Maternity and Paternity Leave in Otolaryngology Residency Training in the United States

Alice L. Tang, MD; Adam Miller, BS; Samantha Hauff, MD; Charles M. Myer III, MD; Vinita Takiar, MD, PhD; Rebecca J. Howell, MD; Jonathan R. Mark, MD

Objectives/Hypothesis: This study evaluates the existence and nature of maternity and paternity leave policies for residents during otolaryngology training. The study sought to survey program directors (PDs) on the impact of parental leave.

Study Design: Cross-sectional survey.

Methods: An electronic survey was sent to 103 otolaryngology residency PDs. A link to a 10-page, 30-question survey was provided. Descriptive statistics and comments were collected.

Results: Forty-one respondents (39.8%) completed the survey, all of whom were from university-based programs. Programs from the Midwest (n = 11, 26.8%), Northeast (n = 12, 29.3%), South (n = 12, 29.3%) and West (n = 6, 14.6%) were represented. Sixteen (42%) programs reported having a written formal maternity leave policy for trainees, and 13 (32%) programs had a paternity-specific policy. Four programs reported using short-term disability, whereas 11 programs reported using the Family Medical Leave Act to accommodate parental leave. Policies primarily followed the Accreditation Council for Graduate Medical Education and American Board of Otolaryngology guidelines, with factors such as clinical duties and call schedules left to the programs’ discretion. Although the majority of PDs (56%) reported support of residents who planned to become pregnant during training, many expressed concerns regarding the burden on co-residents and the difficulty of fulfilling training obligations for the resident taking leave.

Conclusions: Many institutions do not have parental leave policies and logistics regarding leave are left to the discretion of individual programs. Surveyed PDs addressed the challenges of becoming a parent during training and the potential burden placed on the program when trainees take leave.

Key Words: Maternity leave, paternity leave, formal parental leave, otolaryngology training.

Level of Evidence: 4

INTRODUCTION

A recent systemic review of parental leave policies during graduate medical education (GME) found that existence of formal policies ranged between 22% and 90% across different specialties, and it reported persistent negative attitudes from program directors (PDs) toward becoming a parent while in training.1,2 Female physicians planning a pregnancy during residency face unique challenges, especially those women training in otolaryngology and other surgical subspecialties. The extensive training requirements, long work hours, physical strain, work exposures, and overall stress have been thought to contribute to an increased number of pregnancy complications and discouragement of family planning for female residents.3

A survey of PDs in the field of plastic surgery revealed a lack of uniformity in formal parental leave policy among programs.4 In fact, of the plastic surgery programs that responded, only 36.5% reported an official maternity policy, and details regarding duty restrictions, scheduling, and postpartum accommodations were severely lacking overall. The current study aims to evaluate the policies regarding maternal and paternal leave in otolaryngology residencies across the country. Additionally, we surveyed otolaryngology PDs for their opinions regarding trainees who take parental leave during training.

MATERIALS AND METHODS

An electronic survey was sent to 103 otolaryngology residency directors. Email addresses were gathered via the Accreditation Council for Graduate Medical Education (ACGME) program Web pages, and online research publications. An explanation of the study was provided with a link to a 10-page, 30-question electronic survey using SurveyMonkey (SurveyMonkey, Inc., Palo Alto, CA). We used descriptive statistics to present the data.
TABLE I.
Program Director Demographics (N = 41)

<table>
<thead>
<tr>
<th>Geographic Region</th>
<th>No. (%)</th>
</tr>
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<tbody>
<tr>
<td>Midwest</td>
<td>11 (26.8)</td>
</tr>
<tr>
<td>Northeast</td>
<td>12 (29.3)</td>
</tr>
<tr>
<td>South</td>
<td>12 (29.3)</td>
</tr>
<tr>
<td>West</td>
<td>6 (14.6)</td>
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</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>No. (%)</th>
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<tbody>
<tr>
<td>Male</td>
<td>24 (61.5)</td>
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<tr>
<td>Female</td>
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<td>Unanswered</td>
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<table>
<thead>
<tr>
<th>Age range, yr</th>
<th>No. (%)</th>
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</thead>
<tbody>
<tr>
<td>30–35</td>
<td>1 (2.5)</td>
</tr>
<tr>
<td>36–40</td>
<td>3 (7.5)</td>
</tr>
<tr>
<td>41–45</td>
<td>15 (37.5)</td>
</tr>
<tr>
<td>46–50</td>
<td>5 (12.5)</td>
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<tr>
<td>51–55</td>
<td>8 (20)</td>
</tr>
<tr>
<td>56–60</td>
<td>4 (10)</td>
</tr>
<tr>
<td>61–65</td>
<td>4 (10)</td>
</tr>
<tr>
<td>Unanswered</td>
<td>1 (2.4)</td>
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</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>No. (%)</th>
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</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>26 (74.3)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1 (2.9)</td>
</tr>
<tr>
<td>Asian</td>
<td>6 (17.1)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (5.7)</td>
</tr>
<tr>
<td>Unanswered</td>
<td>6 (14.6)</td>
</tr>
</tbody>
</table>

