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ABSTRACT

This handbook provides a framework to assist program directors and other administrators as they discuss questions men and women in premedical and medical schools face with respect to: (1) parenting issues; (2) practical and policy-related questions about becoming parents; and (3) whether it is possible to be both a devoted and effective professional and a parent. The publication is organized into four sections. The first section, "Facts of Life about Being a Parent in Medicine: Hard Questions, Some Answers," consists of responses to six questions: (1) when is the best time to start a family? (2) what about the health of physician-mothers and their children? (3) what else does a physician-in-training need to think about regarding starting a family? (4) how should medical students respond to program directors' inquiries about their personal lives and childbearing plans? (5) what about shared schedule residency slots? and (6) what are legal rights to maternity leave? The second section explores maternity and parental leave policies related to medical students, residents, and medical school faculty. Section 3 summarizes the status of child care arrangements, and the final section offers a brief sketch of what the future may hold. A 50-item bibliography concludes the document. (LL)

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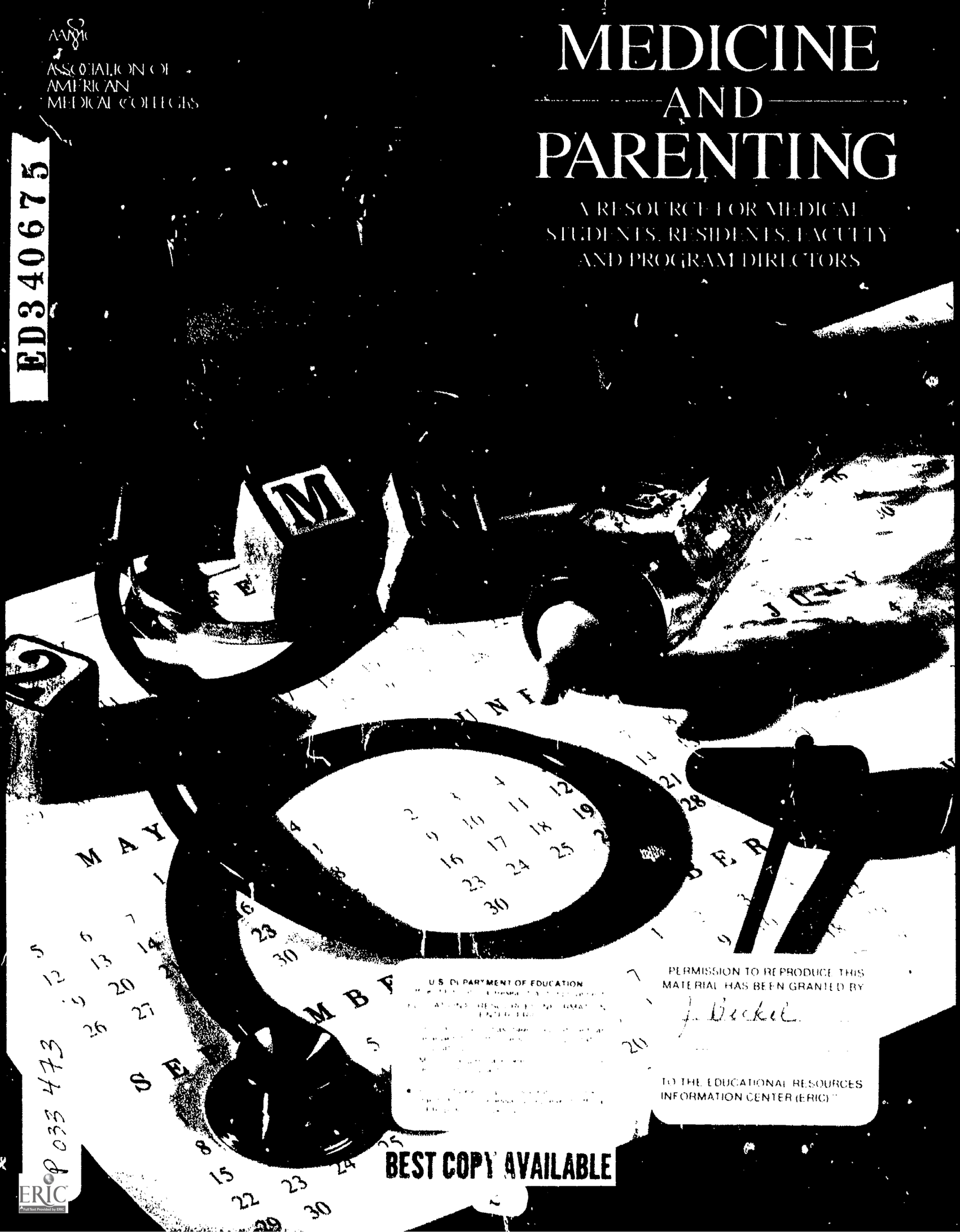
A RESOURCE FOR MEDICAL STUDENTS, RESIDENTS, FACULTY AND PROGRAM DIRECTORS



MEDICINE AND PARENTING

A RESOURCE FOR MEDICAL STUDENTS, RESIDENTS, FACULTY AND PROGRAM DIRECTORS

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MEDICINE AND PARENTING: A RESOURCE FOR MEDICAL STUDENTS, RESIDENTS, FACULTY, AND PROGRAM DIRECTORS

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MEDICINE AND PARENTING: A RESOURCE FOR MEDICAL STUDENTS, RESIDENTS, FACULTY, AND PROGRAM DIRECTORS

PURPOSES OF HANDBOOK

In its discussions of the needs of women in academic medicine, AAMC's Women in Medicine Coordinating Committee gives high priority to resources related to childbearing and childrearing. Women premedical and medical students are looking for examples of physicians who are happy with both their careers and their family-related choices. They frequently ask the questions: "when can I have a baby?" and "how should I arrange time off?" Residents have questions about leave policies, specialty board certification requirements, and ways to minimize burdens on their fellow residents. Faculty have questions about elder care as well as child care and want to know about leave policies, part-time options, and whether academic promotion guidelines include a "stop the clock" provision. Graduate students in basic science departments and fellows in teaching hospitals also have particular concerns.

