is affecting the medical community. With an increasing number of residents reporting that they plan to become parents during residency and will require leave, program directors, residents, and the public are looking to the Accreditation Council for Graduate Medical Education (ACGME) for a comprehensive national policy on pregnancy and parental leave.[2–4] Currently, the ACGME requires that all sponsoring institutions provide written policies on residents' leaves of absence, including parental leave; that the policies comply with applicable laws; and that institutions ensure that each residency program provides residents with a written policy explaining how a leave of absence will affect their ability to satisfy criteria for residency completion.[5] Beyond this, specific policies and recommendations are not detailed. As a result, significant heterogeneity exists among institutions and programs regarding work responsibilities surrounding pregnancy, allowed length of absence for parental leave, and whether this leave is paid or unpaid. Notably, residents' ideal parental leave policy, across multiple specialties, has not been described, potentially due to the varying specialty board requirements.

The ACGME's Council of Review Committee Residents (CRCR) is a 34-member council composed of residents from all accredited specialties who serve as members of the specialty review committees. In addition to providing a resident voice on the review committees, the CRCR meets twice a year to discuss national issues critical to residents and to advise the ACGME Board of Directors. Prior work by the CRCR has included exploring residents' perspectives on physician well-being, developing leadership education within residency programs, creating residency mentorship milestones, and instituting the *Back to Bedside* initiative.[6] At the May 2017 CRCR meeting, members explored the topic of parental leave with the aim of comparing their institutions' policies and identifying the components of a parental leave policy most important to residents. The opinions of the CRCR reflect the opinions of the membership, which spans various specialties and levels of training and is representative of the larger resident stakeholder group.

DOI: http://dx.doi.org/10.4300/JGME-D-19-00231.1

Editor's Note: The ACGME News and Views section of JGME *includes data reports, updates, and perspectives from the ACGME and its Review Committees. The decision to publish the article is made by the ACGME.*

Resident Perspective Exercise: Approach

At the May 2017 CRCR meeting, 34 residents from medical, surgical, and hospital-based specialties participated in a 2-phase discussion designed to address resident perspectives on varying aspects of parental leave and eventually lead to recommendations for policy development at the institutional, accreditation, and specialty board levels.

The committee first divided into 4 groups tasked with answering questions derived from 4 case presentations concerning resident leave. The groups were initially divided by the following demographics: current male parents, current female parents, gender-mixed residents planning to have a child in the near future, and gender-mixed residents uncertain if planning to parent in the future or self-identified as not wanting to be parents. After discussing the cases presented in BOX 1, the groups were then reassigned so members from each prior group were represented in each new group. The new groups were asked to make a list of policies and services that would benefit individuals in the 4 case scenarios, focusing specifically on finding win-win situations for all parties

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/11/3/362/2372236/jgme-d-19-00231_1.pdf by guest on 16 June 2024

involved, including the resident taking leave, co-residents, and program directors.

Resident Perspective Exercise: Results

In the first case scenario, residents addressed prenatal work conditions, maternity leave policies, and lactation considerations as if they were a pregnant female resident having a conversation with her program director. Residents expressed a desire that the overall tone of the conversation be congratulatory. When discussing prenatal work conditions, common themes among the groups were concerns surrounding time for physician appointments, options for lighter rotations toward the end of pregnancy, and job safety, particularly in the areas of radiation and infectious disease exposure. Those in surgical specialties also expressed the importance of being given opportunities for taking breaks, sitting, and hydrating. Most residents expressed concern about the lack of available time for leave from clinical duties, being required to use vacation time for leave, and limitations of leave based on board requirements. Regarding the amount of maternity leave thought to be appropriate, residents requested anywhere from 6 to 12 weeks of leave. All residents endorsed paid leave. In addition, residents recommended access to lactation rooms close to their usual work areas, a refrigerator for milk storage, adequate time for pumping, and affordable day care options. Residents also stated that it is important to notify the program and their co-residents of a pregnancy as early as they feel comfortable in order to facilitate any accommodations needed. One group recommended that programs develop a support plan for residents who experience miscarriages.

In the second case scenario, residents addressed division of labor and changes in schedules based on specific rotation needs as if they were the co-resident of a pregnant resident. Residents overwhelmingly preferred a team approach to cover calls, utilizing resources such as locum tenens physicians, physician extenders, and residents who were on sick call, as well as a pay it forward system to cover the resident on maternity leave. Residents also stressed the importance of program directors telling their co-residents ahead of time the expectation of being called in to work and even suggested moonlighting opportunities for these residents. There was also a focus on programs acknowledging the residents who take extra call shifts.

In the last case scenario, residents addressed paternity and adoption leave policies. All 4 groups believed paternity and adoption leave to be essential parts of a comprehensive resident parental leave policy. Residents felt it was important for any resident partners of a birthing parent to be able to attend appointments leading up to delivery. At least 2 resident groups believed there should be no difference in duration between maternity and paternity leave, as that would lead to the assumption that the female resident is always the primary parent.