RESULTS

**Respondent Demographics**

Forty-one of 103 ACGME otolaryngology residency program residency directors participated in the survey, resulting in a 39.8% response rate. However, not all respondents answered every question, and therefore, some questions had a lower response rate. Programs from the Midwest (n = 11, 27%), Northeast (n = 12, 29%), South (n = 12, 29%), and West (n = 6, 15%) were represented (Table I). Program director demographics who participated in the survey are listed in Table I. Thirty-seven respondents (90%) have children. Of those, 8% had a child during medical school, 32% during residency, 19% during fellowship, and 49% as faculty. PDs served an average of 7.0 ± 5.4 years. All programs that participated were university based.

There were a total of 639 residents represented from the 41 responding programs, with an average of 15.6 ± 6.6 total residents from each institution. There were 29/41 (70.7%) respondents that had a female resident take maternity leave during their tenure, and 30/41 (73.2%) respondents who experienced a male resident taking paternity leave (Table II). Respondents reported that men took an average of 1.34 ± 0.74 weeks (range, 0 days–4 weeks), whereas women took an average of 5.16 ± 1.88 weeks (range, 2–9 weeks) of leave (Table II). For female trainees, 21 programs reported leave of 4 to 6 weeks, with 6 weeks of leave most common (n = 12).

**Parental Leave Policies for Trainees**

Of the programs that responded to the question, 42% (16/38) had a written maternity leave policy specific to the otolaryngology training program, and 34% (13/38) had a specified paternity leave policy (Fig. 1). Of the programs that reported having a formal parental leave policy, the three most commonly included elements were: time required to fulfill program requirements, compensation during leave, and amount of leave permitted (Fig. 2). For trainees, short-term disability was used by 12% (4/34) of programs, the Family Medical Leave Act (FMLA) was used by 33% (11/34) of programs, and 47% (16/34) of programs required their residents to use vacation time for parental leave. Residents were required to extend their training time at 12% (4/34) of the programs. Reasons that programs lacked a formal maternity/paternity leave policy included: small class sizes and insufficient coverage if leave was permitted, a shortfall of clinical hours required for training, and a concern for inadequate clinical training. Although many programs lacked explicit policies regarding duties, schedule, and accommodations during and following pregnancy, many directors commented that these issues were typically dealt with on an as-needed basis.

**Opinions Toward Parental Leave**

When asked if there was a best time during residency to plan a pregnancy, 50% (17/34) of the respondents answered “yes.” Of the 19 respondents who commented on this question, 12 PDs suggested that taking parental leave during the research block would be ideal. Six respondents specifically suggested a particular year of residency as the ideal time, which varied from postgraduate year PGY1 to PGY3, PGY4, or PGY5. No respondents answered that the second year of residency would be an ideal time.

Although nearly all PDs (97%, 31/32) have a supportive or neutral stance on residents planning pregnancy during training, 12% believed becoming a parent had a

**TABLE II.**

Reported Parental Leave Duration of Trainees.

<table>
<thead>
<tr>
<th>Male, duration, wk, n = 30</th>
<th>No. of Progra</th>
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<tr>
<td>&lt;1</td>
<td>4</td>
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<tr>
<td>1–2</td>
<td>26</td>
</tr>
<tr>
<td>&gt;2</td>
<td>2</td>
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<table>
<thead>
<tr>
<th>Female, duration, wk, n = 29</th>
<th>No. of Progra</th>
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</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
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<tr>
<td>4</td>
<td>7</td>
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<td>5</td>
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<td>6</td>
<td>12</td>
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<tr>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>9+</td>
<td>1</td>
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negative impact on a male resident’s training (Fig. 3), and
38% believed it had a negative impact on a female resi-
dent’s training (Fig. 4). Over one-third (35%) of the respon-
dents felt that there was a negative impact on co-residents
during the period of maternity or paternity leave (Fig. 5).
Additional comments from PDs regarding pregnancy dur-
ing otolaryngology residency are shown in Figure 6.

