

HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-23)  
Leave Policies for Medical Students, Residents, Fellows, and Physicians (Reference Committee C)

EXECUTIVE SUMMARY

This report is written in response to policies adopted at the 2022 Interim Meeting that call for study. Clause four of American Medical Association (AMA) Policy H-405.960, “Policies for Parental, Family and Medical Necessity Leave,” asks that the AMA:

4. study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.

Clauses two and five of AMA Policy H-405.947, “Compassionate Leave for Medical Students and Physicians,” ask that the AMA:

2. study components of compassionate leave policies for medical students and physicians, to include: (a) whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; (b) policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; (c) whether leave is paid or unpaid; (d) whether obligations and time must be made up; and (e) whether make-up time will be paid.
5. study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.

This report provides background information and history on parental and bereavement/compassionate leave policies for medical students, residents, fellows, and physicians. It also discusses the feasibility and impact of such policies, an overview of AMA contributions in this space, and recommendations in order to clarify and strengthen the AMA’s position on these topics and improve the well-being of medical students, residents, fellows, and physicians in practice.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-23

Subject: Leave Policies for Medical Students, Residents, Fellows, and Physicians

Presented by: Cynthia Jumper, MD, MPH, Chair

Referred to: Reference Committee C

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1 At the 2022 Interim Meeting of the American Medical Association (AMA) House of Delegates,  
2 testimony was received on three resolutions related to leave policies:

- 3 • 302-I-22, “Expanding employee leave to include miscarriage and stillbirth”
- 4 • 303-I-22, “Medical student leave policy”
- 5 • 308-I-22, “Paid family/medical leave in medicine”

6  
7 As a result, two policies were adopted as amended in lieu of these resolutions, one of which  
8 requested study. Amended Policy [H-405.960 \(4\)](#), “Policies for Parental, Family and Medical  
9 Necessity Leave,” asks that the AMA:

- 10  
11 4. study the impact on and feasibility of medical schools, residency programs, specialty boards,  
12 and medical group practices incorporating into their parental leave policies a 12-week  
13 minimum leave allowance, with the understanding that no parent be required to take a  
14 minimum leave.

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16 Also, Resolution 309-I-22, “Bereavement Leave for Medical Students and Physicians,” was  
17 adopted as amended with a change in title (from “Bereavement” to “Compassionate”). It has  
18 become new policy [H-405.947 \(2\) and \(5\)](#) and asks that the AMA:

- 19  
20 2. study components of compassionate leave policies for medical students and physicians, to  
21 include: (a) whether cases requiring extensive travel qualify for additional days of leave and, if  
22 so, how many days; (b) policy and duration of leave for an event impacting pregnancy or  
23 fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an  
24 assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy  
25 arrangement, or an event that impacts pregnancy or fertility; (c) whether leave is paid or  
26 unpaid; (d) whether obligations and time must be made up; and (e) whether make-up time will  
27 be paid.

- 28  
29 5. study the concept of equal compassionate leave for pregnancy loss and other such events  
30 impacting fertility in a physician or their partner as a benefit for medical students and  
31 physicians regardless of gender or gender identity.

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33 This report is written in direct response to these calls for study regarding parental and  
34 compassionate leave policies.

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36 BACKGROUND

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*Considerations of competency in medical education*

Before addressing the particulars of parental and compassionate leave, the tantamount issue of educational and professional competency must be acknowledged. Upon completion of medical school, medical students (“students”) must achieve established requirements and competencies to be awarded a MD/DO degree; hence, taking leave may prolong training and related costs. Likewise, resident and fellow (“trainee”) physicians must achieve competencies for independent practice in the specialty of their program. Different from medical school, residency is a service-learning experience where trainees provide patient care services. Thus, it is important to distinguish which educational activities and/or clinical services are essential to demonstrate competency and could be missed when a trainee is on leave. Nonetheless, all medical students and trainees should have access to leave; but there can be consequences for taking leave due to the demands of professionalism and duty to patients and the public. Physicians in practice are equally deserving of such leave but may also face consequences.

For the purposes of this report and its recommendations, the use of the word “trainees” includes those individuals in non-standard training (NST) programs.

