

ple that she was interested in medicine, but she's been uncharacteristically quiet of late. Will she end up being a top clinician, a chief, a chair, or a dean someday? Or will she compare academic medicine

with other fields that seem more open to women and decide that it's not the right place for her?

Dr. Andrews is the dean of Duke University School of Medicine, Durham, NC.

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Becoming a Doctor, Starting a Family — Leaves of Absence from Graduate Medical Education

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Colleagues offered congratulations when Mike and Anya announced that they were expecting a baby — due a few months before their expected graduation from residency programs in radiology and family medicine. Both had plum jobs lined up across the country, where grandparents could help with child care.

Mike's radiology program director told him he could take 8 weeks of parental leave and that the American Board of Radiology would exempt him from making up this time. Mike's fellow residents were relieved that the extra on-call responsibility would not be distributed among them but rather would be covered by moonlighters. Unfortunately, Anya's program director, citing American Board of Family Medicine policy, reported that any parental leave she took would delay her graduation, because she had already taken her vacation for the year. Though he acknowledged that Anya was competent to practice independently, the director stated that she would nevertheless have to make up any time away from the program. To complicate matters, the hospital provided 8 weeks of paid maternity leave but only 2 weeks of paid paternity leave.

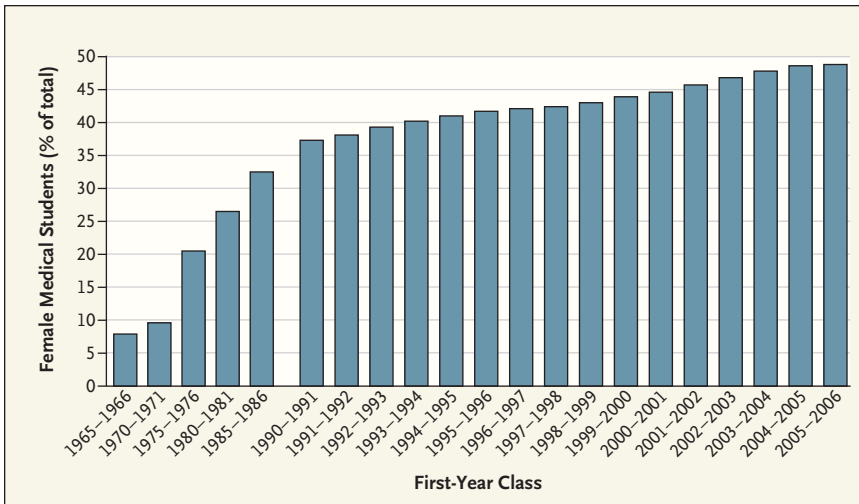
To retain their job offers, the couple decided that Anya would return to work just a few days after childbirth. She shouldered extra on-call duties during her second trimester in order to have a lighter schedule later on. Fortunately, the pregnancy and childbirth were uncomplicated and, fighting exhaustion, Anya completed her residency close to the planned date. The couple managed to make ends meet on Anya's salary while Mike cared for their infant.

Mike's colleagues took pride in the "enlightened" policies that allowed a male resident to serve as primary caregiver for his newborn without negative repercussions for his career. Anya's mentors, on the other hand, wondered whether the profession's explicit recognition of family leave had made things better or worse.

Two decades ago, researchers studying pregnancy among women who were training at Harvard teaching hospitals concluded that, though pregnancy and childbearing were "a natural and expected part of all our lives," most Harvard-affiliated institutions "were unprepared for pregnancies among members of the house staff" — as evidenced by the fact that four

fifths of the training programs had no maternity-leave policy.¹ Family-leave policies have since been developed at both institutional and national levels. Most teaching hospitals now provide explicit parental leave (often with pay), and the federal government and member boards of the American Board of Medical Specialties (ABMS) have developed relevant regulations (see the Supplementary Appendix, available with the full text of this article at www.nejm.org). Nevertheless, the issues surrounding parenting during training continue to challenge educators and policymakers, as well as residents and fellows. The personal and educational needs of trainees with children often collide with their colleagues' expectations, their hospitals' workforce needs, and the requirements of the ABMS and the Accreditation Council for Graduate Medical Education (ACGME).

With women now accounting for half of all medical students (see graph), and with training in many specialties now extending well into the fourth decade of life, the problems have become more pressing. A study of matriculants at Yale University School of Medicine showed that before



Proportion of Medical Students Who Are Women, 1965–2006.

