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VIEWPOINT

VOICES OF CARDIOLOGY

Working Toward Greater Support of Fellows During Pregnancy, Lactation, and Parenthood

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Just as Hippocrates vowed his life to practicing the highest standards of medicine, cardiovascular disease fellowship program directors strive not only to provide comprehensive training for our fellows, but also to support them for long-term success in both professional and personal lives. Pregnancy and parenthood are natural events residents and fellows experience during training due to the biological timing of our trainees. Despite the regularity with which we encounter this issue, there is no uniformity in how fellows are counseled and helped by program directors and the educational system at large regarding parental leave. In this issue of *JACC: Case Reports*, Oliveros et al. (1) focus on this topic. Whereas the field of cardiology has been trying to reduce and abolish sex disparities among our profession, the need to challenge our community of educators to assist us to do better is obvious.

Many issues involved in pregnancy, lactation, and parenthood are similar among trainees in various residencies and fellowships. However, cardiovascular fellowship training involves additional challenges due to the inherent intensity of cardiology training and the potential for exposure to radiation, with radiation-related concerns also being relevant in radiology and radiation oncology residencies (2). Mwakyanjala et al. (3) recently reported that in a small single graduate medical education program, expectant cardiology trainees were 5 times more likely to modify their rotation schedule prior to delivery as compared to new fathers. Adding more complexity to this problem is the hybrid status of residents and fellows as part employee and part student and/or trainee. Due to the different health care models worldwide, our perspectives are exclusively germane to cardiovascular fellowship training in the United States.

The U.S. federal Family and Medical Leave Act permits 12 weeks of leave to employees who have worked for an employer for 12 months, with a qualifying number of hours in the prior year. At many institutions, individuals employed during the previous 12 months can receive 6 weeks of paid leave. With the competitiveness and wide choice of programs across U.S. cardiology fellowships, it is commonplace for medicine residents to relocate to a new institution for further training. This invariably places many cardiovascular fellows at risk for not qualifying for extended leave and suffering the financial hardship of being without a paycheck. In addition, fellows must also spend out of pocket for health plan premiums during any portion of unpaid leave. This issue, however, is not entirely under the control of fellowship program directors or offices of graduate medical education but in substantial part is covered by federal law. Thus, we strongly support the recent recommendation proposed by the Alliance for Academic Internal Medicine that there should be a policy of 6 weeks of paid maternity leave for all women across graduate medical education (4). In addition, dialogue with the American Board of Internal Medicine (ABIM) and federal lawmakers is clearly needed for more supportive policies.

The overarching concern from residents and fellows is that the current system does not allow

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adequate time off for childbearing, recovery, and bonding. ABIM, the certifying organization for medical specialties, allows a trainee 1 month away (inclusive of vacation, illness, Family and Medical Leave Act, etc.), with an additional month granted without the need for training extension if the Clinical Competency Committee and program director attest to the fellow meeting standards of competency and ABIM's approval is obtained to apply the Deficits in Required Training Time Policy (5). Thus, 8 weeks of leave is the maximum time possible for trainees who do not wish to delay their training completion date. With many fellows anticipating extended sub-subspecialty training, this affixes an additional layer of complexity that may include delayed starting of the next fellowship program. Smaller training programs or those that have more than 1 trainee on leave face significant challenges in schedule rearrangements for inpatient service obligations and call. In a recent study, 69% of trainees surveyed felt unfairly burdened when co-fellows took parenteral leave time (2). Moreover, while this redistribution of work often causes annoyance among peers, there are also significant feelings of self-reproach by the expecting fellow. Whereas in a competency-based education model, duration of training should not be the most important consideration, we are still guided by the traditional time-based model of training in cardiovascular and other fellowships. There are numerous competing interests program directors must balance: support the pregnant fellow in her journey while not compromising her education; provide new parents (fathers included) with adequate time off for parental bonding; balance fairness and equity when reallocating call and/or service assignments; and ensure the fellowship continues to meet the clinical needs of the department, as the fellows are often integral team members in academic cardiology programs.

Our suggestions to foster an environment supportive of pregnancy and parenthood are the following:

- Enforce locally all existing institutional and graduate medical education policies regarding radiation exposure and accommodation of lactation needs. Each fellowship program director should take the lead on this. Best practices should be recognized and creative problem-solving experiences should be shared nationally with other program directors.
- Offer a didactic on radiation safety, including preconception concerns, to all entering fellows as part of their orientation and ensure access to the hospital's radiation safety officer to provide further advice.
- Reduce the stigma associated with childbearing and/or family extension of leave during cardiology training by openly discussing it with trainees on entrance to the program, reflecting that this is natural timing for pregnancy and parenthood, and foster an amiable environment that encourages early discussion for schedule planning. If trainees feel safe to disclose confidential conception planning, careful rotation scheduling can ameliorate many programmatic impacts.
- Support provision of parental leave for nonbirthing parents that will promote a cultural shift away from sex stereotypes associated with parenthood.
- Rearrange schedule assignments such that trainees' anticipated leave occurs during elective rotations without assigned call to minimize need for coverage. Small programs or those with multiple expecting trainees require creative solutions to fill schedule gaps.
- Be innovative with clinical responsibilities for new parents returning to work. As suggested by Oliveros et al. (1), consider opportunities for remote imaging or electrocardiographic interpretation and other flexible rotations (e.g., cardiac rehab supervision, outpatient specialty clinics). Faculty supervision of fellows during such arrangements may require creative use of faculty time.
- Assemble lactation resources for trainees from your institution's graduate medical education office.

Although there are multiple stakeholders and considerations involved when implementing and supporting a unified action plan for parental leave for our cardiology fellowship trainees, we have no doubt that program directors along with the American College of Cardiology can be strong voices in this overdue endeavor.

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REFERENCES

1. Oliveros E, Bai C, Rao A, Santos Volgman A. Pregnancy during cardiology training: we need a policy. J Am Coll Cardiol Case Rep 2019;1:221–4.

2. Sarma AA, Nkonde-Price C, Gulati M, et al. Cardiovascular medicine and society: the pregnant cardiologist. J Am Coll Cardiol 2017;69:92–101.

3. Mwakyanjala EJ, Cowart JB, Hayes SN, et al. Pregnancy and parenting during fellowship. J Am Heart Assoc 2019;8:e012137.

4. Vassallo P, Jeremiah J, Forman L, et al. Parental leave in graduate medical education: recommendations for reform. Am J Med 2019;132:385–9.

5. American Board of Internal Medicine. Policies and Procedures for Certification [PDF file]. June 2019. Available at: https://www.abim.org/~/media/ABIM%20Public/Files/pdf/publications/certification-guides/policies-and-procedures.pdf. Accessed June 20, 2019.

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