Maternity Leave for Practicing Family Physicians

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Background. Approximately 37% of all medical students and 36% of family medicine residents in training in the United States are women. The American Academy of Family Physicians (AAFP) has developed a recommended parental leave policy for residents in training but has not established a similar policy for physicians in practice. The purpose of this study was to assess the prevalence of maternity leave policies for practicing family physicians.

Methods. A 14-item self-administered survey questionnaire was designed and mailed to 940 AAFP members randomly selected from the total active female membership.

Results. A 52% response rate was obtained. The mean age of respondents was 35 years. Only one third of the physicians not in solo practice reported having a stated maternity leave policy in their current place of practice. Academic programs, when compared with single specialty family practice groups, multispecialty groups and health maintenance organization (HMO) or preferred provider organization (PPO) groups, were more likely to have maternity leave policies and to provide salary on leave. Practice groups with eight or more partners were more likely to have policies that provided salary and benefits while on leave. Ninety percent of respondents requested maternity leave guidelines for practicing family physicians.

Conclusions. Women family physicians expressed strong interest in the development of maternity leave guidelines for their specialty. Guideline components are outlined.

Key words. Physicians, women; pregnancy; health policy; salaries and fringe benefits; AAFP. *J Fam Pract 1992; 35:39-42.*

In 1987 women comprised approximately 11% of the total American Academy of Family Physicians' (AAFP) active membership of 34,832. By 1990 the number had risen to 14% (Information and Research Division, AAFP, Kansas City, Mo, 1991). Female membership is projected to grow to 25% of the total by the year 2000. The vast majority of these women will be of childbearing age, 45 years and younger, at the turn of the century.

Women physicians are changing the practice of family medicine in numerous ways. Personal and professional issues important to women physicians have had significant impact on residency training requirements and practice guidelines.

For example, maternity leave in training and practice has become relevant largely because of the rapidly increasing number of women entering US medical schools and doing residencies. According to 1991 data of the American Association of Medical Colleges, 37% of all medical students are women (AAFP, Kansas City, Mo, June 1991). Between 1978 and 1991 the number of women in family medicine residencies increased by 300%, from 840 to 2626. Currently, 36% of all family medicine residents are women (AAFP, 1991).

In response to these changing demographics, the AAFP's Committee on Women in Family Medicine mailed a 1-page questionnaire regarding parental leave to 383 family practice residency directors in April 1987. Of the 237 programs that responded, 68% reported having an established maternity leave policy that provided for an average leave of 6 weeks (AAFP, 1991).

In January 1990, the committee drafted a recommended parental leave policy for family practice residents in training, which was adopted by the AAFP Board of Directors in April 1990.[1] This was distributed to all family medicine residency programs.

As the family medicine residency data were being collected, a survey of all women who were active members of the AAFP was conducted to determine the existence of a stated maternity leave policy for women who had completed their training and who were in practice.

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This study reflects the views of the author and not those of the American Academy of Family Physicians Committee on Women in Family Medicine.

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The goal was to assess the need for similar "recommended" guidelines for practicing physicians.

This paper (1) presents the results of the 1987 AAFP physician survey, and (2) outlines a strategy for developing maternity leave guidelines in practice groups.

Methods

A 14-item self-administered survey was designed to obtain demographic information about the family physician, her practice type and size, and the existence and nature of a maternity leave policy in the practice. Physicians were also asked to describe individual plans for leave in the event of pregnancy, and to designate whether leave guidelines for practicing physicians would be helpful.

In December 1987, the survey questionnaire was sent to 940 female members of the AAFP. This comprised a random, systematic sample of every fourth woman of the 3796 women who were active members. It excluded residents and students and included dues-paying members who had either completed a 3-year accredited residency program or been "grandmothered" into the organization by practicing in the field of family medicine.

Physicians were asked to complete the survey questionnaire anonymously and return it in a postpaid envelope. There was no second mailing. The questionnaires were analyzed by Student's *t* test for continuous variables and Pearson chi-squares for categorical variables using SPSS/PC software (Statistical Packages for Social Sciences, Chicago).

Results

A total of 491 questionnaires were returned, for a 52% response rate to the single mailing.

Physician Characteristics. The mean age of respondents was 35 years; the median age was 34 years. The average number of years in practice was 5.4. Of the 491 respondents, 75% were married, and 55% had either 1 or 2 children. Approximately 85% of women worked more than 30 hours per week, and 68% were on call at least once per week. Practice types varied, as shown in Table 1.