*Parental leave*

History of FMLA and unpaid leave

The federal [Family and Medical Leave Act](#) (FMLA) was introduced in Congress every year from 1984 to 1993, when it finally was signed into law by President Bill Clinton. It entitles “eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

- Twelve workweeks of leave in a 12-month period for:
  - the birth of a child and to care for the newborn child within one year of birth;
  - the placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
  - to care for the employee’s spouse, child, or parent who has a serious health condition;
  - a serious health condition that makes the employee unable to perform the essential functions of his or her job;
  - any qualifying exigency arising out of the fact that the employee’s spouse, son, daughter, or parent is a covered military member on “covered active duty;” or
- Twenty-six work weeks of leave during a single 12-month period to care for a covered servicemember with a serious injury or illness if the eligible employee is the servicemember’s spouse, son, daughter, parent, or next of kin (military caregiver leave).”<sup>1</sup>

If an employee has worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and worked at a location where the company employs 50 or more employees within 75 miles, then they are eligible for FMLA leave.<sup>1</sup> The minimum 1,250 hours of service is set by the [Fair Labor Standards Act](#) (FLSA) principles for determining compensable hours or work. Also, special rules may apply if both parents are employed by the same company.

The FMLA is administered by the U.S. Department of Labor for most employees and by the Office of Personnel Management for most federal employees. Answers to frequently asked questions are provided on the FMLA [website](#). States are allowed to determine standards that go beyond the federal law. In response to the COVID-19 pandemic, many states have enacted or expanded family

1 leave permanently. As of June 2022, seven states (WA, CA, NY, CT, RI, MA, NJ) had enacted and  
2 implemented state FMLA laws; four states (OR, CO, MD, DE) had enacted but not yet  
3 implemented such laws.<sup>2</sup> For members of the armed forces, FMLA leave may also be applied to the  
4 foreign deployment of the employee's spouse, son, daughter, or parent and is called "qualifying  
5 exigency."<sup>3</sup>

### 6 7 Medical students

8  
9 Given that FMLA applies to employed persons, it does not apply to medical students. Thus, such  
10 policies are at the discretion of educational institutions. Kraus et al., studied the current state of  
11 parental leave policies for medical students by reviewing 199 MD-granting and DO-granting  
12 medical schools in the U.S. and its territories. They concluded that many schools do not have easily  
13 accessible parental leave policies; many such policies are not separate from formal leaves of  
14 absence and do not allow for the minimum 12 weeks allowed per FMLA. Further, schools do not  
15 ensure on-time completion of medical education by tailoring policies to the student academic year.<sup>4</sup>  
16 Likewise, medical students outside of the U.S. are facing similar issues.<sup>5</sup> Without explicit,  
17 equitable leave time, students are forced to make difficult decisions about family planning and/or  
18 delays in medical education.<sup>6</sup>

19  
20 A recent article by the Association of American Medical Colleges discusses two studies which  
21 reviewed parental leave policies at U.S. MD and DO schools. The article references research that  
22 found only about 1/3 of medical schools had a parental leave policy. Further, it noted a difference  
23 in MD vs DO schools; while 25% of the MD-granting schools had a public policy, 60% of the 44  
24 DO-granting schools did.<sup>4</sup> The second study found that "only 14% had "substantive, stand-alone  
25 parental leave policies." While most schools offered general leave of absence policies that were not  
26 specific to parenting, the researchers also found that policies crafted specifically for pregnant and  
27 parenting people were substantially different from general leave policies."<sup>7</sup>

28  
29 An example of a medical school's own parental leave policy is the University of North Carolina  
30 School of Medicine's [New Child Adjustment Policy](#), which offers up to six months parental leave  
31 while retaining health insurance and financial aid and avails remote classes options during the  
32 transition back to school.<sup>8</sup> By comparison, the University of Chicago Pritzker School of Medicine  
33 uses the same policy as the undergraduate school, allowing a one-quarter/ten-week leave with  
34 benefits.<sup>8</sup>

### 35 36 Trainees

37  
38 Given that many residency programs fall short of the 50 employees required to qualify for FMLA's  
39 12-week minimum leave, many programs or institutions have been implementing their own  
40 policies. In July 2021, the American Board of Medical Specialties released a new [policy](#) to their  
41 member boards regarding parental, caregiver, and medical leave during training for achieving  
42 board eligibility. The policy states that such boards "must allow for a minimum of 6 weeks of time  
43 away from training for purposes of parental, caregiver, and medical leave at least once during  
44 training, without exhausting all other allowed time away from training and without extending  
45 training."<sup>9</sup> One year later, the Accreditation Council for Graduate Medical Education (ACGME)  
46 issued a requirement that all ACGME-accredited programs offer six weeks of paid leave to all  
47 residents/fellows for medical, parental, and caregiver leave, effective on the trainees' first day in  
48 their program.<sup>10</sup> To further address resident leave policies, in 2022, the ACGME published an  
49 article in their "ACGME Answers" series.<sup>11</sup>

