

HOD ACTION: Recommendations in Council on Medical Education Report 3 adopted and the remainder of the report filed.

REPORT 3 OF THE COUNCIL ON MEDICAL EDUCATION (A-22)
Onsite and Subsidized Childcare for Medical Students, Residents and Fellows
(Resolution 304-J-21, Resolve 3)
(Reference Committee C)

EXECUTIVE SUMMARY

There is a nationwide lack of options for affordable, accessible, quality childcare for the U.S. public in general, but in particular for individuals of lower income and with work schedules that are non-traditional, varied, or inflexible. Medical students and resident physicians who are parents face childcare challenges that include low or even non-existent income, rigid academic schedules, and training and service requirements that extend the workday well beyond what can be easily accommodated by most childcare providers. Annual costs of childcare range from approximately \$6,000 to \$33,000, depending upon the state, age of the child, and type of provider. The U.S. Department of Health and Human Services considers childcare affordable if it costs families no more than seven percent of their income. Most working families (over 60 percent) exceed this level of expenditures for center-based childcare, regardless of parents' marital status, race, age, or education level, and across a broad range of income levels. The salaries of residents are low, particularly considering the number of hours they typically work and their job responsibilities; the median first year salary in 2021 was \$58,650. Residents who are parents affirm that resources that would be most helpful to assist with childcare are onsite childcare with extended hours and childcare subsidies.

The struggle of juggling childcare and medical education can further increase stress for individuals who are in an environment shown to increase levels of depression and burnout. Affordable, onsite childcare with extended hours could address many of the concerns of all health care workers who are parents, and substantial subsidization of childcare expenses in locations where onsite childcare is impractical would provide additional and much needed support to families who face financial restrictions in obtaining affordable, flexible childcare. Meeting this need may place a significant financial burden on medical schools and graduate medical education institutions that may be operating on already small margins, but enabling families to provide a nurturing environment for young children is an essential goal for society.

HOD ACTION: Recommendations in Council on Medical Education Report 3 adopted and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-22

Subject: Onsite and Subsidized Childcare for Medical Students, Residents and Fellows
(Resolution 304-J-21, Resolve 3)

Presented by: Niranjan V. Rao, MD, Chair

Referred to: Reference Committee C

1 INTRODUCTION

2
3 Resolution 304-J-21, “Decreasing Financial Burdens on Residents and Fellows,” introduced by the
4 Resident and Fellow Section (RFS), asked that the American Medical Association (AMA) work
5 with several stakeholders to reduce some of the expenses residents and fellows experience that are
6 a result of their training status, including assistance with managing educational debt and ensuring
7 healthy food options in hospitals for staff and patients. Resolve 3, “That our AMA work with
8 relevant stakeholders to ensure that medical trainees have access to on-site and subsidized child
9 care,” was referred by the House of Delegates to explore the topic further and develop
10 recommendations to reduce financial burdens on trainees while also maintaining equity, both
11 among trainees and among all health care workers. This report is in response to the referral.

12
13 BACKGROUND

14
15 High-quality care of young children has undisputed benefits, for the child, families, and society at
16 large.¹ The United States, however, is an outlier in comparison to other rich nations in expectations
17 of who provides childcare and how it is funded.

18
19 Parents in the U.S. are guaranteed (with some exceptions) 12 weeks of leave to take care of a new
20 child without fear of losing their job—the result of the Family and Medical Leave Act (FMLA)
21 passed in 1993—but the FMLA guarantees only unpaid leave.² Some states have passed laws
22 guaranteeing some form of paid leave, and many employers provide paid leave as well.

23
24 Organizations that oversee the education, training, and eventual certification of resident/fellow
25 physicians and medical students have specific regulations as well. In July 2021, for example, the
26 American Board of Medical Specialties (ABMS) created policy requesting that “Member Board
27 eligibility requirements must allow for a minimum of 6 weeks of time away from training for
28 purposes of parental, caregiver and medical leave at least once during training, without exhausting
29 all other allowed time away from training and without extending training. Member boards must
30 allow all new parents, including birthing and non-birthing parents, adoptive/foster parents, and
31 surrogates to take parental leave.”³

32
33 Similarly, beginning in July 2022, training programs accredited by the Accreditation Council for
34 Graduate Medical Education (ACGME) are required to provide to residents at least one paid leave
35 of a minimum six-weeks duration for “approved medical, parental, and caregiver leave(s) of
36 absence.”⁴

