What to Expect When They’re Expecting: Addressing Policy Nuances of Resident Parental Leave

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The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Internal Medicine (ABIM) recently updated their policies affecting resident parental leave.1–3 This change is a significant step toward gender equity in childcare, as parental leave has well-established benefits for parents and children. Maternity leave is associated with improved maternal mental and physical health, increased breastfeeding rates, and lower infant and child mortality.4–7 Although there is less research on the benefits of parental leave for the non-birthing parent, paternity leave specifically is associated with increased infant caretaking, more father-child bonding, improved infant health, and increased employment and pay for mothers.8,9 However, parental leave policy change is meaningful only if these policies can be applied to the real world. Resident leave policies are notoriously difficult to interpret10 and overwhelming to implement.11 Without clear guidance, what was intended as a step toward gender equity may unintentionally become a source of stress to programs and trainees.

The authors of this perspective presented a pre-course and a workshop on parental leave at Academic Internal Medicine Week 2023. Our stepwise approach to parental leave for trainees involved understanding the relevant policies, exploring individuals’ values, and striving for consistency and transparency to all trainees. Throughout the conference, we received numerous questions about how to apply the new ACGME and ABIM policies to specific, real-life scenarios that program directors are experiencing regularly. This article is in direct response to the questions, concerns, and ideas that were raised at the workshop, which demonstrated the need for immediate, actionable guidance on the application of new leave policies.

This perspective first reviews the updated ACGME and ABIM policies affecting resident parental leave, then will work through 3 challenging cases, taken from a combination of scenarios given during the conference, discussing how we would apply the relevant policies to individuals in the real world.

UNDERSTANDING THE NEW RULES

ACGME’s Institutional Requirements

ACGME is a private, not-for-profit organization that sets standards for US graduate medical education programs and their institutions.12 On July 1, 2022, ACGME enforced an updated version of Institutional Requirements, with Section IV.H addressing vacation and leaves.
The full verbiage of ACGME’s updated Institutional Requirements is shown in Figure 1. Briefly, institutions must provide residents and fellows with 3 key benefits: a minimum of 6 weeks of leave, paid at the equivalent of 100% salary, and an additional 1 week of paid time off, separate from the first 6 weeks of leave. These benefits start on the first day a resident is required to report to work.

ABIM’s Time Away Policies

ABIM has 2 policies affecting resident parental leave: Leave of Absence and Vacation Policy, and Deficits in Required Training Time Policy. These policies address how much time residents can take away from training and still sit for internal medicine board examination. Figure 2 outlines ABIM’s policies and the calculations for how much time away residents can take. In brief, trainees may take a maximum of 20 weeks of time away from training and still sit for boards.

When reviewing leave policies, it is essential to understand what each policy actually addresses and what is outside its scope. For example, ACGME’s Institutional Requirements address the benefits that institutions must provide to trainees. They are not internal medicine specific, and they have nothing to do with clinical competency. Rather, they address benefits and paid time off. ABIM’s policies address something completely different—the maximum amount of time residents can take away from training and still sit for boards. They address dwell time for internal medicine training. Three scenarios will help readers better understand these different policies and apply these changes.

APPLYING THE NEW RULES

Each of these scenarios is addressed to an internal medicine residency program director.

Case 1: The Non-Birthing Parent

You receive an e-mail from one of the postgraduate year 3 (PGY-3) residents. He is adopting a baby in January. He has taken 8 weeks away from training so far (4 weeks as a PGY-1 and 4 weeks as a PGY-2). He is meeting all milestones. How much time off can he take? Will his leave be paid? Does it matter that he’s not the birthing parent? Does this time away need to be reported?

Applying ACGME policy to Case 1.