1 Many boards have their own leave policies for trainees to achieve board eligibility. For example,  
2 the [American Board of Surgery](#) (ABS), starting with the 2021-2022 academic year, states that “48  
3 weeks of full-time clinical activity in each of the five years of residency, regardless of the amount  
4 of operative experience obtained” are required.<sup>12</sup> The remaining four weeks of the year are  
5 considered non-clinical time that may be used for any purpose, such as vacation, conferences,  
6 interviews, etc. All time away from clinical activity (i.e., non-clinical time), including vacation and  
7 time taken for interviews, visa issues, etc., must be accounted for on the application for  
8 certification.”<sup>12</sup> Details are available on the ABS website. Many specialty societies have policies  
9 regarding parental leave; some even support paid leave.

10  
11 Research published in the last few years indicates that several specialties have been analyzing their  
12 leave policies and are developing guidance for program directors to help make the transition back  
13 to work after parental leave smoother and less overwhelming. As an example of such research, a  
14 national survey of 422 program directors in internal medicine showed that while many programs do  
15 have program-level policies, others default to institutional policies which tend to be less flexible. It  
16 concluded that more than half of respondents favored a national standard to guide the development  
17 of program-level parental leave policies so long as programs with limited resources are provided  
18 flexibility.<sup>13</sup>

## 19 20 Physicians

21  
22 Parental leave policies for physicians may vary depending on the employer, given physicians work  
23 in a variety of settings—private practice, group practice, academia, hospitals, health systems,  
24 insurers, associations, etc. As stated earlier, a physician qualifies for FMLA (or their state policy  
25 that may go beyond FMLA) if their employer has 50 or more employees. Otherwise, the physician  
26 is likely bound by non-federal employer policies that may or may not include paid or unpaid leave.

27  
28 The American College of Obstetricians and Gynecologists (ACOG) supports paid parental leave as  
29 essential for the well-being of parent and child, endorsing a minimum of six weeks with full  
30 benefits and 100% of pay. ACOG also offers guidance for medical schools, training programs,  
31 ACGME, specialty boards, and medical practices regarding the incorporation of paid parental leave  
32 policies as part of the physician’s standard benefit package.<sup>14</sup>

## 33 34 What about paid leave?

35  
36 The established federal norm, per FMLA, is twelve weeks of unpaid leave despite ample evidence  
37 of the benefits (for both parent and child) of paid leave, including improved health and job  
38 satisfaction.<sup>15</sup> In the U.S., employer-provided paid leave is more prevalent among high-paying,  
39 professional occupations and within large companies.<sup>16</sup> Many other countries endorse paid leave.  
40 Among the 38 countries that are members of the Organization for Economic Co-operation and  
41 Development, the U.S. is the only one without a national paid maternity or family leave policy.<sup>17</sup>  
42 Recent attempts to change U.S. law to paid leave have failed. In 2021, the Robert Wood Johnson  
43 Foundation published a brief entitled “Improving Access to Paid Family Leave to Achieve Health  
44 Equity,” which not only provides principles for a paid family leave program for all but explains  
45 how paid leave policies can support economic growth and address racial and socioeconomic  
46 disparities in order to promote health equity.<sup>16</sup>

## 47 48 *Bereavement/compassionate leave*

## 49 50 Definition and terminology

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1 According to the Fair Labor Standards Act (FLSA), the U.S. Department of Labor does not require  
2 payment for time not worked, even if it is to attend a funeral.<sup>18</sup> Rather, this type of benefit is  
3 determined by an employer. An employer has the authority to decide if it will offer bereavement  
4 leave to its employees and set its own definition of such leave, as well as to determine the number  
5 of paid and/or unpaid days of absence from work and if documentation is required to explain the  
6 absence. For example, AMA Human Resources Policy 615.01 states that bereavement leave  
7 “allows employees to take time off without loss of pay for bereavement due to a death of an  
8 immediate family member, i.e., spouse, child, stepchild, grandchild, mother, father, stepmother,  
9 stepfather, grandmother, grandfather, mother-in-law, father-in-law, brother, sister, significant other,  
10 or domestic partner, or any other individual related by blood or whose close association with the  
11 employees is the equivalent of a family relationship.”<sup>19</sup> Employers must abide by state laws. As of  
12 2019, California was the only state to legally require paid bereavement leave for certain public-  
13 sector workers, such as state employees. Relatedly, Oregon requires bereavement leave for  
14 qualifying employees, but the employer can decide if paid or unpaid.<sup>20</sup> Globally, the U.S. falls  
15 behind such countries as Canada, France, and the United Kingdom that support more generous  
16 leave.<sup>20</sup>

17  
18 In the past, such leave may have been referred to as “funeral leave.” While “bereavement” has been  
19 a more commonly used term, an even more inclusive adjective is “compassionate” which  
20 acknowledges that there may be other reasons, besides death, in which a person is bereaved and in  
21 need of time off work. While new AMA human resources policy uses the term “compassionate,” it  
22 was noted in doing the research for this report that most schools and programs still use the term  
23 “bereavement”; thus, the latter term will be used in this report.