1 Medical schools are not required to have a parental leave policy for medical students to be
2 accredited by the Liaison Committee on Medical Education (LCME) or Commission on
3 Osteopathic College Accreditation (COCA). In addition, although medical schools may have
4 parental leave policy that includes medical students, a recent study found that this policy is not
5 easily accessible for students at two-thirds of medical schools, both MD-granting and DO-
6 granting.⁵

8 AVAILABILITY AND EXPENSE OF CHILDCARE IN THE UNITED STATES

9
10 While there are now established regulations regarding family leave for the U.S. population, easily
11 accessible and affordable childcare remains elusive for the general public, although the need is
12 great. In 2016, 40 percent of children younger than six years old were cared for solely by their
13 parents; the remaining 60 percent—nearly 13 million children—received on average 30 hours of
14 care per week from a non-parent. For children younger than three, non-parental care includes
15 home-based childcare (65 percent of children—including 42 percent cared by a relative); 35
16 percent of children younger than three are in center-based care. Preschool-aged children are more
17 likely to be cared for outside of the home, with 31 percent of three- to five-year-olds in home-based
18 childcare, and 69 percent in center-based care.¹

19
20 In 2019, 5.2 million childcare providers cared for 12.3 million children under the age of 13 in their
21 homes.¹ Family childcare homes are typically less expensive compared to center-based childcare,
22 often because of lower wages for family childcare providers. In 2017, the national average yearly
23 cost of childcare for infants to four-year-olds was approximately \$10,000 for center-based care and
24 \$8,000 for family home-based care.⁶ In 2015, depending on the state in which the care took place,
25 in-home-based childcare costs ranged from \$25,000 to \$33,000, and center-based care ranged from
26 \$5,700 to close to \$16,000.⁷

27
28 Average childcare expenses for children under five in 2017 consumed 13 percent of the income of
29 families who pay for childcare. The U.S. Department of Health and Human Services (HHS)
30 considers childcare affordable if it costs families no more than seven percent of their income. Most
31 working families (over 60 percent) exceed this level of expenditures for center-based childcare,
32 regardless of parents' marital status, race, age, or education level, and across a broad range of
33 income levels.¹

34
35 More than half of the childcare centers serving three- to five-year-olds were open less than 30
36 hours per week in 2012. About half of center-based care only serves children in certain age ranges;
37 for example, one-third of programs accept children ages three through five only. This can make it
38 difficult for parents of younger children, or those with more than one young child, to find an
39 acceptable childcare solution for their children. Center-based care also varies in other dimensions,
40 including enrollment size, affiliation, and organizational structure.¹

41
42 The lack of providers creates hard choices for families even if they can afford childcare. In a recent
43 study, the Center for American Progress used U.S. census tracts to identify areas where there are
44 more than three young children for every licensed childcare slot, categorizing these areas as
45 "childcare deserts." Over half of Americans live in such deserts, with low-income and rural
46 families more likely to live in areas that are underserved.⁸

47
48 Aside from the availability of childcare and the cost of such care, proximity to a parent's
49 workplace, hours of operation, services for children with different abilities, cultural and language
50 fit, and other dimensions also influence parents' childcare options. One study found that location

1 and minimizing travel time is very important to families' decisions in that over 75 percent choose a
2 provider within five miles of their home, although that distance varied by whether the family lived
3 in an urban, suburban, or rural area. Furthermore, parents were willing to pay substantially more
4 for a provider that is one mile closer. Distance was the strongest predictor of whether a family
5 selected a particular childcare provider, even more important than quality, cost, and other important
6 factors for childcare decision making.⁹

7
8 Medical students and residents are at a particular disadvantage considering many of the
9 aforementioned difficulties with finding suitable childcare. Medical students face several
10 considerations during their preclerkship years that increase the burdens associated with childcare,
11 including high student loan burden, schedules that often preclude income-generating work, and
12 mandatory class attendance that affects students' ability to care for sick children (who may be
13 excluded from childcare during illness). Once students advance to their clinical rotations, they face
14 the added challenge of longer work hours that may begin prior to the opening of or extend past
15 closing time of childcare facilities in addition to a general lack of control of their work schedule.
16 Students on rotations with overnight call face additional barriers.

