text and site for BSSR studies, and as a home to many BSSR researchers, we believe primary care research belongs in the definition of BSSR.

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References

1. Office of Behavioral and Social Sciences Research. Behavioral and social sciences research definition. https://obssr.od.nih.gov/about/bssr-definition/. Published 2019. Accessed Mar 11, 2020.
2. Office of Behavioral and Social Sciences Research. Behavioral and social sciences research definition archived. https://obssr.od.nih.gov/about/bssr-definition-archived/. Published Jul 2010. Accessed Mar 11, 2020.
3. Bronfenbrenner U. Environments in developmental perspective: theoretical and operational models. In: *Measuring Environment Across the Life Span: Emerging Methods and Concepts*. Washington, DC: American Psychological Association Press; 1999.
4. Borrell-Carrió F, Suchman AL, Epstein RM. The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *Ann Fam Med*. 2004;2(6):576-582. 10.1370/afm.245.
5. Oyama O, Kosch SG, Burg MA, Spruill TE. Understanding the scope and practice of behavioral medicine in family medicine. *Fam Med*. 2009;41(8):578-584.
6. Starfield B. A framework for primary care research. *J Fam Pract*. 1996;42(2):181-185.
7. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.

From the American Board of Family Medicine

From the Association of Family Medicine Residency Directors

Ann Fam Med 2020;18:280-282. https://doi.org/10.1370/afm.2551.

FAMILY LEAVE FOR FAMILY MEDICINE RESIDENTS: TIME FOR A NEW WAY FORWARD

Female resident to fellow classmates: *"I wanted to let you know that I am pregnant… and I am sorry."*

Restrictive residency training program policies and culture regarding Parental and Family Leave are common and have not changed significantly over time.[1] Residents who have children during residency continue to face barriers to receiving adequate time away to care for themselves and their newborns. New parents often still face negative cultural biases related to the perceived impact on their education, clinical work, and sharing of workload among colleagues.[2,3] While family leave in residency training was historically utilized for birth mothers, it has in recent years begun to be considered for fathers and other non-birth parents. Graduate Medical Education (GME) programs nationwide will see an increase in the number of residents requesting Parental and Family Leave, especially with women now comprising more than 50% of medical school graduates, and with shifting cultural norms toward diversity of parenting roles and family structures.

Allowable time away from training is affected by multiple issues, some of which may not be coordinated or consistent with each other. These include human resource policies of different institutions in which residency programs reside, varying definitions of Family Leave types, American Council on Graduate Medical Education (ACGME) training requirements, and medical specialty boards' requirements for board eligibility. The ACGME has had no specific leave policy on parental leave; rather, allowable time away from training has largely been determined by the medical specialty boards. Leave policies of sponsoring institutions add another dimension to the equation that residents and their program directors must consider in planning for time away for residents welcoming a child into their family.

Numerous articles have been published on this topic in recent years, largely focused on the variability of approaches to leave-of-absence decisions that result in inequity both across and within residency programs.[4-7] Specialty boards contribute to this inequity with wide variation in the time required to become board eligible at the end of training.[8,9] Currently, American Board of Family Medicine (ABFM) policy does not distinguish parental or family leave from a "general leave" policy. Family Medicine residents are limited to 1 month of leave per academic year, for any reason. This is among the least amount of time allowed across boards[3] and has been called out by Family Medicine residents as being "least family friendly" of the specialty boards. Both anecdotal and survey findings across specialties have reported 2 major drivers of resident choice to return to training sooner than required after childbirth: (1) a strong desire to not have to extend their training to become board eligible, and (2) a pervasive culture within medical training that is less supportive of new parents than it is of those residents whose leave results from a serious personal medical condition or illness and/or death of an immediate family member.