#### 24 25 Compassionate leave in medical education and practice

26  
27 There is little published research on this topic. A PubMed® search of the terms “funeral leave,”  
28 “bereavement leave,” and “compassionate leave” yielded zero results in regard to policies in  
29 medical schools, training programs, and physician practices.

30  
31 Bereavement policies vary across medical schools. Given students are not employees of their  
32 school, they are not offered paid leave. However, they may be allowed time off. Some medical  
33 schools may establish their own policy, while many others follow the same bereavement policy as  
34 their university. For example, the University of Illinois Urbana-Champaign provides publicly  
35 available student bereavement [guidelines](#).<sup>21</sup> Without standardized leave time and grief resources  
36 across medical schools, some students took matters into their own hands and started [BereaveMed](#),  
37 an “online resource that is designed to help medical students address their experiences with death  
38 and grief through connection and collaboration.” It also provides a directory of mental health and  
39 wellness resources that are available at many medical schools.<sup>22</sup>

40  
41 Graduate Medical Education (GME) programs, as employers, are more likely to have established  
42 bereavement policies, which may be established by the program itself or may follow the policy of  
43 the institution. As such, the number of days and requirements may vary. For example, the policy of  
44 the GME program at Emory School of Medicine notes that a program director may approve up to  
45 five days of paid bereavement leave per occurrence.<sup>23</sup>

46  
47 Physicians in medical group practices will likely have bereavement leave available, but the details  
48 will vary depending on the size and ownership of the practice.

#### 49 50 DISCUSSION

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1 *Parental leave: Feasibility and possible impact of increasing minimum to 12 weeks*

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3 If a medical student is absent from school for 12 weeks, that equates to approximately three months  
4 of schooling (i.e., nearly a semester). While this absence poses challenges, medical schools may  
5 consider investigating institutions with established best practices in parental policies, such as those  
6 that include a provision of an academic adjustment option guaranteeing approval to return from  
7 such leave.<sup>7</sup> Establishment and implementation of such policies may also contribute to the  
8 furtherance of equity among medical students. In doing so, institutions should consider the merits  
9 of a broad versus prescriptive policy given the challenges that may be unique to students and  
10 institutions. The rise in interest and implementation of competency-based medical education  
11 (CBME) may one day foster paths for students to take such leave and still demonstrate competency  
12 in order to graduate. On the other hand, there may be unintended consequences that impact not  
13 only the student on leave, but also their peers, the faculty who are overseeing their competency,  
14 and the institution which carries the fiscal responsibilities. Consideration should be given to  
15 whether a student's financial aid covers prolonged schooling due to leave, if schools will incur  
16 additional expense for providing make-up education, and if there should be additional tuition costs  
17 for students who need significant make-up time.

18  
19 Like students, a 12-week absence from training can have an impact on the resident/fellow  
20 competency given the missed educational and clinical experiences. It can also impact their peers  
21 who may need to assume added responsibilities for the absent resident/fellow, the program staff  
22 who must figure out how to supplement the missed training in order to ensure successful  
23 completion of a residency/fellowship as well as monitor any impact on other residents and patients,  
24 and the program/institution which has the fiscal responsibility. As pointed out earlier, paid leave  
25 versus unpaid leave is an additional consideration. For GME, consideration must be given to the  
26 sources of GME funding and if/how trainees are funded on leave versus those who are active in  
27 their training.

28  
29 To teach an effective educational program, students, residents, and fellows play an important role.  
30 Large or sudden changes in the participation of learners can impact the quality of education. Such  
31 education requires both teachers and learners to take responsibility for the educational program. If  
32 possible, advanced notification of the need for leave, with privacy protections, may be important to  
33 maintain quality education.

34  
35 Similar to residents/fellows, the feasibility and impact on the group practice of a physician taking  
36 12-week parental leave time can be tenuous and difficult. While there are clear benefits to the  
37 physician-parent and child, the other practice members would need to provide coverage which  
38 impacts their time—both professional and personal—and possibly their wellness. In smaller  
39 practices, there may not be enough personnel to provide such coverage.