17
18 Residents, though salaried employees, have circumstances that make them unique in the workforce.
19 Resident physicians have dual roles, pursuing their education while providing clinical service.
20 Once matched into a training program by way of the National Resident Matching Program
21 (NRMP) or other matching program, residents are obligated to matriculate into that program, with
22 very few exceptions. Residents do not have the liberty to choose a job based upon a schedule or
23 consider part-time or non-traditional hours to balance home responsibilities and their career. Part-
24 time residency positions are a rarity, and the reduction in hours impacts the ability to meet
25 educational requirements necessary for completion of training. Resident work hours are "limited"
26 to 80 hours per week and commonly start earlier in the day and end later than typical jobs.
27 Weekend shifts and overnight call, which can be up to a 32-hour continuous shift, further
28 differentiate their "work hours" from others in the workforce. Part of the rigidity of residents' work
29 schedules results from the necessary scheduling of all residents in the program to make sure the
30 service is staffed in compliance with ACGME work hour regulations. It is imperative to contrast
31 this with other careers, where opting for a particular schedule (e.g., part time hours, evening shifts,
32 or weekends) may be an inconvenience or undesired, but not an impossibility. As with students,
33 residents have little to no control over their work schedule.

34 35 REQUIREMENTS FOR CHILDCARE FOR MEDICAL STUDENTS AND RESIDENTS

36
37 There are no requirements or standards from the LCME, COCA, or ACGME regarding childcare
38 for medical students or residents. The American Hospital Association (AHA) does not have
39 requirements either; however, the AHA recognizes that employee stress concerning childcare is
40 one issue that can affect employee well-being and retention and suggests that reducing these
41 stresses may require hospitals to rethink and expand available support.¹⁰

42 43 CHILDCARE OPTIONS FOR MEDICAL STUDENTS AND RESIDENTS

44
45 Two articles published in the *Journal of the American Medical Association* in the 1980s promoted
46 the need for and advantages of hospital-based childcare options. In 1989, it was reported that 40
47 percent of hospitals provided or helped provide some form of childcare for employees. Eleven
48 percent had onsite childcare, and 7.3 percent had facilities located near the hospital. Larger
49 hospitals were more likely to provide childcare benefits.^{11,12} The childcare experiences of health
50 care personnel during the COVID-19 pandemic, when many childcare providers closed, led many
51 workers to stay home and not report to work at a time when their presence and expertise were

1 vital.¹³ In response, the leaders of the AHA, the American Nurses Association, and the AMA sent a
2 letter to the U.S. Congress, asking that Congress prioritize COVID-19 emergency funding,
3 including funding for “quality child care for front line health care personnel in need through direct
4 funding to front line health care personnel and facilities, or, like some states have done, partnering
5 with schools and daycare centers to provide funding to ensure there is quality child care.”¹⁴ The
6 negative effects of reduced childcare options on health care workers during the pandemic have
7 been well documented.^{15,16,17}

8
9 A 2020 survey of Association of American Medical Colleges (AAMC) member institutions found
10 that, of the responding organizations, 49 percent provided childcare assistance before COVID-19.
11 Of those, 62 percent (18/29) expanded childcare options during the pandemic. Of the 27
12 organizations (46 percent) that provided no childcare assistance before COVID-19, only two
13 expanded their support as a result of the pandemic.¹⁸ Early career female physicians who are
14 parents were more likely, compared to their male counterparts, to lose childcare during the
15 pandemic and to become the primary provider of childcare or schooling. In addition, these same
16 mothers suffered more symptoms of depression compared to fathers during the pandemic, possibly
17 a result of the increased work/family conflict.¹⁹

18
19 Before the COVID-19 pandemic, many hospitals and health care systems affiliated with graduate
20 medical education (GME) offered forms of childcare assistance, some in the form of onsite
21 childcare, financial subsidies, priority-status on childcare waitlists, and referral networks.^{20,21,22,23}
22 As an example, the Wellstar Health System has 11 hospitals and several clinics and facilities in
23 Georgia, with onsite childcare centers at its two largest hospitals. The total annual budget for the
24 two onsite centers is over \$3 million. Over 240 employees typically utilize the childcare centers,
25 including residents, fellows, and attending physicians. (Personal communication, Michele Harris,
26 Wellstar Health System.)

27
28 Some medical schools, such as Yale School of Medicine,²⁴ Rush University,²⁵ Michigan State
29 University,²⁶ University of North Texas Health Science Center,²⁷ and Harvard Medical School,²⁸
30 also provide childcare options and childcare subsidies for medical students. The University of
31 Cincinnati (UC) Medical Center implemented a program at the outset of the COVID-19 pandemic
32 through local YMCAs that allowed employees, including residents and fellows, to leave their
33 children (six weeks and older) at a participating YMCA daycare center from 6 am to 6 pm. The
34 medical center subsidized 50% of the daily costs for its employees. The program was discontinued,
35 in part because the YMCA resumed its pre-COVID-19 programming. (Personal communication,
36 Christine Ann Buczek, UC Medical Center in Cincinnati, OH.)