Such questions and concerns reach the ears of deans, admissions interviewers, student affairs officers, residency program directors, department chairs, and teaching hospital executives. Some of these administrators wonder whether it is possible to be both a devoted and an effective professional and parent. Their concerns are usually logistical and financial but may have philosophical roots as well.

While this handbook cannot resolve these concerns, it does provide a framework for their consideration. It is intended to assist program directors and other administrators as they discuss parenting issues with students, residents and faculty and as they develop institutional leave policies. This handbook is also intended to address the most common practical and policy-related questions that medical students, residents, and faculty have about being parents and physicians. Unfortunately, insufficient information is available regarding any special needs of postdoctoral fellows or graduate students in the basic sciences.

AAMC's Women in Medicine Coordinating Committee hopes that Women Liaison Officers (WLOs) and medical school deans

will find this handbook to be a useful impetus for a variety of activities. WLOs will have many opportunities to take a leadership role in this regard, especially in working toward flexible leave policies. A variety of supportive activities can also be sponsored. For instance, last year Yale University's Office for Women in Medicine invited all interested faculty, housestaff and fellows to attend an evening discussion called "Demystifying Pregnancy During Medical Training". At the University of Pennsylvania School of Medicine, a group called "Mothers and Medical Students" has formed to network with each other, to discuss what course arrangements work best, and to sponsor seminars for students who are considering having children.

Each WLO is being provided multiple copies to distribute to appropriate clinical department chairs, program directors, and others with educational responsibilities in graduate medical education. Deans are encouraged to consider purchasing additional copies for distribution to women students. Questions about the issues raised in this handbook may be addressed to your institution's WLO or to AAMC's Director for Women's Programs (see title page) from whom a WLO roster may be obtained.

INTRODUCTION

In medicine as in most other professions, a woman's childbearing "clock" coincides first with educational requirements and then with the tenure or competence-proving timetable. No pause buttons are built into the continuum. In medicine, the situation is especially acute, because of the length of training and because of the around-the-clock demands of patient care. Both men and women in medicine thus face difficult questions about adapting their personal lives to fit educational and professional demands. A few men have articulated these dilemmas (Milgrom), but because women continue to be the primary care-takers both of children and of aging parents, women more often are the ones to call attention to the problems.

Employers in the U.S. have tended to look upon children as liabilities instead of as a national resource, and most have not adapted their personnel policies to the needs of the family. However, as readers of *Harvard Business Review*

can attest, major companies are beginning to recognize that flexible personnel policies can help to engender greater employee loyalty and greater productivity and in the long run, save rather than cost the company money (Rodgers, Schwartz).

Virtually all other advanced societies have moved faster than the U.S. in adding flexibility to personnel and education systems in order to accommodate family care-takers (Kamerman). The U.S. is the only industrial nation lacking a nationwide parental leave policy (Caplan-Cotenoff, U.S. Department of Commerce). In Europe, the creation of flexible leave policies appears to be part of a general movement toward decreasing work hours and achieving a more balanced life. There is also a greater appreciation that these are family issues not just women's personal problems.

Some physicians and medical school administrators may still be scaring off applicants to medical school with claims that medicine and family life do not mix. As women now comprise about 40% of new entrants to most medical schools, a more forward-looking approach by medical educators is to find equitable ways to accommodate pregnancies. Moreover, women now comprise over 30% of all residents in the following specialties: dermatology, family practice, obstetrics/gynecology, pathology, pediatrics, physical medicine, preventive medicine, and psychiatry (Rowley). The majority of these women are of childbearing age, and because of their educational priorities, many have postponed having children. In some cases, competition for the best residents has stimulated program and hospital directors to institute an attractive parental leave policy. Whatever the stimulus, medicine needs to learn how better to use the best talents of *all* its trainees and practitioners--not just those without family responsibilities.

Organized as responses to six questions, the first section of this handbook offers some "facts of life" related to being a parent in medicine. The second section provides overviews of leave policies for medical students, residents, and faculty. Third is a summary of the status of child care arrangements. Finally, a brief sketch of what the future may hold is attempted.

FACTS OF LIFE ABOUT BEING A PARENT IN MEDICINE: HARD QUESTIONS, SOME ANSWERS

1. When is the best time to start a family?

Every available woman physician has been asked this question innumerable times. The answer is, of course, "it all depends....." There is general agreement, though, because of the time demands and stress of new clinical responsibilities, that the most inconvenient time to be pregnant is internship. A close second is the third year of medical school. However, a number of women have successfully managed both pregnancy and training responsibilities during even these years.

Experienced physicians also recommend that young women planning families not convey a sense of entitlement regarding institutional accommodations to their childbearing or childrearing aspirations. Such an attitude is likely to undermine colleagues' or superiors' support (Gyure).