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41 *Compassionate leave: Feasibility and possible impact*

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43 The calls for study in Policy H-405.947 seeks information on the components of such policy and/or  
44 exceptions to said policy. These factors may include extensive travel calling for additional days of  
45 leave or events affecting pregnancy, fertility, surrogacy, and adoption. Further, it seeks to clarify  
46 whether notification should be required in advance of taking said leave, if such leave is paid or  
47 unpaid, if obligations and time must be made up, and if said make-up time will be paid.

48  
49 Despite the variance and lack of standardization of such policies across medical schools, resident  
50 and fellowship programs, and physician practices, generalized notions of the feasibility and impact  
51 of such policies can be postulated but may not apply to every environment.

1 For example, extensive travel for bereavement leave is a very real possibility in the case of a death,  
 2 where an individual may need to journey a long way to attend to such matters. Travel alone takes  
 3 up some of those leave days, let alone the intended actions and time to grieve. Negative events  
 4 related to fertility, pregnancy, and childbirth (e.g., co-morbidities, pregnancy loss, an unsuccessful  
 5 round of an assisted reproductive technology procedure) as well as failed adoption or surrogacy  
 6 arrangements also result in emotional grief and may require time and rest. These circumstances  
 7 may apply to an individual as well as their partner, regardless of gender and gender identity. As  
 8 discussed earlier, determining if education/work time must be made up is largely at the level of the  
 9 individual circumstance. For residents, fellows, and physicians, determining whether such leave is  
 10 paid or unpaid and if that make-up time (should it be required) will be paid is a financial decision  
 11 for the employer; there may be opportunity to provide standardization to such decisions so that all  
 12 parties are informed in advance. Another consideration is that by establishing policies, the  
 13 opportunities for flexibility may be diminished or removed. Such considerations do seem feasible  
 14 but require time and attention from leadership to be successfully implemented. There are pros and  
 15 cons when it comes to impact that need to be considered for each environment, balancing  
 16 competency, well-being, and equity for all individuals.

17

## 18 RELEVANT AMA POLICY AND ENGAGEMENT

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20 The AMA has ample policy in support of leave for students, residents, fellows, and physicians,  
 21 including a new policy on compassionate leave (I-22). While this list provides links to each item,  
 22 the full policies are enumerated in the Appendix:

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- [Policies for Parental, Family and Medical Necessity Leave H-405.960](#)
- [AMA Statement on Family and Medical Leave H-420.979](#)
- [Compassionate Leave for Medical Students and Physicians H-405.947](#)
- [Parental Leave H-405.954](#)
- [Paid Sick Leave H-440.823](#)
- [Parental Leave and Planning Resources for Medical Students D-295.308](#)
- [Support for Residents and Fellows During Family and Medical Leave Time H-310.908](#)
- [Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs H-295.856](#)
- [FMLA Equivalence H-270.951](#)
- [To Amend The Family Leave Act D-420.999](#)
- [Gender-Based Questioning in Residency Interviews H-310.976](#)
- [Residents and Fellows' Bill of Rights H-310.912](#)
- [Principles for Graduate Medical Education H-310.929](#)
- [CMS to Pay for Residents? Vacation and Sick Leave D-305.968](#)
- [Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923](#)
- [Cultural Leave for American Indian Trainees H-350.957](#)

In particular, “Policies for Parental, Family and Medical Necessity Leave” (H-405.960) recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed. “Parental Leave” (H-405.954) encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the FMLA: a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.



1 Also, the “Residents and Fellows’ Bill of Rights” (H-310.912) supports paid leave for all purposes  
2 (family, educational, vacation, sick) to be no less than six weeks per year.  
3

4 On a related note, the Council’s [report](#) on “Support for Institutional Policies for Personal Days for  
5 Undergraduate Medical Students was adopted at the 2022 Annual Meeting. As a result, new policy  
6 states that the AMA “support a requirement that each medical school have policy defining 1) the  
7 number of days a medical student may be excused from each curricular component; 2) the  
8 processes for using excused absences, providing alternative, timely means of achieving curricular  
9 goals when absent from a curricular component; and 3) effective mechanisms to communicate  
10 these policies at appropriate times throughout the curriculum; and that schools be encouraged to  
11 create a mechanism by which at least some portion of such days can be used without requiring  
12 explanation.” This policy further demonstrates AMA’s encouragement of institutional policies and  
13 its commitment to address the well-being of students.  
14