DISCUSSION
In the present study, we found that policies regarding
maternity and paternity leave lack consistency among oto-
larngology residency programs in the United States. The
majority of respondents had no formal program-specific
policy, but rather follow non-specific institutional and
ACGME guidelines.5 Additionally, our results showed
that most PDs are supportive or neutral toward the deci-
sion of becoming a parent during training, and some even
felt that it may have a negative impact on the individual
resident, his or her co-residents, and/or the program.
Fewer than 50% of the programs that responded had
a formal parental leave policy for residents. A systematic
review by Humphries et al. found that among other spe-
cialties, pediatric and radiology residency programs have
the highest rates of formal maternity leave policies (90%
and 88%, respectively).1,6 The prevalence of formal poli-
cies among surgical programs was lower: 67% in general
surgery, 42% in urology, and 37% in plastic surgery.1,4,7
The variation among and within specialties and programs
is partially due to the lack of an existing formal parental
leave policy from the ACGME. The ACGME guidelines
state that institutions must have a written policy for
vacation and leaves of absence that are consistent with
applicable laws, but it does not go beyond this generic
statement to specifically address parental leave. Part of
the difficulty in the establishment of formal parental
leave policies stems from the conflict of one’s legal right
to 12 weeks of unpaid leave (FMLA) while still necessitat-
ing 48 clinical work weeks per year.
The American Board of Otolaryngology (ABO) states
that leaves of absence and vacation may be granted to
residents at the discretion of the program director in
accordance with local rules. They specifically note that
such leaves and vacation may not exceed 6 weeks in any
one academic year.8 For female residents taking 6 weeks
of maternity leave, PDs must negotiate with the trainee
whether vacation time will be sacri-
cific for the year and/or how time away from training will be made up oth-
erwise. As a result, programs are left to their own discre-
tion with solutions including a variable combination of

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Fig. 1. Proportion of programs with specific parental leave policies and other means of leave. FMLA = Family Medical Leave Act. [Color figure can be viewed in the online issue, which is available at www.laryngoscope.com.]

Fig. 2. Covered elements of parental leave policy. [Color figure can be viewed in the online issue, which is available at www.laryngoscope.com.]
vacation time, short-term disability, FMLA, and/or extension of residency, which may or may not be feasible depending on an individual’s postgraduate plans. Although this does allow PDs to tailor accommodations to their individual residents, the unpredictability can also be a significant source of stress on the trainee.3

Currently, a consistent theme across PDs’ comments is that leave exceeding 6 weeks during 1 academic year must be made up to be compliant with ABO guidelines; the inability to take parental leave beyond this amount is a frequently encountered problem, especially for female residents. Complications from pregnancy, need for cesarean section, and postpartum issues are unpredictable, out of the parent’s control, and occasionally necessitate additional leave. In fact, studies have demonstrated that obstetrical complications have been shown to be higher in female residents during training when compared to age-matched controls.9,10 Although many childcare issues within the first year can be mitigated with careful planning and back-up caretakers, ultimately, parents may need to tend to their children in urgent, unplanned situations, just as any parent does. In scenarios where make up time is mandated, the pursuit of an advanced surgical training match is unfairly complicated. Clear, standardized parental leave policies in otolaryngology training that account for some of these elements would significantly alleviate stress on both the trainee and the program.