Leave Policies. Approximately one third (112) of the physicians not in solo practice reported having a stated maternity leave policy provided by their places of practice. The average duration of leave that would be provided to those with a stated maternity leave policy was 8.7 weeks; the median leave duration was 6 weeks. The range of leave was from 4 weeks for a normal spontaneous vaginal delivery and 8 weeks for a cesarean birth to 1 year for either type of delivery. Most common were 6, 8, and 12 weeks of leave. Overall, 65% of maternity leave policies provided salary to the physician during her entire absence; 84% provided employee benefits for the duration of the physician's maternity leave. For those women working in a practice with no maternity leave policy, only 40% had discussed a leave policy with their employer or colleagues.

Table 1. Practice Type and Current Maternity Leave Policy Reported by 491 Women Family Physicians

Practice Type	Respondents No. (%)	Maternity Leave Policy Present* No. (%)	Salary Paid† No. (%)
Solo	129 (26.3)	— —	— —
Single specialty	197 (40.1)	54 (28.3)	58 (43)
Multispecialty	57 (11.6)	22 (39.3)	22 (50)
HMO/PPO employee	36 (7.3)	11 (32.4)	12 (42.9)
Academic training program	50 (10.2)	25 (53.2)	28 (75.5)
Not specified	22 (4.5)	— —	— —

**Significant at P < .01.*
†Significant at P < .004.
HMO denotes health maintenance organization; PPO, preferred provider organization.

Employer and Colleague Discussions. The mean age of respondents who had not discussed maternity leave with colleagues was higher than the mean age of those having held such discussions (34 vs 33 years old, $t = -2.8$, $P = .03$). Married physicians were more likely to discuss maternity leave with their employer and colleagues ($P < .001$). Though not of statistical significance, there appeared to be a trend for women who already had children to be more likely to discuss maternity leave ($P < .08$).

Practice Type and Size. Practice type correlated with the presence of a stated policy ($P < .01$) and paid salary ($P < .004$) as shown in Table 1. Practice type did not correlate with payment of benefits during maternity leave.

Larger practices tended to have policies, though differences were not of statistical significance. Practice groups with more than eight physicians were more likely to have policies with paid leave ($P < .02$), and groups with more than six physicians were more likely to provide benefits during maternity leave ($P < .03$).

Request for Guidelines. Of those responding to the question "Would maternity leave guidelines for practicing physicians be beneficial?" 90% responded yes. Age, marital status, number of children, and practice type and size had no correlation with the request for guidelines. Pro and con comments related to possible AAFP practice guidelines were varied and included some of the following remarks.

"[Negotiations] had been difficult and stressful and I wished strongly at the time that some guidelines [had] been available. . . . One other issue I came across was with my malpractice insurance. I called to find out if I could have a reduction in premium during the 4 months I was not practicing. . . . I was told they had no policy for maternity leave and I would have to keep up my total premium. However, if, instead of sitting home with my baby, I had taken a leave to be a missionary in Africa, then they had a policy where I could pay a lower premium to cover [my previous work]."

"If the guidelines were restrictive, eg, 6 weeks, some large clinics like ours with better benefits might have a tendency to become less liberal. . . ."

"It should be left to individuals to negotiate depending on the ability of [a] clinic to either absorb [the] work load or hire temporary replacement."

"This is an individual item that should be negotiated. If there are too many regulations regarding this, it may hamper the female physician in obtaining employment."

"Guidelines should be liberal and should support female physicians in small groups . . . and serve as a model for maternity leaves in other fields [and] show that family physicians care about the quality of family life!"

"Individual needs do vary, but many of us are finding the issue of leave is a new one for most practices, and attitudes of colleagues vary dramatically."

Discussion

The issue of maternity leave will become of even greater importance as more women complete family medicine residency training and begin practice. It is possible that the existence and terms of a particular maternity leave policy will play a role in site selection for these new graduates. This hypothesis should be tested by further study. If true, it is surely of interest to potential male and female partners or employers who seek to include women physicians in their practices.

The lack of correlation between age, marital status, and number of children with the physician's plans for leave of more or less than 8 weeks may simply reflect individual variation in desire for family involvement as well as differences in resources for child care and economic support. Conversely, it may reflect an unsupportive work environment where such requests are perceived to be unwelcome.

Academic programs were most likely to have maternity leave policies and to provide salary for the leave. This may indicate that family medicine academic programs are already sensitive to the issue of maternity leave for residents and may have department policies that include faculty and staff. In addition, academic physicians are more likely to be paid a fixed salary that is less proportionately based on individual billings and productivity.