#### 15 SUMMARY AND RECOMMENDATIONS 16

17 The AMA recognizes the importance of leave policies for medical students, residents, fellows, and  
18 physicians. Such policies may positively impact one’s physical, mental, and emotional health,  
19 thereby reducing stress and burnout, improving satisfaction, and ultimately uplifting patient care.  
20 The lack of standardization of parental and bereavement leave policies may contribute to  
21 inequities. Given that each institution, program, or practice develops its own related policies,  
22 informed by state laws as well as human resources and legal counsel, it is difficult to create  
23 universal standards.  
24

25 Medical schools, graduate medical education programs, and physician practices should be  
26 encouraged to offer parental and bereavement leaves that, at minimum, are consistent with federal  
27 and state laws and institutional policies. Medical schools should acknowledge that delay of  
28 childrearing for the sake of education has significant personal implications. Programs or practices  
29 with fewer than 50 employees should address how they can best accommodate their employees. All  
30 authorities discussed in this report must evaluate the benefits and challenges of implementing such  
31 policies and do what is best for the learner/physician’s well-being.  
32

33 The Council on Medical Education therefore recommends that the following recommendations be  
34 adopted and the remainder of the report be filed:  
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36

- 37 1. That the fifth and fifteenth clauses of AMA Policy [H-405.960](#), “Policies for Parental,  
38 Family and Medical Necessity Leave,” be amended by addition and deletion, to read as  
39 follows:  
40

- 41 5. Our AMA recommends that medical practices, departments, and training programs  
42 strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-  
43 month period for their attending and trainee physicians as needed, with the understanding  
44 that no parent be required to take a minimum leave.  
45

- 46 15. In order to accommodate leave protected by the federal Family and Medical Leave Act,  
47 our AMA encourages all specialties within the American Board of Medical Specialties  
48 (ABMS) to allow graduating residents to extend training after the traditional residency  
49 completion date while still maintaining board eligibility, in the event of leave beyond six  
50 weeks. Our AMA encourages specialty boards to develop flexible policies for board  
51 certification for those physicians who take leave beyond the minimum of six weeks of

1 family or medical leave (per [ABMS policy](#)) and whose residency programs are able to  
2 certify that residents meet appropriate competencies for program completion.

- 3  
4 2. That AMA Policy [H-405.960](#), “Policies for Parental, Family and Medical Necessity  
5 Leave,” be amended by addition to read as follows:

6  
7 19. Medical schools are encouraged to develop clear, equitable parental leave policies and  
8 determine how a 12-week parental, family, or medical leave may be incorporated with  
9 alternative, timely means of completing missed curriculum while still meeting competency  
10 requirements necessary to complete a medical degree.

- 11  
12 3. That the first and fifth clauses of AMA Policy [H-405.947](#), “Compassionate Leave for  
13 Medical Students and Physicians,” be amended by addition and deletion with a change in  
14 title to read as follows:

15  
16 Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician  
17 Residents and Fellows

18  
19 1. Our AMA urges:

20 (a) medical schools, and the Liaison Committee on Medical Education and Commission on  
21 Osteopathic College Accreditation to incorporate and/or encourage development of  
22 compassionate leave policies. Such compassionate leave policies should consider inclusion  
23 of extensive travel and events impacting family planning, pregnancy, or fertility (including  
24 pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted  
25 reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy  
26 arrangement). These policies should determine how compassionate leave may be  
27 incorporated with alternative, timely means of achieving curricular goals when absent from  
28 curricular components and to meet competency requirements necessary to complete a  
29 medical degree;

30 (b) residency and fellowship training programs, their sponsoring institutions, and  
31 Accreditation Council for Graduate Medical Education to incorporate and/or encourage  
32 development of compassionate leave policies as part of the physician's standard benefit  
33 agreement. Such compassionate leave policies should consider appropriateness of coverage  
34 during extensive travel and events impacting family planning, pregnancy, or fertility  
35 (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an  
36 assisted reproductive technology procedure, a failed adoption arrangement, or a failed  
37 surrogacy arrangement). These policies should also include whether the leave is paid or  
38 unpaid, outline what obligations and absences must be made up, and determine how  
39 compassionate leave may be incorporated with alternative, timely means of achieving  
40 curricular goals when absent from curricular components and to meet competency  
41 requirements necessary to achieve independent practice and board eligibility for their  
42 specialty;

43 (c) medical group practices to incorporate and/or encourage development of compassionate  
44 leave policies as part of the physician's standard benefit agreement. Such compassionate  
45 leave policies should consider appropriateness of coverage during extensive travel and  
46 events impacting family planning, pregnancy, or fertility (including pregnancy loss, an  
47 unsuccessful round of intrauterine insemination or of an assisted reproductive technology  
48 procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These  
49 policies should also include whether the leave is paid or unpaid and what obligations and  
50 absences must be made up.  
51