This study revealed that some PDs expressed avid support of residents planning pregnancy during their training, but many also expressed concern regarding the negative impact it can have on the program and the resident professionally. Specifically, 38% of respondents believed that becoming a parent negatively affected the training of female residents, whereas only 12% felt this way about the training of male residents. A similar survey demonstrated that general surgery PDs were significantly more likely to report that becoming a parent negatively affects female trainees’ work as compared to their male counterparts (61% vs. 34%).2 This perception is pervasive and is not exclusive to otolaryngology; however, other studies evaluating this have shown it to be false. A qualitative study by Cole and colleagues interviewed pregnant residents in otolaryngology, and found that operative case numbers and key indicator cases did not appear to differ from residents at the same training level, indicating that operative experience may not be negatively impacted by
Women bear greater burden because of biological factors like breast feeding (and in some cases still existing stereotypes that require them to do more than 50% of divisible child-related duties) but they are the stronger species so, in general, they can handle it. Bottom line is that it is a break even for them too. Post-partum depression is something about which we need to be vigilant, but I have not seen a case among any residents I have trained.”

“Perceptions of workload shifting adversely affect women who have a baby during residency. Also, people will often tend to avoid offering her opportunities, assuming she’d rather be with her child(ren). This, sadly, continues into faculty status.”

“Mostly neutral. Some increased work-load, rescheduling, etc.”

“Harder to juggle and concentrate.”

“I think it made my female residents much more efficient when they were at work. More than my male residents, they would comment a little more about childcare issues or if their son/daughter was sick. It may have divided their attention some but overall the quality of their work didn’t change.”

“We have had 2 female residents have children during residency. Both were outstanding residents, amazing work ethic… doubt pregnancy and motherhood made them significantly better as residents. But general feeling is that efficiency was already high, and perhaps higher with baby. We did not see a decline in performance [of these] incredible individuals. I would guess that some do well and some struggle at least to some degree.”

“It is just so much added responsibility.”

“I have not been a PD for a female trainee with children, but I would think that the second shift phenomenon would play a significant role and could have a negative impact on their training”

“There are only so many hours in the day and when people have children during training they have less time for education and they must prioritize. It is a life choice which is appropriate for adults to make.”

A survey of plastic and reconstructive surgery PDs found that 36% of respondents discourage pregnancy due to the burden on coworkers, on the resident’s training, or on the function of the department as a whole.4 It is not surprising then that many PDs in our survey advised residents to plan pregnancy during research or elective rotations to lessen the strain on the program. Greater than one-third of the respondents believed that parental leave would have a negative impact on co-residents. Some PDs suggested that pregnancy before residency or later in training (i.e., PGY4) may be preferable; however, more research is needed to validate this perception and clarify maternity leave.3 Pregnancy during obstetrics–gynecology residency did not impact the number of major procedures residents performed.11 In general surgery, women who had children born during training did not differ from their male counterparts in total case numbers or board pass rates.12

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Fig. 4. Impact of parental leave on surgical training for female residents and comments from programs directors. PD = program director. [Color figure can be viewed in the online issue, which is available at www.laryngoscope.com.]

Fig. 5. Opinion of impact on co-residents of the program during a period of parental leave. [Color figure can be viewed in the online issue, which is available at www.laryngoscope.com.]
how parental leave during specific years of training may affect the program and individual residents.

Given that key indicator case numbers are the same at the time of residency completion for otolaryngology and other specialties, these data suggest that female residents are either carrying an increased workload during clinical time, or more likely, giving up elective/research time. In situations where women are encouraged to have children during research electives (10 of our respondents suggested that research rotations offered better timing for pregnancy), there is a potential impact and disadvantage on research productivity. There are data that show that women less often choose academics, and that women are often less competitive for equivalent jobs. Whereas nonparents will use research time to advance professionally, parents will often use this more flexible time to address nonacademic concerns, and of this group, mothers are disproportionately affected. To promote gender equity, and work-life balance in otolaryngology and surgical fields at large, these are issues that need to be considered and addressed.

One of the major limitations of this study is the response rate from the survey. Although we were hoping for full participation from all PDs, we were only able to achieve a response rate of 39.8%. Furthermore, there were a few questions that were left unanswered by some respondents, which resulted in lower response rates for some questions.

Additional Comments:

These comments were in response to what advice would you give to a resident who is planning a pregnancy?

"Not the place of faculty to give such advice. In my opinion... it is very hard on small programs (which all [otolaryngology] programs are) for anyone to be gone for over a month, especially during PGY 2-3 years when taking first call. Also very hard on residents, especially female. I think residents know this intuitively and most avoid pregnancy during this time. People attracted to our program tend to plan to defer children as many are unmarried and our urban setting - with long commutes, high costs, and poor schools near the medical center - makes parenting more challenging."