37 38 MEDICAL STUDENTS’ AND RESIDENTS’ EXPERIENCES WITH CHILDCARE

39
40 Even though most medical students and residents are in their peak childbearing years, there is
41 relatively little known about how many will need childcare during this time and how this has
42 changed over time. It is unknown how many students enter medical school as parents with
43 childcare responsibilities or become parents while in medical school. The most recent Graduation
44 Questionnaire administered by the AAMC finds that 7.3 percent of graduating seniors of MD-
45 granting schools have a dependent who is not a partner or spouse (the type of dependent is not
46 defined, e.g., could be a sibling, child, or parent).²⁹ The lack of knowledge regarding the number of
47 students who may require childcare services prevents adequate preparation and guidance for
48 medical schools and students.³⁰

49
50 There are various estimates of the number of residents who enter GME as parents or become
51 parents while in training. A recent six-institution survey of female residents found that 16 percent

1 had children, and another three percent were currently pregnant.³¹ In 2013, a survey of male and
2 female residents training at three sites of the Mayo School of Graduate Medical Education found
3 that 41 percent of responding residents were parents (and of those, 45 percent had more than one
4 child), and nearly 12 percent planned on having a child during their current residency.³²

5
6 Most residents who are parents will likely have to find some form of childcare. A survey of
7 residents in 2008 at one institution (302 respondents) found that 47 percent of parents used a
8 childcare facility. Other options used included a stay-at-home spouse (37 percent), a nanny (25
9 percent), and extended family members (10 percent). A number of families relocated to take
10 advantage of family members for childcare, after difficulties finding suitable local childcare. The
11 monthly cost per child for facility-based childcare varied, but nearly two-thirds reported costs
12 between \$500 and \$1,500 (in 2008). Most respondents with children would enroll, or strongly
13 consider enrolling their child in hospital-based childcare, especially if extended hours or drop-in
14 emergency childcare were available. Asked if hospital-based childcare options would influence the
15 choice between two otherwise equal residency programs, 71 percent of all respondents—non-
16 parents and parents—said they would rank the program with hospital-based childcare higher.³³

17
18 A survey in 2017 of residents at six teaching hospitals (578 respondents) found that 63 percent of
19 respondents with children had difficulty arranging childcare and relied on multiple sources for
20 childcare. Only 10 percent reported using a daycare facility affiliated with their hospital; nonuse
21 was typically the result of a long waitlist and inconvenience. Most residents with children desired a
22 daycare with extended and weekend daycare hours, which were not available locally. The costs of
23 daycare were considerable; the reported median proportion of pretax salary paid for childcare used
24 by PGY1 and PGY2 parents was 43 percent (interquartile range 41 percent to 71 percent) and
25 decreased modestly with increasing training.³⁴

26
27 Twenty percent of 184 respondents of a 2019 survey at one GME institution had their first child
28 during residency, and an additional 18 percent were parents when they entered residency. When
29 asked about the experience of childcare, 60 percent of parents rated it as quite or extremely
30 stressful, made worse when partners were working fulltime or no family members were nearby to
31 help. Nearly 19 percent had family members relocate to help with childcare. Childcare expenses
32 were significant; 44.3 percent of parents spent between 11 percent and 25 percent, and 37.1 percent
33 of parents spent 26 percent or more of their family income on childcare. Childcare was used by
34 35.7 percent of parents, while 27.1 percent had a partner who stayed home to provide care. Parents
35 were asked what resources would be most helpful to assist with childcare; the most preferred
36 options were on-site day care with extended hours (51.6 percent) and childcare subsidies (25.8
37 percent).³⁵

38 39 THE NEEDS OF THE HEALTH CARE WORKFORCE IN GENERAL

40
41 It is estimated, based on the U.S. Current Population Survey, that nearly 29 percent of the U.S.
42 health care workforce needs to provide care for children aged 3 to 12 years.¹⁵ Many health care
43 workers, including residents and students, work nonstandard work hours, outside the standard
44 business schedule of Monday through Friday, 8 am to 5 pm. The number of childcare centers that
45 provide some form of care during nonstandard hours is small; two percent offer childcare during
46 the evening, six percent offer overnight care, and three percent offer weekend care.³⁶

47
48 Due to the relatively low salaries of most health care workers, including residents—and typically
49 medical students are not wage earners—childcare expenses are well over the seven percent of
50 income that HHS considers affordable. According to the Bureau of Labor Statistics, in May 2020
51 the median annual wage for health care practitioners and technical occupations (e.g., registered

1 nurses, physicians, and dental hygienists) was \$69,870. Health care support occupations (e.g.,
2 home health aides, occupational therapy assistants, and medical transcriptionists) had a median
3 annual wage of \$29,960.³⁷ The median salary in 2021 for first year residents was \$58,650, ranging
4 from \$55,115 for first year residents training in the South, to \$62,534 in the Northeast.³⁸

5
6 RELEVANT AMA POLICY

7
8 D-200.974, “Supporting Childcare for Health Care Professionals”

9
10 Our AMA will work with interested stakeholders to investigate solutions for innovative childcare
11 policies and flexible working environments for all health care professionals (in particular, medical
12 students and physician trainees).