In all cases, residents stated that the culture of the institution should be that of support for a pregnant resident, the partner of a pregnant resident, and adoptive and foster parents. A summary of the parental leave policy recommendations generated from the breakout discussions is presented in BOX 2.

BOX 1 Cases Discussed by Resident Work Groups

1. Imagine you are a 29-year-old female senior resident experiencing her first pregnancy. Things are generally going well in your first trimester, and you are talking to your program director. What would the ideal work situation look like from now until 1 year after delivery? Address the following areas: prenatal work conditions, maternity leave policies, and lactation considerations.
2. Imagine you are the co-resident (same year) of the resident in the previous case. What would your situation be like if her ideal needs were met? Address the following: equitable work/call division of labor leading up to delivery and changes in schedules based on specific rotation needs.
3. Imagine you are the partner of the resident in the first case. What would your ideal situation look like? Specifically address paternity/spousal leave policy and considerations if your partner is also a resident.

Conclusions

With increasing rates of residents planning to become parents, and with a focus on promoting physician wellness and preventing burnout, it has become imperative for the graduate medical education community to develop consistent, compassionate parental leave policies. Residents from varied family backgrounds and specialties demonstrated consensus for an ideal parental leave policy, notably that the policy should cover parents of all genders, that leave should be paid, and that the needs of co-residents should be

BOX 2 Parental Leave Policy Recommendations

1. Parental leave that is inclusive of all types of parents, including male, female, and adoptive parents.
2. Policies that provide for paid parental leave.
3. Transparent policies that are uniform among institutions, the Accreditation Council for Graduate Medical Education, and the American Board of Medical Specialties, which provide for protected leave for all residents regardless of training level or years of employment.
4. Policies that support residents covering for those on parental leave, including compensation for internal moonlighting and acknowledgment of their support for their co-residents.
5. Policies that address the availability of lactation rooms and affordable day care options.

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/11/3/362/2372236/jgme-d-19-00231_1.pdf by guest on 16 June 2024

addressed. A tone of support from residency leaders and institutions is also considered vital. To ensure that policies are fairly applied to all, residents desire parental leave policies that are transparent and consistent among the various larger institutions that dictate their training and readiness for board certification.

References

1. Daniel H, Erickson SM, Bornstein SS. Women's health policy in the United States: an American College of Physicians position paper. *Ann Intern Med*. 2018;168(12):874. doi:10.7326/M17-3344.
2. Blair JE, Mayer AP, Caubet SL, Norby SM, O'Connor MI, Hayes SN. Pregnancy and parental leave during graduate medical education. *Acad Med*. 2016;91(7):972–978. doi:10.1097/ACM.0000000000001006.
3. Smith C, Galante JM, Pierce JL, Scherer LA. The surgical residency baby boom: changing patterns of childbearing during residency over a 30-year span. *J Grad Med Educ*. 2013;5(4):625–629. doi:10.4300/JGME-D-12-00334.1.
4. Finch SJ. Pregnancy during residency: a literature review. *Acad Med*. 2003;78(4):418–428. doi:10.1097/00001888-200304000-00021.
5. Accreditation Council for Graduate Medical Education. Common program requirements (residency) sections I–V. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf. Accessed April 4, 2019.
6. Khan NR, Rialon KL, Buretta KJ, Deslauriers JR, Harwood JL, Jardine LDA. Residents as mentors: the development of resident mentorship milestones. *J Grad Med Educ*. 2017;9(4):551–554. doi:10.4300/JGME-D-17-00415.1.

All authors are members of the Council of Review Committee Residents, Accreditation Council for Graduate Medical Education. **Christin Giordano McAuliffe, MD,** is a Resident, Department of Medicine, Vanderbilt University Medical Center; **Kristy L. Rialon, MD,** is an Assistant Professor, Department of Pediatric Surgery, Baylor College of Medicine, Texas Children's Hospital; **Dustin M. Hipp, MD, MBA,** is a Fellow, Section of Critical Care Medicine, Department of Medicine, Baylor College of Medicine; and **Kate B. Krucoff, MD,** is a Resident, Division of Plastic, Maxillofacial, and Oral Surgery, Duke University.

The authors would like to thank the Accreditation Council for Graduate Medical Education (ACGME) Council of Review Committee Residents (CRCR) staff for organizing meetings, recording events, and valuing the resident perspective on graduate medical education issues, as well as Thomas Nasca, MD, MACP, who encourages CRCR members to share their concerns with ACGME leadership.

Corresponding author: Christin Giordano McAuliffe, MD, Vanderbilt University Medical Center, 1211 Medical Center Drive, Nashville, TN 37232, 203.216.5426, christin.m.giordano@vumc.org

Downloaded from http://meridian.allenpress.com/jgme/article-pdf/11/3/362/2372236/jgme-d-19-00231_1.pdf by guest on 16 June 2024