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Pregnancy and Residency — Overdue for Equity

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We are three female physicians, each of whom, many years ago, faced the dilemma of whether and how to combine pregnancy and residency. One of us (S.K.) became pregnant as an intern and didn't request, nor was offered, any adjustment to her schedule. When she developed preeclampsia and required 1 month of bed rest, concern about whether she was burdening her fellow trainees added to the stress of worrying about her fetus's and her own health. When she returned to work after delivering an infant with low birth weight by emergency cesarean section, long shifts compounded the exhaustion associated with caring for a newborn. Another (J.E.H.) deferred pregnancy until she finished residency, thereby risking infertility and the pregnancy complications that are more common in older women, having concluded that the demands of medical training were incompatible with childbearing. And the third (D.G.K.) took leaves from her medical training related to two pregnancies and subsequently graduated 2 years behind her class, which disrupted her career. Though we had different experiences and made different choices, we shared a common assumption: we couldn't expect to both have a healthy pregnancy and successfully complete residency with our peers. In the 1980s and 1990s, that was simply the way it was.

Incremental progress has been made during the years since then, yet current residents who wish to become pregnant often perceive they have the same limited options we encountered: pursue a pregnancy without alterations to a grueling work schedule; defer pregnancy until after residency and incur the increased risk of infertility and maternal and fetal complications associated with older age; or take time off during pregnancy and the postpartum period and accept a potentially stalled career trajectory.[1] Recovering from childbirth, breast-feeding, and caring for an infant — which aren't easy for anyone — are especially daunting for residents, who often work overnight shifts and may work up to 28 hours during one shift. The persistence of a male-dominated culture in medicine[2] helps maintain the status quo of a residency system that wasn't designed to support trainees who are pregnant or caring for newborns.

At a time when there are more female than male students entering medicine,[3] it's especially crucial that the structure and culture of medical training enable physicians who wish to become pregnant to do so without personal or professional penalty. A new status quo would benefit physicians of all genders.

Incremental, though insufficient, progress has been made during the past 30-plus years. Duty-hour restrictions, night-float coverage, enhanced hospital ancillary support (e.g., the availability of phlebotomists for drawing blood), and the federal Family and Medical Leave Act (FMLA), which provides up to 12 weeks of unpaid leave for certain employees, have the potential to benefit all residents. Workplace lactation rooms have benefitted postpartum trainees.

At the state level, there have been some positive reforms: Massachusetts, for example, enacted a 12-week paid-parental-leave policy. New parents can take the leave at any time during the year after the birth or adoption of a child; the law also applies to new foster parents. In 2021, the American Board of Medical Specialties established a progressive leave policy that applies to all its member boards, offering residents and fellows in programs of 2 years or longer a minimum of 6 weeks of parental, caregiver, or medical leave, which trainees can take without exhausting vacation or sick-leave time and without requiring an extension in training. In 2022, the Accreditation Council for Graduate Medical Education followed suit, requiring that sponsoring institutions offer 6 weeks of paid leave for new parents, regardless of gender, and specifying that the right to take such a leave starts on the first day of the training program.

These policies are welcome, but they are often implemented in-

consistently or in unhelpful ways.[4] For example, not only are leaves taken under the FMLA frequently unpaid, but residents may be categorized as essential personnel who can be excluded from this benefit. Residency program directors may not be fully aware of or may misinterpret new policies established by certifying boards, or they may lack the institutional infrastructure or will to comply with them.

Some leave policies may be relatively unknown and underutilized. For example, the American Board of Internal Medicine (ABIM) provides an option for "interrupted full-time training," which allows a resident to take blocks of time away from training, provided that they work at least 6 months of the year and continue to see their patients in an outpatient clinic. Another such ABIM policy is the "deficiencies in required training time" clause, which specifies that, so long as the program director deems a resident to be competent, the resident may not be required to make up time taken away from training. Merit-based assessments may also be used to determine whether any extensions to training are necessary after a leave.

In response to the slow uptake of policies at some institutions and unsupportive local and national institutional cultures, the Society of General Internal Medicine's Women and Medicine Commission (which D.G.K. chairs) launched a parenting in medicine initiative, which seeks to support trainees throughout pregnancy as well as physician parents.[5] The initiative provides residents with information about their rights during pregnancy and sponsors programming to equip chiefs and program directors to support parents and change institutional cultures to be accepting and supportive of pregnancy and parenting in medicine, during residency and beyond.

We believe the challenges related to combining pregnancy and residency arise fundamentally from the lack of gender equity in medicine. The policies described above could help create opportunities for all physicians to pursue both their professional and reproductive goals and greatly improve a system that was designed for people who don't become pregnant or take on substantial parenting responsibilities. Healthy parents who are supported in having healthy babies, career satisfaction, and a reasonable work–life balance ultimately strengthen our profession and our society. To truly move forward, however, we believe medicine needs to undergo structural and cultural change to respect the needs and preferences of people of all genders.

When 50% or more of the workforce may become pregnant during their medical careers, medical training, clinical practice, and research opportunities should be designed to support alternative work structures. We believe such policies should be the professional norm, not accommodative perks offered by particularly progressive institutions. Responsibility for advancing these policies needs to lie within the system itself, not fall to trainees who are already juggling personal and professional goals.

An argument could be made that alternative work structures will add to the ever-increasing costs of medical care and place additional burdens on physicians who don't have children. But this argument misconstrues these pathways as accommodations or "favors," rather than part of an intentionally developed system that meets the needs of its constituents. Creative solutions could be found to these perceived barriers; for example, advanced practice providers could cover shifts to avoid overstretching other residents. Flexible schedules often allow physicians to spend time on research, administration, or other academic pursuits without feeling like they are burdening their colleagues; pregnant residents deserve the same flexibility.

As physicians, we know how babies are made and how they develop, and we understand the particular needs of people who carry and deliver them. In addition, we know that the ages at which most people undertake residency training (primarily during their 20s and 30s) coincide with the time when people who wish to become pregnant are most likely to be able to do so and to have a low-risk pregnancy. We believe the way forward depends on acknowledging the biologic realities of pregnancy and committing to gender equity.

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