Larger practice groups are also more likely to have a maternity leave policy with paid salary and benefits. Larger groups may find it easier to absorb the loss of income from a physician on maternity leave. Conversely, smaller, single-specialty family practice groups may not have policies because of their need to individualize leave options based on the physician's estimated loss of income.

Clearly, Americans are struggling to define what is an appropriate parental leave policy for men and women in the workplace. As more women enter the field of family medicine, maternity leave will become an even more important issue for practice groups. The Pregnancy Discrimination Act of 1978 forbids discrimination against pregnant workers by employers and requires that pregnancy be treated as disability. The Act requires that women be offered benefits for pregnancy-related medical conditions equal to those provided for other medical conditions.[2] It does not, however, mandate pregnancy coverage in the absence of a general disability plan.

The physiologic and psychologic response of women physicians to childbearing is variable, and may differ from that of nonphysicians. In one study, Katz et al[3] demonstrated that there was a 58% increase in catecholamine excretion during work in pregnant physicians and ICU nurses compared with excretion during nonworking periods, and a 64% greater excretion of catecholamine compared with working women in other professions who served as controls. The authors suggest that increased levels of catecholamines are indicative of mental and physical stress, which adversely affect pregnancy outcomes.

The optimal duration of maternity leave after birth is a highly individual matter. Bowman and Allen[4] outline and compare specific pros and cons of physician childbearing before medical school, during medical school, during residency, and after training. They describe a variety of issues including unanticipated bonding and guilt that may accompany childbirth and need to be considered when formulating leave policy.

The American Medical Association, American College of Physicians, and American Academy of Family Physicians medical specialty societies have responded to the so-called feminization of medicine by recommending written policies on parental leave for residents in training.[1,5,6] Recommendations for practicing physicians, however, have only recently been considered.

In October 1989, the Women in Medicine advisory panel of the American Medical Association (AMA) sur-

Table 2. Maternity Leave Guideline Recommendations

Any maternity leave policy must have as its primary goal a desire to safeguard the health of the mother and infant. Individual family practice groups have unique needs, and no one policy is appropriate in all settings. Minimal policy components, however, should be based on the following guidelines:

1. The practice's maternity leave policy should be discussed with all new physicians at the time of employment. It should not be the new employee's responsibility to request this information.
2. The duration of maternity leave before and after delivery should be specified for full- and part-time physicians.
3. A mechanism for requesting maternity leave should be outlined.
4. If preterm birth complications arise, procedures to modify practice duties and responsibilities should be considered to reduce risks to the mother and child.
5. In the event of birth complications, procedures to alter the originally proposed dates for maternity leave should be clear.
6. The maternity leave should be clearly designated as leave of absence, sick leave, short-term disability, or vacation, or a combination thereof.
7. Clarification as to whether the physician or practice will pay health, disability, and malpractice premiums during maternity leave should be made.
8. If an extended maternity leave is negotiated, means to handle items 6 and 7 above should be specified.
9. It is necessary to specify whether vacation, sick leave, pension vesting, etc, accrue during maternity leave. The option of payback for time-off should also be addressed.
10. Clarification should be made as to whether flexible planning for maternity leave is available and whether similar procedures may be followed for adoptive or paternity leave.

veyed medical group practice administrators regarding maternity leave policies. Approximately 25% of the 892 group practices that responded indicated having a standard policy of granting maternity leave. Groups with six or more physicians were nearly twice as likely as smaller groups to have a policy.[2] The range of leave for 43% of the groups was from 43 to 90 days. A variety of compensation packages were provided. The AMA 1989 survey of group practices also revealed a lack of experience in this area among many groups.

These findings prompted the AMA Board of Trustees to expand their 1984 Maternity Leave for Residents policy to include physicians in practice. They recommend written policies that are detailed, specific, and include a minimum 6-week maternity leave allowance for women in residency programs as well as those in group practices.[2]

In 1987, members of the American Association of Women Radiologists (AAWR) also surveyed 131 diagnostic radiology departments and 30 radiation therapy departments regarding maternity leave policies for their members. They found few departments with formal policies. Likewise, they recommended that every private practice group and academic institution have both a maternity leave policy and disability policy that would be available for review by current and prospective employees.[7]

No specific maternity leave recommendations exist for AAFP active-member physicians in practice. Based on the patient survey, there is strong interest in the development of maternity leave guidelines for practicing family physicians. A recommended policy is provided in Table 2.

All practices should be encouraged to develop a maternity leave policy that reflects the human values[8] of our specialty. Such efforts will go far to create and sustain an environment that enables women family physicians to thrive both as mothers and health care providers.

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