While little quantifiable information is available on medical students' becoming parents, the number of dependents reported on the MCAT questionnaire can be compared with the number reported by the same students four years later on the AAMC Graduation Questionnaire (GQ). Of 1988 medical school graduates, about 11% of those originally reporting zero dependents acquired at least one in the intervening time; and 51% of those originally reporting one, acquired at least one more (personal communication from Robert Haynes, research associate, AAMC Section for Operational Studies). While a gender analysis of that data has not been completed, GQ data is available by gender. In 1989, 87% of women and 84% of men graduates reported zero dependents.

A survey of residents and fellows at the point of their completion of training at University of Minnesota-affiliated hospitals revealed that 65% of the women physicians and 86% of the men were married; 33% of the women and 60% of the men were parents (Dennis et al.).

An extensive study of pediatricians revealed that men had an average of 2.6 children; and women, 1.7. For both sexes residency was the most common time to have the first child; however, board certified women were more likely than non-certified women to have postponed their childbearing until fellowship or after training (LeBailly and Brotherton). A 1983 AMA survey of

women physicians revealed that two-thirds of respondents had at least one child; almost half of these women had their first child during training (AMA, 1984). A 1985 survey of women physicians under 50 years of age found that 64% had children of their own, and of these, 43% had the first child during residency and 13% during a fellowship (Sinal et al., 1985). A 1988 survey of women internal medicine faculty revealed that, of the women who were currently married or had been married, 79% had children. The mean age at the birth of the first child was 30.6 years and at the birth of the second, 32.9 years. Forty-six percent of the respondents with children had their first child after completion of training. Almost three-quarters reported being satisfied with the timing they had chosen (Levinson, et al.).

A study of male and female residents whose families experienced a pregnancy during residency also produced noteworthy results (interestingly, this study of residents grew out of and utilized AAMC's Women Liaison Officer network). About 30% of both the female residents and the spouses of male residents said they should have timed their pregnancies differently. Both groups missed little work because of pregnancy (fewer than 7 days per trimester), but spouses took much longer maternity leaves (15.5 weeks) than female residents (5.8 weeks) (Harris et al.).

Thus, while there may be no "ideal" time to start a family, young women working toward a career in medicine should be encouraged by these reports that medicine and parenthood are not incompatible.

2. *What about the health of physician-mothers and their children?*

The American College of Obstetricians and Gynecologists' guidelines indicate that there is a "window" of disability that usually begins about two weeks before delivery and ends six weeks postpartum but that the onset, termination and cause of the disability can only be determined by the woman's physician. The guidelines also state that: "The return to work following delivery is not a decision to be made unrelated to home and job circumstances. . .although the six to eight week window is a useful rule of thumb in the normal uncomplicated case, it is still necessary to evaluate each pregnant worker individually." (ACOG)

Not all specialties have addressed health-related questions regarding their pregnant

residents. A few articles have appeared for residents in pediatrics (Klevan et al.), radiology (Sheth et al.), and psychiatry (Stewart and Robinson). From the limited studies conducted, it appears that continuing to work as an anesthesiologist while pregnant does not pose additional hazards to mother or child (personal communication from Marcelle Willock, M.D., Chair, Department of Anesthesiology, Boston University Medical Center).

Studies of the health of working mothers and their newborns have produced very mixed results, with some evidence for increased complications when the mother worked more than 40 hours per week (Bernstein). A study of 116 women physicians who completed pediatric training in the last five years found that 38% were pregnant during their residency (Klevan et al.). Of the 17 complications reported, 35% were serious enough to require hospitalization. When asked to describe the experience of being pregnant during residency, 52% said "tolerable" and 24% found it "miserable"; 37% said they would not get pregnant during residency if they had it to do over again.

On a more positive note, the study comparing female residents and spouses of male residents mentioned above (Harris et al.) also found that, while reporting greater stress during their pregnancies, the residents had no more adverse outcomes than the spouses (Osborne et al.). A much larger but similarly-designed study of residents likewise found no significant differences between women residents and residents' wives in the proportion of pregnancies ending in miscarriage despite the fact that during each trimester the women residents worked many more hours than the wives (Klebanoff et al.). The only difficulties experienced more frequently by women residents were preterm labor (but not delivery) and preeclampsia; the authors suggest that the latter finding could be due to a difference in diagnostic vigilance. As in other studies of pregnant workers' hours, Klebanoff et al. also found that when residents worked very long hours (100 or more per week), there was an increased incidence of preterm delivery and delivery of infants who were small for their gestational age.

Another finding from the Levinson et al. study will be of interest to physicians who hope to breastfeed: 79% of these women faculty with children reported breastfeeding their infants. Those who chose to breastfeed did so for an

average of 6.5 months, and 81% returned to work while doing so. These results indicate that medical centers should anticipate a need to accommodate this activity.