"This, of course, depends on one's health status and age. It should be discussed with one's partner and physician first. Early, confidential disclosure to the Program Director is essential for planning rotations and call schedules. [There are] Residency Review Committee rules for time off during a residency and this must be considered in the resident's counseling. Once the resident feels comfortable announcing the pregnancy/child acquisition, it should be disclosed to the colleagues who participate in the same call pool (senior vs. junior) so that the challenges of a healthy pregnancy, adequate clinical training and call equity can be balanced."

"Not against pregnancy during residency but it can be difficult."

"Rotation planning (avoiding overly strenuous). Hydration and mobilization planning during pregnancy to avoid stasis and dehydration complications."

"Very personal decision. Plan as much as possible and let the program director know as soon as possible."

"Having had a child during residency, I would advise them that it is difficult to balance child care and residency training, but slightly easier later in training. They also need to understand how much time is available to them for leave and that they are more likely to deliver early or suffer complications. I would also encourage them to think long and hard about the burden they are placing on their fellow residents; the absence of a resident, particularly in a small program, is burdensome for those trying to cover."

"I have a soft spot for residents who want to start a family during residency. I purposely had both of my kids when I was a resident (PGY1 and PGY3) but I am a male so it is vastly different than my 2 female residents who took maternity leave. I have had 2 male residents take short paternity leave. I definitely support them and will explicitly tell them, but I always make sure they know the extra burden it will add to their own family and their resident family. At my program, I find it fortunate (or unfortunate) that we are a small program. The residents know each other very well and are eager to support each other. What helped the program is that 3/4 residents took their parental leave when they were PGY5s. Everyone knew them/liked them so when they asked for it, it wasnt a big deal.

Fig. 6. Program director support for residents considering parental leave during training with comments. PGY = postgraduate year. [Color figure can be viewed in the online issue, which is available at www.laryngoscope.com.]
We have tried to include the raw number of answers in addition to the percentage as a whole for interpretation. Another limitation of this research is the potential selection bias for PDs with strong opinions toward parenthood during training. Additionally, respondents are likely basing their answers on memory introducing a recall bias.

Despite these limitations, our study demonstrates that many of the programs that participated in our survey do not have a formal parental leave policy. This is likely representative of all programs across the country. The lack of clarity regarding leave is not only a significant source of anxiety and stress for residents growing their families, but also causes logistical dilemmas for co-residents and residency programs. These factors contribute to the negative attitudes toward parenthood in GME and feed into the culture of delaying parenthood until training is finished.

Proposed Guidelines for Parental Leave

Where do we go from here? Understanding that the ACGME requires that more than 6 weeks off during an academic year must be made up, any formal policy should be mindful of this requirement. Garza et al.5 provided proposed solutions for standardizing maternity leave in plastic surgery training. Surgical specialty residencies face similar obstacles including length of training, minimum case number requirements, and variability in size of program (i.e., trainees/year). Thus, formal parental leave policy in otolaryngology training programs should consider the following elements (adapted from Garza et al.5).

A defined length of time for maternity leave. A key question that must be addressed is whether time that must be made up should come at the end of residency or if one can utilize future vacation time to complete residency as scheduled. This dilemma is especially important when considering fellowship training and could unduly deter from postresidency education. We suggest 6 weeks of paid maternity leave (with the use of short-term disability, vacation, and sick time with the distribution at the discretion of the PD).

Adoption and paternity leave. Having an established leave policy for fathers and parents planning adoption will promote a culture in which building and nurturing a family during training is not only feasible, but also supported. We propose 2 weeks of paid leave with the option of using vacation and sick time for a total not exceeding 6 weeks per academic year.

Service coverage. The spirit, if not the law, of postgraduate medical education is that residents are present primarily for their education and not to provide service to the host department. Programs must be mindful that having co-residents assume an increased workload and call to cover for those on leave feeds into the culture of resentment. We suggest the option of paying for coverage (by either co-residents, non-ACGME accredited fellows, or other associates) from department funds, if available, to maintain seamless service throughout one’s leave. If a more liberal leave policy is employed by an institution or a department, one must work with the ACGME to streamline a process for a temporary increase in resident maximum case number requirements, and variability in size of program (i.e., trainees/year). Thus, formal parental leave policy in otolaryngology training programs should consider the following elements (adapted from Garza et al.5).

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