A study published in *Family Medicine* in October 2019 demonstrated wide variation among Parental and Family Leave policies and practices across family medicine residency programs. Nearly 30% of programs offered no paid maternity leave. Of those that did, most offered 6 weeks or less and only 2 offered 12 weeks or more leave time. For new fathers, nearly 40% offered no paid paternity leave option and 10 offered no paternity leave at all. Notably, this study also demonstrated that family medicine residents, on average, utilize less Family Leave time than is offered by their training programs by one-half to 1.5 weeks.[10] ABFM data for 2019 show 355 leave of absence records in which a reason was cited; these were related to maternity (240; 67%), paternity (20; 5%), personal medical (78; 22%), or family medical (17; 5%) reasons. The preponderance of both maternity and paternity leave was taken in the PGY-2 or PGY-3 years, while personal medical leave was equally balanced across training years. Female residents were more likely to take personal medical leave (59% vs 41% for male residents) and significantly more likely to be represented in numbers of residents utilizing family medical leave (82% and 15%). Very few residents needed more than 1 leave of absence during their training. For those whose residency was extended based on needed leave, the average time for extension was 54.5 days with a range of 4 to 233 days. Approximately one-half (48%) utilized vacation time toward their leave of absence, with an average of 13 days used (range 1-30).

Reconsideration of the current approach across our specialty is necessary to support resident well-being and to optimize early childhood development for the children of resident trainees. Fathers and other non-birth parents need to be supported as well, so that they may participate in early bonding and contribute to early child care responsibilities. Finally, sponsoring institutions should support residents through other impactful events, including significant personal illness and care of a critically ill or dying member of the resident's immediate family.

The ACGME and the member boards of the American Board of Medical Specialties (ABMS) have been working together to address concerns regarding Family and Parental Leave policies in GME, with the belief that existing approaches are insufficient to support resident well-being, optimize the early childhood development of trainees' children, and promote equality of gender participation in parenting and household activities. The 2 organizations held a summit on this topic in February 2020. A diverse group of participants assembled—residents/fellows, program directors, chairs, designated institutional officials (DIOs), health system leaders, ACGME and ABMS leadership, including those from respective member boards—to review the current evidence and imagine a new way forward that all could endorse. Dr Tom Nasca, President and CEO of ACGME, led the conference with a story of his personal experience, decades earlier, as a father who went back to work immediately after the birth of his children. He followed this with a reminder of the clear evidence supporting the importance of the early newborn period on future cognitive development of children, challenging us to consider changes in both policy and culture that would support the investment in this important period. Additional speakers shared data on the attrition of female residents from training because of issues related to narrowly defined leave policies, little support for childrearing demands, and required extensions of training.[11,12] Additive to this is a culture they encounter that often left them feeling inadequate and burned out. As it currently stands, The House of Medicine makes it difficult for us to practice what we preach.

After robust and rich conversations over a day and a half, consensus around the direction of change was clear. Common themes included:

- New policies should be inclusive of any and all personal and family leave needs: childbirth, personal leave for medical conditions, and care of immediate family members during serious illness or death/bereavement.
- Family and Parental leave should be normalized with no differences between a resident giving birth, a resident with a hematologic condition requiring bone marrow transplant, or a resident parent with an older child who has a serious physical or mental health issue requiring close support and care. The consistency needed extends not only to policies, but also to the culture of how we treat our trainees and they treat each other.
- ACGME and ABMS should develop a "time away from training" policy that supports a family friendly culture and gender equity, This policy should establish a floor of 6 weeks allowable leave per year of training and should include a requirement that a minimum of 1 week of vacation time be preserved for use each year beyond the leave. Banking of leave for time off should be allowed, but not to the extent that a resident is permitted to exhaust all vacation time before a leave of absence. Time away for the Family and Parental leave is not a "break." These residents also need vacation options for personal wellness just as other residents who do not require time away.
- Policies must be clear and accessible to everyone, including students who are selecting residency programs. Proactive planning for coverage requirements needs to be established, and program directors and sponsoring institutions would benefit from any com-

mon guidance that can be provided by ACGME and ABMS Boards.

The ABFM Board of Directors and executive leadership are committed to a change in policy related to training standards for board certification that will provide for a more supportive approach to changes in the lives of residents and their family members. We hope to share this with the community before the 2020-2021 academic year. Our approach will be inclusive and permissive, while at the same time remaining consistent with our duty to the public to assure that a board-eligible or board-certified physician completing residency training is worthy of entrusting their care. We will work to support residency programs in understanding and implementing these new guidelines, cognizant of some of the challenges this will present to managing both educational and coverage needs. The ACGME will play a corresponding role in policy development and resources. It is the right time and the right thing to do. We look forward to the transition ahead and working together to promote healthy residents and healthy families.