3. What else does a physician-in-training need to think about regarding starting a family?

The following observations are offered:

o Child*bearing* marks the beginning of child*rearing*. In addition to investigating maternity and paternity leave policies, provisions for child care leave and the availability of child care facilities should be considered. With regard to child care, students need to ask themselves such questions as: will I be able to rely on members of my family to help? how much additional debt will child care expenses entail? can I afford to borrow this extra sum? is having a child caretaker who speaks the same language as I do important to me? what is the minimum age of children that day care facilities in my area accept? what will I do when my child is sick?

o While a recent study of residents and fellows show that both young men and women physicians desire to improve the balance between family and professional responsibilities, married men with children still planned on working in their practices significantly more hours than married women with children (Dennis et al.). Whether due to preference or to economic and other pressures to maintain high levels of professional responsibilities, husbands more often than wives sacrifice time with their families, leaving women with more caretaking responsibilities than they may have anticipated.

o All parents need support. Many physicians have the tendency to deny their limitations and to maintain that, if they just put their minds to it, they can do anything. But, especially in households where both parents are professionals, parents need help in meeting their responsibilities to their children. Practical supports are easy to name but often hard to find and keep: child care center, babysitter, housecleaner, professional or live-in domestic help. A good support system also includes a sympathetic pediatrician, a network of colleagues, and, if not members of the extended family, then friends in the community.

o Having a child is expensive; while largely borne by the child's parents, these expenses may affect others. A medical student with children presents a higher budget than one without. Residents

should be aware of costs experienced by the teaching hospital. When a sizeable proportion of residents have babies, there are many ramifications: the high cost of delivering a baby translates into increased health insurance premiums, plus there are a variety of costs associated with filling in for absent residents, e.g., extra workload on other residents and staff, disruptions in rotation schedules.

o A resident who becomes pregnant will want to initiate a discussion with her program director *early on* in order to maximize the planning time available and to minimize disruptions for patients and for the other residents. If she is in a relatively small program, a resident should evidence awareness that her pregnancy is likely to have a high impact on the program, especially if any other resident is also pregnant. A cooperative and realistic, rather than demanding, approach to the resulting disruptions will help the other residents and program director to adjust.

4. How should medical students respond to program directors' inquiries about their personal lives and childbearing plans?

According to medical students graduating in 1988 who responded to AAMC's Graduation Questionnaire, residency directors tend to ask women personal questions more frequently than men. Women were more likely to be asked about the stability of their interpersonal relations (25% of women compared to 17% of men) and their intention to have children (40% compared to 16%). Women were five times more likely to be questioned about their commitment to medicine and twice as likely to be asked about their spouse's support for their decision to pursue medical training. Women were also seven times more likely than men to report an offensive incident occurring during their interview. On the positive side, fewer than 1% of students reported being asked about form of contraception or about sexual preference.

The law prohibits discrimination in hiring decisions on the basis of sex (including pregnancy), race, religion, national origin, age, and handicap. Questions pertaining to any of these subjects may be evidence of an impermissible discriminatory

intent. Candidates are not required to answer them; and if a program does not select a resident, the fact that the questions were asked can be offered in support of a claim against the program.

If a student feels that an interviewer is overly aggressive in pursuing questions, he or she may contact the federal Equal Employment Opportunity Commission or the state agency that handles discrimination claims. Understandably, few women have ever filed a claim because of questions about childbearing plans. Applicants naturally wish to please rather than alienate interviewers and therefore try to respond to all questions. However, *before their interviews* women applicants should prepare and practice answers to predictable personal questions. Immediately after their interviews, students who are uncomfortable about anything that occurred should write down their memories of what transpired so that they are empowered to take action later if advisable. The student affairs dean and/or WLO should be good sources of advice in these regards.

Women who hope to have a child during residency or who are uncertain of their plans need to think very carefully about how their responses may be received. The first dilemma is whether to be honest or to deny childbearing hopes. Probably most program directors have known residents who claimed not to be considering pregnancy but who did become pregnant during training; these directors may now be suspicious of other residents "misleading" them.

Students who are considering pregnancy should familiarize themselves with key facts and studies mentioned in this handbook and may wish to read a very helpful booklet on the residency interview published by the AMA Women in Medicine Project (AMA, 1985). Rather than feeling threatened by program directors' questions about children, which are usually asked out of legitimate concern for staffing requirements, students should put the shoe on the other foot. Prospective residents will want to find out in advance how supportive the program director is, how the leave policies work, and how absences are handled. Not only will this discussion provide the student with valuable insights, the student can also use this opportunity to assure the program director that she understands that any resident's pregnancy has implications for the program. The student may also wish to give the director an idea of her plans for managing her increased responsibilities.

Finally, students should also be advised to turn the conversation back to their commitment to medicine and to their academic and professional qualifications.

5. What about shared schedule residency slots?

Section 709 of the U.S. Health Professions Educational Assistance Act of 1976 mandated "shared schedule positions in residency programs in family practice, general pediatrics, general obstetrics and gynecology in institutions receiving federal assistance," with such a position defined as follows: "training in a residency program which is shared by two individuals and in which each individual engages in at least two-thirds but not more than three-quarters of the total training prescribed, receives for each year an amount of credit toward certification equal to the amount of training engaged in, receives at least half the salary, and receive all appropriate employee benefits." A 1977 survey revealed that about one-quarter of teaching hospitals had developed options for some type of reduced schedule training in at least one specialty (Shapiro et al.). Few reports on this subject have been published since then although Fisman et al. reported success with part-time residency training in psychiatry (Fisman et al.).

Last year, 618 (14%) of residency programs reported the availability of part-time or shared residencies, which represents an increase of over 100 from the previous year (Rowley et al.). Of the 618, 50% were in family practice, internal medicine, pediatrics, psychiatry, or child psychiatry. The largest numbers of programs offering shared-schedule positions were in New York, California, Pennsylvania, Michigan, Texas, Ohio, and Massachusetts.