ACGME requires sponsoring institutions to provide all residents with at least 6 weeks of paid medical, parental, or caregiver leave(s) of absence at least once during training. ACGME’s policy applies to all residents, including birthing and non-birthing parents. This

“The Sponsoring Institution must have a policy for vacation and leaves of absence, consistent with applicable laws. This policy must:

1. Provide residents/fellows with a minimum of six weeks of approved medical, parental, and caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws at least once and at any time during an ACGME-accredited program, starting the day the resident/fellow is required to report;
2. Provide residents/fellows with at least the equivalent of 100 percent of their salary for the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken;
3. Provide residents/fellows with a minimum of one week of paid time off reserved for use outside of the first six weeks of the first approved medical, parental, or caregiver leave(s) of absence taken;”

Figure 1  Accreditation Council for Graduate Medical Education’s (ACGME) institutional requirements, Section IV.H.
responsible for 6 weeks of fully paid parental leave.

A resident’s exact leave options will vary by institution. Leave options may differ based on postgraduate year and whether a trainee is a birthing parent. For example, at some institutions, short-term disability may be used only by birthing parents. Because there is variability among institutions, we encourage internal medicine program leadership to build a chart outlining specific leave options at their institutions (Figure 3).

Applying ABIM policy to Case 1. This resident is meeting his milestones, so it would be reasonable for his program director to activate the Deficits in Required Training Time Policy for him. If the policy is activated, this resident may take a total of 20 weeks of time away from training and still be eligible to take boards. He has taken 8 weeks of time away so far, so he may take 12 weeks of time away during his PGY-3 year, completing his 36 months of training. No additional information about time away from training will need to be reported, thus not affecting graduation, licensing, or board eligibility.

Case 2: The Intern at Orientation
You receive an e-mail from a newly matched categorical intern that she is pregnant, due on June 20. The interns are due to report at orientation on June 12, with a clinical start date of June 26. Will her leave be paid even if it starts prior to her clinical work? How much time off can she take?

Applying ACGME policy to Case 2. ACGME’s Requirements for Sponsoring Institutions state that leave may be taken “at any time” during training “starting the day the resident/fellow is required to report.” Thus, if this intern is required to report on June 12 for mandatory orientation, her leave benefits must start on that date too. Her exact leave options would vary by institution, but she would qualify for at least 6 weeks of leave, paid at the equivalent of 100% of her salary.

Applying ABIM policy to Case 2. At the start of orientation, it is impossible to know if any intern, not just those taking parental leave, will need training extension. Program directors need to assess clinical competency over time before they can make an accurate statement about training extension. At orientation, the program director would have no idea if it might be appropriate to activate the Deficits in Required Training Time Policy for any intern. This uncertainty adds a challenge to planning leave for residents early in their training.

In this situation, we must acknowledge uncertainty and take the time to explore residents’ values prior to jumping to planning a leave schedule. This concept
was a key feature of our workshop and is outlined in Figure 4. Is training extension something that might be acceptable to this intern? Or do they feel strongly about avoiding training extension at all costs? What does their support system look like? What are their biggest concerns about leave? Understanding the resident’s priorities will help build a leave schedule that honors what is most important to them.

This scenario also highlights the importance of program leadership having a shared mental model for clinical competency required for graduation for all residents, not just those taking leave. Programs need to be consistent and transparent with criteria for activating Deficits in Required Training Time. For example, does the program only activate for a few outstanding residents who are exceeding expectations in all sub-competencies? Or do we assume that it will be activated for most residents, except for the small percentage requiring remediation? Knowing the answers to these questions will not get rid of all uncertainty, but it will provide more transparency and can give the resident an idea of how likely training extension will be.