- 1           5. Our AMA supports the concept of equal compassionate leave for death or loss (e.g.,  
2           pregnancy loss and other such events impacting fertility in a physician or their partner) as a  
3           benefit for physicians, medical students, medical trainees, and physician residents and  
4           fellows, regardless of gender or gender identity.  
5
- 6           4. That the fourth clause of AMA Policy [H-405.960](#), “Policies for Parental, Family and  
7           Medical Necessity Leave,” be rescinded, as having been fulfilled by this report.  
8
- 9           5. That the second clause of AMA Policy [H-405.947](#), “Compassionate Leave for Medical  
10          Students and Physicians,” be rescinded, as having been fulfilled by this report.  
11  
12  
13  
14
- 15          Fiscal note: \$500

APPENDIX: RELEVANT AMA POLICIES

**H-405.960, Policies for Parental, Family and Medical Necessity Leave**

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule

accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.

15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.

17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.

18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.

#### **H-420.979, AMA Statement on Family and Medical Leave**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

#### **H-405.954, Parental Leave**

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.
3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early childcare and unpaid childcare by extended family members.
4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

#### **H-440. 823, Paid Sick Leave**

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

#### **D-295.308, Parental Leave and Planning Resources for Medical Students**

1. Our AMA will work with key stakeholders to advocate that parties involved in medical training (including but not limited to residency programs, administration, fellowships, away rotations, physician evaluators, and research opportunities) do not discriminate against students who take family/parental leave.
2. Our AMA encourages medical schools to create comprehensive informative resources that promote a culture that is supportive of their students who are parents, including information and policies on parental leave and relevant make up work, options to preserve fertility, breastfeeding, accommodations during pregnancy, and resources for childcare that span the institution and the surrounding area.

**H-310.908, Support for Residents and Fellows During Family and Medical Leave Time**

Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.

**H-295.856, Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs**

Our AMA: (1) supports the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved; and (2) encourages the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved.

**H-405.947, Compassionate Leave for Medical Students and Physicians**

1. Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement.
2. Our AMA will study components of compassionate leave policies for medical students and physicians to include: a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; c. whether leave is paid or unpaid; d. whether obligations and time must be made up; and e. whether make-up time will be paid.
3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
4. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
5. Our AMA will study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.
6. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.

**H-270.951, FMLA Equivalence**

Our AMA will advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

**D-420.999, To Amend The Family Leave Act**

Our AMA will work to simplify the Family Medical Leave Act form, reducing the physician work required for completion.

**H-310.976, Gender-Based Questioning in Residency Interviews**

The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the “Common Requirements” and the “Institutional Requirements” of the “Essentials of Accredited Residencies,” to ensure that there is no gender-based bias.

**H-310.912, Residents and Fellows' Bill of Rights**

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require



salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following “Residents and Fellows’ Bill of Rights” as applicable to all resident and fellow physicians in ACGME-accredited training programs:

#### RESIDENT/FELLOW PHYSICIANS’ BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific

responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience.

Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

**H-310.929, Principles for Graduate Medical Education**

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) **PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty. Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.** Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff

organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

**D-305.968, CMS to Pay for Residents? Vacation and Sick Leave**

Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave.

**H-310.923, Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools**

Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) allow trainees to take leave and attend religious and cultural holidays and observances, provided that patient care and the rights of other trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances.