According to the National Resident Matching Program (NRMP), last year 50 programs indicated the possibility of shared residencies; students must find a "mate" and apply together for these positions (Berlfein). The NRMP acknowledges, however, that many more than 50 programs actually make shared residencies available; if a program director wants a candidate who expresses an interest in a shared position, the director may be open to helping arrange such a position. Program directors may respond "you want a reduced schedule--then you figure it out". One method which appears to work particularly well in internal medicine is for three residents to

share two positions; each person then works eight out of 12 months in the year. Another good method is two months on/two months off. Either is preferable to residents' sharing the daily routine by putting in half days (Berlfein).

The American Academy of Family Physicians (AAFP) recently has developed a publication entitled "Reduced Schedule Training" which contains results of its survey of family practice residency programs. This survey showed that 93% of the programs do not offer the reduced option, either because it would not be feasible for the size of the program or because the program had not received inquiries about such positions. AAFP also offers a clearinghouse that can provide examples to individuals wanting information about options. (For more information, contact Denise Haushahn, AAFP, 8880 Ward Parkway, Kansas City, MO 64114-2797/(816) 333-9700).

The difficulty students often have is finding a partner looking for a similar residency position. The American Medical Women's Association (AMWA) is creating a clearinghouse for such people; students who are interested should contact AMWA (801 N. Fairfax St., Alexandria, VA 22314/(703) 838-0500). In conclusion, it is to be expected that, as more students inquire about the possibility of a reduced schedule, program directors will become more responsive and adaptive.

6. *What are my legal rights to maternity leave?*

Due to the nature of their relationship to a training program, students should not expect "legal rights" to maternity or other types of leave.

The primary Federal law related to pregnant *workers* is the Pregnancy Discrimination Act (PDA) of 1978 amended Title VII of the 1964 Civil Rights Act to prohibit discrimination on the basis of "pregnancy, childbirth, or related medical conditions." The Equal Employment Opportunity Commission enforces the Act. The law requires that women affected by pregnancy "be treated the same for all employment purposes. . .as other persons not so affected but similar in their ability or inability to work." Thus the PDA requires that women be offered benefits for pregnancy-related medical conditions equal to those provided for other medical conditions, but does not mandate pregnancy coverage in the absence of a general disability plan (Caplan-Cotenoff).

Treating pregnancy disability like other

temporary disabilities grew out of [illegible]th the legal battle to treat pregnancy discrimination as sex discrimination and the fear that treating women workers differently (even if it means additional benefits) would disadvantage women in the job market (Ford Foundation). This classification of pregnancy as a disability is one reason for the widespread practice of requiring that sick days be used for salary support.

Legislation which would provide job protection for workers needing time off to care for family members, permit 10 weeks unpaid leave, and guarantee continued health care benefits for workers on leave was passed in 1990 by the U.S. Congress but vetoed by President Bush. Several states have enacted family leave legislation that goes beyond the PDA; these laws mainly give job guarantees to employees who are temporarily out of work for family or personal medical reasons. Five states (California, Hawaii, New Jersey, New York, Rhode Island) have temporary disability insurance programs which pay salary replacement benefits while employees are temporarily unable to work (Women's Legal Defense Fund).

With regard to *students'* rights to *insurance benefits* relative to pregnancy, in 1990 the U.S. Department of Education ruled that student health insurance offered by colleges and universities must include maternity benefits. Although schools are not required to provide health or accident insurance to students, those which do must offer pregnancy coverage on the same basis as coverage for other temporary disabilities. The Department of Education considers an institution a health insurance provider if it endorses a particular insurance product and offers it to students (Association of American Colleges).

MATERNITY AND PARENTAL LEAVE POLICIES

A recent American Medical Association survey of medical group practices revealed that half have no woman physician in the group and that three-quarters have no woman physician who has given birth while practicing in the group (AMA, 1990). These numbers help to explain why only one-quarter of the practices reported having a standard leave policy allowing for maternity leave.

However, all U.S. medical schools and most residency programs have women trainees and faculty. And unlike many events and illnesses, the

outcome and timing of a pregnancy can usually be predicted. Leave policies can help both programs and mothers and fathers with this planning and also help to assure that everyone is treated equitably, including women who do not give birth. It is true that some administrators in programs without policies have been very generous and flexible with leave arrangements for their residents/faculty, and the existence of a policy may curtail such arrangements. However, such arrangements can create a sense of personal favor and can never be equitably applied. When a policy is in place, the leave is uniformly available and understood to be legitimate.

Attitudinal change often lags behind policy change, and in medicine the perspective prevails that physicians must be singularly devoted to the profession. A policy that spells out the rights and responsibilities of parents vis-a-vis work/educational program is a necessary but not sufficient step forward. Creating a climate in which physicians can combine work and family needs to be both a short- and long-term goal.

Maternity leave is different for medical students, residents and faculty, and is therefore covered in three separate sections. While insufficient information is available regarding the needs of graduate students in basic science departments and postdoctoral fellows, in many instances, these categories of trainees may be considered faculty.

1) Medical Students:

As students are paying tuition for the privilege of receiving an education, the question of "leave policies" has an altogether different cast than it does in the employment context. Usually a student's need for flexibility in the curriculum or for time-off for whatever reason is addressed individually by the appropriate medical school administrator. Clearly, some curricula and some administrators are more open than others to students' flexibility needs. For instance, the University of California-San Francisco's curriculum allows a fifth-year which was intended to encourage students to do a research project but which a number of women have used for childbearing purposes (personal communication, David Altman, M.D., Associate Dean, University of California-San Francisco School of Medicine).