Data are from the Association of American Medical Colleges.

1950, only 24% of the physician-mothers surveyed had had their children during training; by 1989, the proportion had reached 42%.² Caring for a baby during training may also be more difficult than in past eras, since fewer trainees of either sex have a nonworking partner at home. Indeed, the Yale study documented that even 18 years ago, although the length of maternity leave had increased over time, women's level of satisfaction with that length had decreased.²

Over the past two decades, studies have explored women's experiences with pregnancy and childbearing during residency. Early studies documented the dearth of formal policies, the tendencies of residents to take short maternity leaves and to discontinue breast-feeding on their return to training, and a perception that the environment was not receptive to pregnancy. Other studies examined the medical outcomes of pregnancy among women subject to the intensive demands of residency; several suggested an in-

creased incidence of certain complications among trainees, but a landmark study comparing female trainees to the wives of male trainees found few differences in outcomes. Nevertheless, studies have documented a number of obstacles perceived by women considering pregnancy during residency, including a lack of support from faculty members and other residents, the challenge of optimally timing childbearing in relation to their careers, and the difficulty of obtaining child care.

In response to such findings and growing pressure, professional organizations such as the American College of Physicians and the American Medical Association began, in the late 1980s and early 1990s, to take the formal position that residency programs should establish written policies on parental leave. The ACGME now requires that graduate medical educational institutions give trainees printed statements of such policies.

In parallel with these developments, family-leave policy was

evolving in the larger political arena. For years, the relevant federal policy was limited to the 1978 Pregnancy Discrimination Act amendments to the Civil Rights Act of 1964, which prohibits the differential treatment of pregnant women in employment. After debate between business interests and advocates for workers and families, Congress enacted the Family and Medical Leave Act (FMLA) in 1993. This law dictates that covered employers (generally, organizations with more than 50 employees) allow eligible employees (generally, those with a year of service) up to 12 workweeks of unpaid leave during any 12-month period for the birth and care of a newborn child, the adoption of a child or the taking in of a foster child, the care of a seriously ill member of their immediate family, or the care of a serious health condition of their own.³

Although the FMLA's provisions are not as far-reaching as other countries' maternity-leave policies, they present a unique challenge for the medical profession, which requires particularly long, intensive training. A trainee who takes one or more 12-week annual leaves may fail to achieve the necessary competence to perform as an independent practitioner. This negative effect may be exacerbated by the current limits on duty-hours, which reduce the time spent performing direct patient care.⁴

Some ABMS member boards have recently enacted stricter limits on the amount of leave trainees may take before being required to make up missed time. Other boards have had long-standing provisions regarding the duration of leave,⁵ but since these were gen-

erally not enforced until recently, trainees and program directors are often surprised by the need to extend residency or fellowship beyond a planned graduation date. Though boards' policies vary considerably, there is a trend toward ensuring the completion of a fixed number of months of active training.

These strict regulations are problematic, because extending training even by a few months may cause substantial hardship for both trainees and programs. Because most programs follow an academic-year cycle, a brief extension of training at one stage may lead to a longer interruption of progress toward more advanced training. The extension of training may also delay eligibility for board-certification examinations that are offered only annually or biennially.

For the programs, extending the training period creates additional expense (if trainees are paid during leave) and may cause them to exceed ACGME-established limits on the number of residents in a program. Although training institutions are bound by the FMLA to provide leave, the

graduate medical education programs within those institutions are not policy-bound to extend the duration of training. Thus, residents and fellows may have to negotiate for an extension and may conceivably be refused one.

From the point of view of training programs — and perhaps future patients — regulations limiting residency leave make sense. They attempt to ensure that residents are exposed to the full curriculum and the duration of training deemed necessary for practicing safely and effectively. They address other trainees' concerns about fairness. And they promote stability for the program and the care-delivery system.

Yet it is unrealistic and inappropriate to expect trainees to delay childbearing or to forgo spending critical time with their infants. We therefore need new solutions. Several avenues appear promising, including the broadened availability of on-site child care and other support, the exemption of competent trainees from making up leave time, the extension of federal reimbursement for graduate medical education to include paid family leave,

and increased part-time training options. Some combination of such initiatives may be needed to support trainees who are juggling the roles of parents and physicians during a critical period of professional development.

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