**H-350.957, Cultural Leave for American Indian Trainees**

Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

## REFERENCES

1. Family and Medical Leave Act [Internet]. U.S. Department of Labor. [cited 2023 Jun 20]. Available from: <https://www.dol.gov/agencies/whd/fmla>
2. Paid Family and Medical Leave as of June 2022 [Internet]. National Conference of State Legislatures. [cited 2023 Jun 20]. Available from: <https://www.ncsl.org/labor-and-employment/state-family-and-medical-leave-laws#:~:text=11%20states%E2%80%94California%2C%20Colorado%2C,paid%20family%20and%20medical%20leave>
3. Fact Sheet #28M(c): Qualifying Exigency Leave under the Family and Medical Leave Act [Internet]. U.S. Department of Labor. [cited 2023 Jun 20]. Available from: <https://www.dol.gov/agencies/whd/fact-sheets/28mc-fmla-exigency-leave>
4. Kraus MB, Jennifer M.V. Talbott, Melikian R, Merrill SA, Stonnington CM, Hayes SN, et al. [Current Parental Leave Policies for Medical Students at U.S. Medical Schools: A Comparative Study](#). 2021 Mar 23;96(9):1315–8.
5. McGrath C, Szabo RA, Bilszta J. [Pregnancy and parental leave policies at Australian and New Zealand medical schools](#). Women's Health. 2022 Jan 1;18:174550572211426-174550572211426.
6. Ortega SR, Barnes JM, Waller JD. [Parental leave in medical school: supporting students as parents](#). Journal of Osteopathic Medicine. 2022 Feb 18;122(5):229–33.
7. Roselin D, Lee J, Jagsi R, Blair-Loy M, Ira K, Dahiya P, et al. [Medical Student Parental Leave Policies at U.S. Medical Schools](#). Journal of Women's Health. 2022 Jun 14.
8. Medical students advocate for parental leave policies [Internet]. Association of American Medical Colleges. [cited 2023 Jun 21]. Available from: <https://www.aamc.org/news/medical-students-advocate-parental-leave-policies>
9. [ABMS Announces Progressive Leave Policy for Residents and Fellows](#). American Board of Medical Specialties. 2020.
10. ACGME is Instituting New Mandatory Medical, Parental and Caregiver Leave Requirements for Residency and Fellowship Programs: Are You Ready? [Internet]. The National Law Review. 2022. Available from: <https://www.natlawreview.com/article/acgme-instituting-new-mandatory-medical-parental-and-caregiver-leave-requirements>
11. ACGME Answers: Resident Leave Policies [Internet]. Accreditation Council for Graduate Medical Education. 2022. Available from: <https://www.acgme.org/newsroom/blog/2022/acgme-answers-resident-leave-policies/>
12. Training & Certification: Leave Policy - General Surgery [Internet]. The American Board of Surgery. [cited 2023 Jun 21]. Available from: <https://www.absurgery.org/default.jsp?policygsleave>

13. Stack SW, Finn KM, Kisielewski M, Law KL, Milne CK, Best JA. [Parental Leave Policies in Residency: A National Survey of Internal Medicine Program Directors](#). *Academic Medicine*. 2022 Jun 23;97(7):1021–8.
14. Paid Parents Leave, Statement of Policy [Internet]. American College of Obstetricians and Gynecologists. [cited 2023 Jun 23]. Available from: <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/paid-parental-leave>
15. Miller KA, Lee LK. [Advocating for Physician Paid Parental Leave](#). *Pediatrics*. 2022 Jun 1.
16. Improving Access to Paid Family Leave to Achieve Health Equity [Internet]. Robert Wood Johnson Foundation. 2022. Available from: <https://www.rwjf.org/en/insights/our-research/2021/05/improving-access-to-paid-family-leave-to-achieve-health-equity.html>
17. Family Database [Internet]. Organisation for Economic Co-operation and Development. 2022. Available from: [https://www.oecd.org/els/soc/PF2\\_1\\_Parental\\_leave\\_systems.pdf](https://www.oecd.org/els/soc/PF2_1_Parental_leave_systems.pdf)
18. Funeral Leave [Internet]. U.S. Department of Labor. [cited 2023 Jun 22]. Available from: <https://www.dol.gov/general/topic/benefits-leave/funeral-leave>
19. Human Resources Policy Manual. Policy 615.01 Bereavement. [cited 2023 Jun 21]. American Medical Association.
20. Trevor J. When it comes to bereavement leave, the U.S. is unspeakably cruel [Internet]. Salon. 2019. Available from: [https://www.salon.com/2019/09/30/when-it-comes-to-bereavement-leave-the-u-s-is-unspeakably-cruel\\_partner/](https://www.salon.com/2019/09/30/when-it-comes-to-bereavement-leave-the-u-s-is-unspeakably-cruel_partner/)
21. Student Bereavement Guidelines [Internet]. University of Illinois Urbana-Champaign. Office of the Dean of Students; [cited 2023 Jun 22]. Available from: <https://odos.illinois.edu/community-of-care/resources/students/bereavement/>
22. BereaveMed: A Medical Student’s Guide to Grief [Internet]. BereaveMed. [cited 2023 Jun 22]. Available from: <https://www.bereavemed.com/>
23. Housestaff Policies, Section 4: Leave Time [Internet]. Emory University School of Medicine. [cited 2023 Jun 22]. Available from: [https://med.emory.edu/education/gme/housestaff/housestaff\\_policies/section4.html](https://med.emory.edu/education/gme/housestaff/housestaff_policies/section4.html)