In most schools, the number of women students bearing children has remained so small

that their needs for flexibility have usually been accommodated without serious problems for faculty or other students. Dalhousie University Faculty of Medicine in Nova Scotia has decided to apply some "preventive medicine" to this subject; wishing to provide guidance to students who request maternity/paternity or adoption leave, the associate dean has drafted a policy with the following principles: a) the educational requirements of the year in question must be met before a student can proceed to the next year; b) students may be able to meet educational requirements through adjustments in the timing of rotations, which must be approved by the associate dean; and c) all arrangements will be dependent upon the availability of learning experiences of an adequate quality to allow the educational objectives to be met. Although these guidelines may sound as if they are meant to protect the administration, they are primarily designed to protect the educational experience of the students, and students have received the guidelines very positively. (Personal communication from Karen Mann, R.N., Ph.D., Associate Dean, Dalhousie University Faculty of Medicine, 12/6/90).

2) Residents:

Studies regarding maternity leave for residents have produced varying results, depending on how questions are phrased, the year of the study and the sample responding. In 1989 Bickel summarized available studies (AMA 1984, Sayres et al., Sinal et al.) and concluded that fewer than 60% of teaching hospitals had a written maternity leave policy for residents (Bickel). Also in 1989 an AMA survey asked program directors if leave was available for maternity; 95% (4641) of respondents said "yes", and 45% reported having paternity leave (Rowley et al.). This survey did not ask about leave *policies*, however. Another AMA survey, completed in early 1990, revealed that 75% of residency programs report "standard policies for granting maternity leave". Responding directors were evenly divided on whether maternity leave is granted in addition to vacation, personal, or sick leave or is deducted from those categories. About half said that they use a combination of one or more of four types of leave (sick, vacation, disability, and maternity). Only 21 of the 900 directors with policies reported exclusive use of a maternity leave category (Personal communication from Phyllis Kopriva, Director, Department of

Women in Medicine, AMA, 12/18/1990).

With regard to time allowed, the 1990 AMA survey found that about one-third of the responding programs allow between four and six weeks; 25% allow less than four weeks; 40% allow more than six weeks. An earlier AAMC housestaff benefits survey revealed that 57% of teaching hospitals with a maternity leave policy reported that no leave is granted prior to delivery. For leave after delivery, 62% reported six to eight weeks and 26%, less than six weeks (Teich).

Revisions to the General Essentials of Accredited Residencies which are under consideration by the Accreditation Council for Graduate Medical Education include the provision that "Candidates for residencies must be fully informed of benefits including....parental leave.....There must be a written institutional policy on leave (with or without pay) for residents that complies with federal and state laws."

The American College of Physicians recently published a position paper on parental leave for residents which recommends the following minimum elements to include in a policy (Levinson):

- Guidelines for length of leave allowed before and after delivery
- Procedures for requesting leave
- Procedures for alteration of leave due to an unanticipated event or complicated delivery
- Whether salary is provided during leave
- Whether benefits are provided during leave (for example sick time, vacation time, short-term disability)
- Whether time absent needs to be made up in order to fulfill requirements of the certification process
- If residents are required to make up additional months, whether they will receive benefits and salary during this time
- If leave is extended, whether the institution or the individual must pay health insurance premiums
- Whether accrual of vacation and sick time continues during parental leave
- Whether flexible planning (for example, returning to work part-time) is available
- Whether the policy applies to adoption and to paternity leave.

With regard to *paternity* leave, a 1987 American Academy of Family Physicians (AAFP) survey of family practice residencies revealed that

27% had paternity leave policies (Murray). As part of a larger effort (see below), AAFP has recently promulgated a recommended policy on paternity leave which includes the following provisions:

o the duration of paid leave time should be made up of vacation and sick leave; additional leave would be made up by extending residency training;

o the father should be entitled to take his paternity leave any time during the first month after delivery;

o attempt should be made to allow the father to have minimal call around the time of the delivery and no call while on leave.

McMaster University Faculty of Health Sciences offers another approach, giving residents the option of one week of unpaid paternity leave at their discretion (with the resident required to give appropriate notice of his intention). Rather than creating separate paternity leave guidelines, some residency programs (e.g., University of Louisville Department of Psychiatry) have instead developed a *parental* leave policy which covers requests for paternity leave.

Clearly, provision of all of these elements presents program directors with a number of logistical challenges. Also, creation of a leave policy is just the beginning. A lot of planning between residents and directors is still required to minimize disruptions. And program directors face important costs associated with adding staff (this need is arising as well in conjunction with efforts to reduce residents' hours). Another difficulty is that residents who take all the leave available to them may be subject to criticism from unsympathetic colleagues and may face concerns about the adequacy of their training. As Little commented in his Sounding Board article appearing with the Klebanoff et al. study, "although [a resident's experience as a mother] may mean as much ultimately to her understanding and development as a physician, it is viewed as a lag or gap in her training" (Little).

Specialty certification boards' requirements vary regarding time allowed during residency for maternity or disability leave; when a board's requirements are more restrictive than a residency program's, this may have the effect of reducing leave time available to a resident. Almost half of the specialties on which information is available allow six weeks per year. The following specialties

specify one month per year: Preventive Medicine, Plastic Surgery, Surgery, Psychiatry, and Ophthalmology. Anesthesiology specifies 20 working days each year. Pathology allows only two weeks per year. Pediatrics takes a more flexible approach allowing three months total during residency (Bickel).