### Table: Parental Leave Options

<table>
<thead>
<tr>
<th>Type of Leave (Examples)</th>
<th>Who is Eligible</th>
<th>Paid?</th>
<th>Max. Amount of Time Allowed (in weeks)</th>
<th>How to Get It</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution-Sponsored Parental Leave</td>
<td>PGY1, PGY2, PGY3 Birthing &amp; non-birthing parents</td>
<td>Yes, 100% salary</td>
<td>2 weeks once during residency</td>
<td>Register on institution portal before leave</td>
</tr>
<tr>
<td>Sick Days</td>
<td>PGY1, PGY2, PGY3 Birthing &amp; non-birthing parents</td>
<td>Yes, 100% salary</td>
<td>2 weeks / year</td>
<td>Inform Program Director &amp; Program Coordinator before leave</td>
</tr>
<tr>
<td>Vacation Days</td>
<td>PGY1, PGY2, PGY3 Birthing &amp; non-birthing parents</td>
<td>Yes, 100% salary</td>
<td>3 weeks / year</td>
<td>Inform Program Director &amp; Program Coordinator before leave</td>
</tr>
<tr>
<td>Short Term Disability (STD)</td>
<td>PGY1, PGY2, PGY3 Birthing parents only</td>
<td>Partial, 60% salary</td>
<td>8 weeks for vaginal birth, 10 weeks C-section / pregnancy</td>
<td>Sign up through institutional portal before leave</td>
</tr>
<tr>
<td>Family Medical Leave Act (FMLA)</td>
<td>PGY2 &amp; PGY3 only Birthing &amp; non-birthing parents</td>
<td>No</td>
<td>12 weeks</td>
<td>Register on institution portal before leave</td>
</tr>
</tbody>
</table>

*Figure 3* Sample chart of parental leave options. PGY = postgraduate year.

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**Case 3: The Second Extended Leave**

The intern from the last scenario decided to take 10 weeks of parental leave in her PGY-1 year. She is now a PGY-3 resident, and she just announced her second pregnancy. She is hoping to take 10 weeks of parental leave again this time. She has taken 14 total weeks of time away from training so far (10 weeks as a PGY-1, 4 weeks as a PGY-2.). She is meeting all milestones. How much time off can she take without extending training? Will this resident’s leave be paid even though it is her second leave?

**Applying ACGME policy to Case 3.** ACGME does not require sponsoring institutions to provide more than one fully paid, 6-week leave. If sponsoring institutions chose to meet the bare minimum requirement, they only need to offer 6 weeks of fully paid leave one time. Using ACGME’s policy alone, you cannot guarantee this resident a fully paid parental leave. In this case, the question of paid leave would largely depend on state law (or federal, if military) and individual institutional policy. Currently, 13 states and the District
of Columbia have enacted paid family leave laws. Thus, this resident might be eligible for more paid parental leave depending on her state and institution.

**Applying ABIM policy to Case 3.** If the program director attests to this resident’s clinical competency, she may take a total of 20 weeks of time away from training and still sit for internal medicine boards. So far, she has taken 14 weeks away from training. Even if the program director decides to activate Deficits in Required Training Time, this resident has only 6 weeks remaining before training extension is required. If a training extension is required and she desires to take the Internal Medicine Board Certifying examination this year, she will need to complete training by August 31.

Again, value-based discussions are essential. How important is it to this resident to take 10 weeks of leave? Would training extension be acceptable to her? Does she want to take boards this year or wait? If some of her leave was unpaid, would it be acceptable to her and her family? No 2 residents will have identical priorities, so program leadership must be prepared to discuss values when planning parental leave.

**CONCLUSIONS**

Fully understanding leave policies is an essential first step to navigating resident parental leave. Through experience and the feedback gathered at recent workshops, we recognize the challenges of applying policy to the intricacies of real life. Case-based application raises difficult questions and discussions that may otherwise get overlooked.

With this application in mind, we encourage educational leaders to work through real-world scenarios to enhance their understanding of changing leave policies. Once we have a firm grasp of the pertinent policies, we must distill this complex information into an accessible form for trainees. At a minimum, trainees should be able to understand the impact of parental leave on their income, length of training, and career path to make informed decisions about expanding their families during residency. Programs can take it a step further helping residents navigate leave via value-based conversations.

Finally, even with transparency, there will never be a one-size-fits-all model for resident parental leave. Every individual has unique priorities and values. It is the job of educational leaders to explore these values when applying general policies to individuals and families. We call on educational leaders in internal medicine to take 2 steps in supporting parental leave for trainees: 1) synthesize the national, state, and institutional leave policies into transparent, program-specific formats that are assessable to trainees; and 2) prepare to have difficult conversations about the often-competing priorities of resident parental leave.
By delineating this work up front, it allows for the focus to be on the residents and their needs instead of the policies.

References