13
14 H-310.912, “Residents and Fellows’ Bill of Rights”

15
16 (5) Our AMA will partner with ACGME and other relevant stakeholders to encourage training
17 programs to reduce financial burdens on residents and fellows by providing employee benefits
18 including, but not limited to, on-call meal allowances, transportation support, relocation stipends,
19 and childcare services.

20
21 H-215.985, “Child Care in Hospitals”

22
23 Our AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2)
24 encourages that priority be given to children of those in training and that services be structured to
25 take their needs into consideration; (3) supports informing the AHA, hospital medical staffs, and
26 residency program directors of these policies; and (4) supports studying the elements of quality
27 child care and availability of child care on a 24-hour basis.

28
29 SUMMARY AND RECOMMENDATIONS

30
31 There is a nationwide lack of options for affordable, accessible, quality childcare for the U.S.
32 public in general, but in particular for individuals of lower income and with work schedules that are
33 non-traditional, varied, or inflexible. Medical students and residents who are parents face childcare
34 challenges that include low or even non-existent income, rigid academic schedules, and training
35 and service requirements that extend the workday well beyond what can be easily accommodated
36 by most childcare providers. The struggle of juggling childcare and medical education can further
37 increase stress for individuals who are in an environment that has been documented to increase
38 levels of depression and burnout.³⁹

39
40 The Build Back Better Act was passed by the U.S. House of Representatives in November 2021.
41 The bill included universal free preschool for 3- and 4-year-olds and ensured that families earning
42 up to 1.5 times their state’s median income would not pay more than seven percent of their income
43 for childcare of young children. Also included were four weeks of federal paid parental, sick, or
44 caregiver leave.⁴⁰ This level of assistance, if enacted, would provide medical students and residents
45 with children some financial support, and some support in the form of childcare (preschool for 3-
46 and 4- year-olds) but would not address the needs of parents with younger children and school-
47 aged children as well as parents with non-traditional work schedules. Opposition in the Senate to
48 the Build Back Better Act has led to consideration of smaller legislative action that would provide
49 support to make childcare more affordable.

1 Convenience and cost are the most important factors for parents in selecting childcare
2 arrangements. Affordable, onsite childcare with extended hours could address many of those
3 concerns, and substantial subsidization of childcare expenses in locations where onsite childcare is
4 impractical would provide additional, much needed support to families who face financial
5 restrictions in obtaining affordable, flexible childcare. Enabling families to provide a nurturing
6 environment for young children is an essential goal for society. Doing so, however, may place a
7 significant financial burden on medical schools and graduate medical education institutions that
8 may be operating on already small margins. If institutions are mandated to provide such services,
9 they may attempt to recoup costs with higher tuition or lowered salaries.

10
11 The Council on Medical Education therefore recommends that the following recommendations be
12 adopted in lieu of Resolution 304-J-21, Resolve 3, and the remainder of this report be filed:

- 13
14 1. That our AMA recognize the unique childcare challenges faced by medical students,
15 residents and fellows, which result from a combination of limited negotiating ability (given
16 the matching process into residency), non-traditional work hours, extended or
17 unpredictable shifts, and minimal autonomy in selecting their work schedules. (New HOD
18 Policy)
- 19
20 2. That our AMA recognize the fiscal challenges faced by medical schools and graduate
21 medical education institutions in providing onsite and/or subsidized childcare to students
22 and employees, including residents and fellows. (New HOD Policy)
- 23
24 3. That our AMA encourage provision of onsite and/or subsidized childcare for medical
25 students, residents, and fellows. (New HOD Policy)
- 26
27 4. That our AMA work with the Accreditation Council for Graduate Medical Education,
28 Association of American Medical Colleges, and American Association of Colleges of
29 Osteopathic Medicine to identify barriers to childcare for medical trainees and innovative
30 methods and best practices for instituting on-site and/or subsidized childcare that meets the
31 unique needs of medical students, residents, and fellows. (Directive to Take Action)

Fiscal Note: \$2,500

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