The AAFP Board of Directors recently adopted a policy on parental leave during residency training. It states that a resident will not be allowed more than 30 days per year away from the residency, without make up of that time, to be eligible to take the Board exam; this 30 days includes vacation and sick leave. The AAFP policy further recommends that the duration of the paid leave be made up of vacation and sick leave which may be up to 30 days per year; additional time would have to be made up by extending residency training and should be covered by a disability program if medically indicated. Furthermore, residency programs are encouraged to allow residents to design home study or reading electives around the delivery date.

The American Board of Internal Medicine has also recently devoted renewed attention to its policies and recognized that combining sick and vacation leave is insufficient for maternity leave: residents are now to be allowed six weeks for pregnancy, in addition to the one month per year which the Board allows for vacation time, illnesses, or delayed starts. The goal is to keep as much flexibility in the system as possible but not to the point where training is de-emphasized.

For residents who take more than the average time off during residency, an additional difficulty may be the timing of the specialty certification board examination. For instance, in Anesthesiology the candidate must finish board requirements by August 31 to be eligible to take the written exam that year.

3) Medical School Faculty:

Increasing numbers of universities are adding flexibility to their personnel policies. A recent survey of 11 private universities including the eight Ivy League institutions was conducted by Yale University demographer Rena Cheskis-Gold (*Chronicle of Higher Education*, 11/7/90, p. A13). The survey revealed that the three most desired leave benefits added in recent years are unpaid leaves of up to a year, fully paid time off from teaching responsibilities, and extension of the

tenure clock. The survey also showed that institutions with the most generous leave policies tend to be those that operate on a quarter system, because their schedules allow for more flexibility.

Information on childbearing and childrearing options for medical school faculty has recently been obtained from 119 of the 126 U.S. medical schools with the following results (Grisso et al.):

With regard to *childbearing leave*: 22% still have no written guidelines; 45% categorize childbearing leave as a form of sick or disability leave; only the remaining 34% have developed specific maternity leave policies.

In order to obtain salary support, a widespread practice (61%) is to require that sick days be used for maternity leave; the median number of sick days available to faculty was 15 per year. Use of vacation time is required by 24% of schools; median number of vacation days is 22. All but 11% of schools permit accrual of sick and vacation days. The available time from sick leave and vacation averaged 6.8 weeks, and on average women faculty took 7 weeks. Thirty-one percent of schools have a separate paid maternity leave which does not depend entirely on vacation or sick days for salary support; at these the median duration of paid leave is 12 weeks. Thus it appears that women at schools with a separate maternity leave policy receive more time off than at schools without a separate policy.

With regard to *job security*, 97% of schools guarantee the same job upon return from maternity leave. All but 6% of schools continue to *contribute to benefit* plans while employees are on paid leaves. However, 80% require that the employee pay for continuation of benefits during unpaid leaves.

Twelve of the 119 (10%) schools reported written provisions for *paternity leave*; five of these pay salaries during these leave but usually for less than one week.

With regard to *adoption*, 38 include provisions for child adoption in either their childbearing or childrearing guidelines. Of these 38, 26 consider adoption leave to be an unpaid leave of absence. Only seven schools provide paid leave of absence for caring for adopted children.

Schools were also asked about written guidelines on *childrearing leave*. Only 32% reported such guidelines, and these usually stipulate leaves of absence without pay. However, 98% of

respondents stated that both male and female faculty can take childrearing leaves. Only three of the responding schools provide salary support for faculty members on childrearing leave, and 86% disallow sick days. Few schools had records of the number of faculty taking childrearing leaves or their duration. With regard to benefits, 70% of schools require that the employee pay the cost of these while on childrearing leave.

In 1989 the Chancellor's Advisory Committee on the Status of Women was instrumental in winning important new provisions for parents within the University of California system. An unusual feature of California's system is that most categories of faculty do not accrue sick leave *per se*; faculty simply do not work when ill. Now in addition faculty who have served for at least one year will receive full pay for up to six weeks for maternity leave. For parental leave, faculty may request an additional six weeks labeled Active-Service Modified Duties. Modified duties usually mean no night or weekend call. Because the issue of full pay for this 12 week period was controversial, each academic unit is left to develop a salary policy; however if a department elects to reduce salary for maternity leave, it must also reduce salary during all sick leave for everybody (personal communication from Diane Wara, M.D., Professor of Pediatrics, University of California-San Francisco School of Medicine).

Real difficulties remain at most schools in deciding how to pay for childbearing and childrearing leave for faculty and who should be eligible. For instance, should postdoctorate fellows be eligible? Is it better to allow 12 weeks at 100% pay or 24 at 50%? All parties will need to cooperate in the negotiations to hammer out fair and feasible answers.

Another important issue for faculty, especially those with young children, is the length of the *tenure probationary period*. The traditional seven-year period, during which assistant professors are expected to establish themselves as researchers, teachers, and clinicians, continues to be defended by some as the most appropriate interval. However, recognizing that all clinical faculty have numerous pressures and may need more time especially with publishing research results, a number of medical schools have lengthened the period for all faculty. Results from the Grisso et al. study above show that while 72% of medical schools allow extension of a faculty member's

tenure probationary period for childrearing leave, the common condition is to require the faculty member to take a one year leave of absence, which many are unwilling or financially unable to do. Fortunately, some schools are now taking a more flexible approach. Case Western Reserve University School of Medicine now grants faculty an automatic extension of one year following a baby's birth; this school also allows extension for other "extraordinary circumstances". The University of Michigan also grants this automatic extension, and recognizing that many adults now have responsibility for aged parents, broadens the language to include other dependent care. The University of Pennsylvania allows the probationary period to be extended proportionally to the duration of the childrearing leave, which may occur at any time after the birth or adoption of a child.