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References

1. Magudia K, Bick A, Cohen J, et al. Childbearing and family leave policies for resident physicians at top training institutions. *JAMA.* 2018;320(22):2372–2374.
2. Willet, L, Wellons, M, Hartig, J et al. Do women residents delay childbearing due to perceived career threats. *Acad Med.* 2010; 85: 640–646
3. Humphries LS, Lyon S, Garza R, Butz DR, Lemelman B, Park JE. Parental leave policies in graduate medical education: a systematic review. *Am J Surg.* 2017 Oct;214(4):634-639.
4. Webb AMB, Hasty BN, Andolsek KM, et al. A timely problem: parental leave during medical training. *Acad Med.* 2019 Nov;94(11): 1631-1634.
5. Stack SW[1], Eurich KE, Kaplan EA, Ball AL, Mookherjee S, Best JA. Parenthood during graduate medical education: a scoping review. *Acad Med.* 2019 Nov;94(11):1814-1824.
6. Gottenborg E, Rock L, Sheridan A. Parental leave for residents at programs affiliated with the top 50 medical dchools. *J Grad Med Educ.* 2019 Aug;11(4):472-474.
7. Weinstein DF, Mangurian C, Jagsi R. Parenting during graduate medical training - practical policy solutions to promote change. *N Engl J Med* 2019; 381:995-997.
8. Varda BK, Glover M. Specialty board leave policies for resident physicians requesting parental leave. *JAMA.* 2018;320(22):2374-2377.
9. Stack SW, Jagsi R, Biermann JS, et al. Maternity leave in residency: a multicenter study of determinants and wellness outcomes. *Acad Med.* 2019;94(11):1738-1745.
10. Wendling A, Paladine H, Hustedde C, Kovar-Gough I, Tarn D, Phillips J. Parental leave policies and practices of US family medicine residency programs. *Fam Med.* 2019;51(9):742-749.
11. Rangel EL, Smink DS, Castillo-Angeles M, et al. Pregnancy and motherhood during surgical training. *JAMA Surg.* 2018;153(7): 644–652.
12. Worthington RO, Feld LD, Volerman A. Supporting new physicians and new parents: a call to create a standard parental leave policy for residents. *Acad Med.* 2019;94(11):1654-1657.

AAFP From the American Academy of Family Physicians

Ann Fam Med 2020;18:282-284. https://doi.org/10.1370/afm.2546.

AAFP TAPS VETERAN FAMILY MEDICINE ADVOCATE AS NEXT CEO/EVP

When longtime AAFP CEO and EVP Douglas Henley, MD, announced last year that he planned to retire this summer, the Academy launched an exhaustive national search for his successor. That intensive 11-month process came to a close on March 11, 2020, when veteran family medicine advocate Shawn Martin was formally named the next CEO/EVP.

Martin, the Academy's senior vice president for advocacy, practice advancement, and policy, is already familiar to many AAFP staff members and family physicians, having served in that role since 2012. Before joining the Academy, Martin served more than a decade as director of government relations for the American Osteopathic Association.

The announcement capped a busy few weeks for Martin, who—in addition to accepting this promotion—recently turned 50 and completed his master's degree in health care delivery science from Dartmouth College in Hanover, New Hampshire. Now he'll move from the Academy's Washington, DC, government relations office to its Leawood, Kansas, headquarters.

He will continue serving in his senior vice president's role until June 1, 2020 and then will work alongside Henley as CEO designee during a transition period until Henley's retirement on August 1, 2020.

AAFP News sat down with Martin to discuss his new role, his vision for the Academy, and the challenges ahead.

Q: You grew up in rural Oklahoma as the son of a family physician. How did your father's medical career shape your understanding of primary care and your interest in health policy?

A: I saw at a young age the impact that a single physician, or a group of physicians, can have on individual patients and on a community. The burden on primary care was real even in the 1970s and '80s. We were