While situations vary from family to family, most women who have young children need temporary alternatives to full-time work. During this time, they need to be able to retain their job-related benefits. Some women will want to work part-time, but in most medical schools this option carries no benefits and is considered a minus on an academic c.v. However, at Yale University School of Medicine, part-time faculty may remain on the tenure track, where they are allowed a 13-year probationary period. Because so little is known about the use faculty make of the part-time option, their satisfaction with it, and how it can be improved, the American College of Physicians is supporting a survey of internal medicine part-time faculty, which is being carried out by Wendy Levinson, M.D. and Janet Bickel.

CHILD CARE ARRANGEMENTS

With regard to women physicians in general, a 1985 survey asked a random sample of women physicians under the age of 50 to note all forms of child care they had used with their first child (Sinal et al., 1989). Responses included: day care center (25%), caretaker in private home (38%), family member (25%), caretaker in own home (48%), and live-in caretaker (21%). Comparing these results with other studies of working women, the authors conclude that in-home care is a more frequent choice for women physicians than for other professional women.

AMA's Department of Women in Medicine

conducted the most recent survey of child care services in hospitals. This survey of 1400 U.S. hospitals indicates that about 17% of community hospitals and 35% of teaching hospitals currently offer child care services (AMA, 1990). Results from the most recent AAMC housestaff benefit survey (which words the question differently from AMA's survey) show 28% of teaching hospitals providing on-site day care for children of housestaff. The costs of day care vary widely among geographic areas and with the age of the child. The 54 hospitals reporting costs by the week had an average cost of $91, with a range from $50 to $150. Eleven reported rates by the month, with an average of $410. The predominant starting time of care was 6:00 or 6:30 AM, and care was usually available only until 5:30 or 6:00 PM (AAMC 1989).

In 1989 the American Medical Women's Association (AMWA) published results of its survey of day care at teaching hospitals; 71 of the 140 hospitals surveyed responded, and of these 29 (41%) reported on-site day care centers (Epps and Bernstein). Five more had near-site programs on university campuses, and nine had new centers opening within one or two months; only three reported no or very little interest in day care. Using this work as a starting point, AMWA has obtained funding to produce a Manual for Establishing Day Care Facilities in Teaching Hospitals. Information from a number of consultants (including the president of the Association of Hospital-Affiliated Child Care Facilities) is being compiled in order to provide detailed information of staffing, insurance, fee scales, and a variety of regulations. For additional information, contact AMWA, 801 N. Fairfax, Alexandria, VA 22314/ (703) 838-0500.

Referral services and other resources should already be available through the state or county of residence or through such agencies as League of Women Voters. Also a number of metropolitan areas publish directories of child care facilities (e.g., *Mothers at Work Book* by L.K. Smith and N.S. Satterfield) which are available in bookstores. The American Academy of Pediatrics publishes a free brochure (see Bibliography) with advice for shopping for quality day care. Information on general issues in child care is available from a variety of sources (Nelson, Hyde, Brazelton).

One study from the corporate world shows

that 77% of women and 73% of men employees take time away from work to handle family issues (Rodgers and Rodgers). Thus *Sloan Management Review* and other business periodicals are beginning to publish articles on creating child care programs (Thomas and Thomas). Organizations as diverse as the U.S. Department of Labor and the American Association of University Professors (Keyes) have also published articles or books with recommendations and pointers.

A particularly good source of information is the Family and Work Institute headed by Ellen Galinsky and Peter Stein at the William Paterson College (300 Pompton Rd., Wayne, NJ 07470/(201) 595-2562). Its recent study of Fortune 500 companies revealed that 86% of the 71 companies surveyed plan to introduce new work/family programs in the next two years. This Institute also reports that a number of major universities (including Harvard, MIT, University of California-Berkeley, and University of Oregon) now have task forces or committees exploring work/family issues (Pennisi).

LOOKING AHEAD

Parental leave and child and elder care issues are increasingly recognized not just as "women's issues" but as issues important for the whole country to address. According to an annual survey conducted by *Working Mother* magazine, those leading the way in this country with regard to child care, family-friendly benefits, and advancement of women include Beth Israel Hospital (Boston), Apple Computer, Dupont, and Merck. In medicine, voices in support of improved options for parents are joining other voices calling for a more humane training environment, including limits on hours worked by residents. Increasingly, in order to recruit and retain the best nurses, students, residents, faculty and staff--academic medical centers, HMOs, and practice groups are paying more attention to the parenting needs of trainees and all classes of employees.

Looking ahead into the not-too-distant future, it is possible to predict that academic medical centers will offer reduced schedule residencies in all major specialties and a minimum of six-to-eight weeks of guaranteed paid leave for

residents and faculty who are new parents. Faculty will also have a choice among options to add flexibility to their schedules while their children are young. Child care facilities with extended hours will accommodate the needs of physicians, other faculty, administrators, residents, nurses and students. Perhaps modeled after the one already in operation at Stride Rite Corporation in Cambridge, Massachusetts (Burke et al.), some centers will also feature inter-generational day care programs for employees that will accommodate both children and elderly adults. To be sure, institutional leaders of both sexes will need to work steadily together to turn these ideals into reality, but time and the direction of cultural and corporate changes are on their side.

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