

Do U.S. Medical Schools Follow Medical Associations' Recommendations on Paid Parental Leave for Faculty?

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Abstract

Paid parental leave is strongly linked to better health and social outcomes for families. Yet, many U.S. employers fall short of the 8–12 weeks advocated by major medical organizations, including the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Medical Association. To assess how well academic medicine follows these standards, we reviewed parental leave policies across all allopathic medical schools in the United States. Our analysis focused on four elements: the presence of a specific parental leave policy versus reliance on the Family and Medical Leave Act, eligibility by parent type, whether compensation was provided, and the length of paid leave. Policy differences were further examined by institutional type, Carnegie classification, and geographic region. Of 156 schools, 134 (85.9%) had accessible data. Only 29 (21.6%) provided birthing faculty with at least 12 weeks of fully paid leave. Across all schools, birthing parents averaged 6.72 paid weeks (median = 6), while non-birthing parents averaged 5.82 weeks (median = 6). Private institutions ($P < 0.001$) and schools in the Northeast ($P < 0.001$) offered longer paid leave. Overall, more than three-quarters of schools did not meet the 12-week fully paid standard for birthing (78.4%) or non-birthing parents (84.3%). These findings suggest that the majority of parental leave policies in U.S. academic medicine remain out of step with recommendations from professional medical associations.

Keywords: Academic medicine, Parental leave policy, Faculty benefits, Maternity leave, Paternity leave, U.S. medical schools

Introduction

Reports from the Organisation for Economic Co-operation and Development and the World Bank indicate that the United States (U.S.) ranks lowest among high Human Development Index nations in terms of childcare support and paid parental leave [1, 2]. Unlike nearly all

other developed countries, the U.S. has no national requirement for paid leave after childbirth [3]. Within healthcare, and specifically at U.S. medical schools, parental leave provisions are particularly limited compared to benefits offered in other professional sectors [4]. One review found that the healthcare industry provides fewer weeks of paid leave than any other field, averaging just four weeks for both primary and secondary caregivers [5]. Although medical institutions routinely adopt recommendations from professional associations to shape clinical care, such alignment is rarely seen when it comes to employment policies like parental leave [6]. As with many U.S. employers, medical schools often provide benefits that diverge from the standards endorsed

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by major medical organizations [6, 7]. This study provides a comprehensive assessment of faculty parental leave policies across U.S. medical schools to track their progress toward meeting these recommendations. Professional bodies such as the American Academy of Pediatrics (AAP) and the American Medical Association (AMA) recommend 12 weeks of paid leave, emphasizing its role in supporting birthing parents' mental health and children's well-being, including consistent medical visits, timely vaccinations, and stronger caregiver-infant bonding [8, 9]. Similarly, in 2023, the American College of Obstetricians and Gynecologists (ACOG) advised at least 8 fully paid weeks, citing benefits ranging from lower infant mortality to improved maternal recovery and long-term workforce retention of women [10]. Yet, despite decades of advocacy, broad policy change remains limited. For instance, more than 25 years ago, four gastroenterology societies jointly called for a minimum of eight weeks of paid leave in their specialty; however, little substantive progress has been made since [11].

Benefits of paid parental leave

Extensive evidence demonstrates that paid leave enhances perinatal care and has lasting health effects for both parent and child [12]. Studies suggest that postpartum support should extend across 12 weeks to optimize outcomes [13–17]. More extended leave is linked with higher breastfeeding and vaccination rates, lower infant mortality, and decreased rates of postpartum depression [18–20]. Furthermore, when non-birthing parents have access to leave, they are more engaged in caregiving, which supports stronger child development and improved cognitive outcomes [21].

Study objective

This study provides the most extensive and up-to-date review of parental leave policies across U.S. allopathic medical schools. It evaluates the extent to which these policies conform to recommendations from professional medical associations and examines whether greater parity between birthing and non-birthing parent leave has been achieved. Prior research has been narrower in scope, focusing either on medical schools ranked by *U.S. News and World Report* ($n = 90$) or on institutions appearing on both NIH funding and *U.S. News* top-10 lists ($n = 12$) [22, 23]. Unlike those studies, the present analysis

integrates institutional policies with federal Family Medical Leave Act (FMLA) provisions and state-level family leave programs, offering a more comprehensive overview of what faculty parents in academic medicine can expect.

Materials and Methods

This study analyzed publicly available documents and therefore did not involve human subjects, so formal ethics approval was not required.

Data collection

In 2022, we compiled information on faculty parental leave policies from all U.S. allopathic medical schools by reviewing human resources and institutional websites. An initial review considered including osteopathic medical schools, but due to the scarcity of publicly accessible benefits data for the 43 osteopathic institutions, they were excluded. Consequently, the analysis focused exclusively on allopathic schools.

Parental leave provisions were extracted from a larger set of faculty benefits, which also included vacation, sick leave, and retirement options. Only policies covering full-time faculty employed directly by the medical school or university were evaluated. Benefits for clinical faculty affiliated with independent medical groups or separate corporations were not assessed. When policy details were unclear or incomplete, human resources staff were contacted for clarification. Data extraction was performed independently by two researchers (RL and HG), and any discrepancies in interpretation were resolved through discussion to produce a finalized dataset.

Policy assessment

Parental leave policies were systematically reviewed across several dimensions: (1) whether schools maintained standalone parental leave policies or relied on the Family Medical Leave Act, (2) eligibility and recipient categories, (3) whether leave was paid or unpaid, (4) the number of compensated weeks, (5) terminology used in policy documents, and (6) coverage for various paths to parenthood, including birth, adoption, and fostering. **Table 1** provides a detailed overview of variables, categories, and definitions used in the analysis.

Table 1. Reference table for policy analysis

Category	Variables	Definitions	Notes
Family and Medical Leave Act (FMLA)	FMLA as sole policy	Medical schools that only referenced FMLA without a distinct parental leave policy in their benefits package.	If the FMLA were the only parental leave policy, both parents would be recorded as receiving 12 weeks of unpaid leave.
	FMLA with additional policy	Medical schools that included both a specific parental leave policy and FMLA in their benefits package.	For schools using FMLA as part of their policy and located in states with mandatory paid parental leave laws (effective by 2022), the state-required paid leave duration was noted for both parents if no other data existed.
	FMLA with conditions	Medical schools with specific requirements for using FMLA for parental leave, such as mandating the use of vacation, sick days, or paid time off (PTO) during the leave.	
	FMLA with flexible options	Medical schools that permitted, but did not mandate, the use of PTO or sick leave for compensation during FMLA parental leave.	
Parental leave eligibility	Eligible parents	Medical schools provide leave to qualifying parents.	Schools relying solely on FMLA or lacking a clear parental leave policy were grouped, as both parents received minimal benefits beyond federal requirements.
Compensation	Paid parental leave	Parental leave that includes any form of compensation.	Schools using only FMLA were marked as ‘paid’ if located in a state with a Paid Family Leave law (effective by 2022) and ‘unpaid’ otherwise.
	Unpaid parental leave	Parental leave without any compensation.	
Method of family building	Birth	Medical schools offering parental leave for childbirth.	Schools relying solely on FMLA were assessed based on FMLA criteria, which treat birth, adoption, and foster placement equally.
	Adoption	Medical schools offering parental leave for child adoption.	
	Fostering	Medical schools offering parental leave for foster child placement.	

Family medical leave act (FMLA) and state-mandated paid family leave

The Family Medical Leave Act (FMLA), established in 1993, allows eligible U.S. employees to take up to 12 weeks of unpaid, job-protected leave to address personal or family health needs [24]. Qualifying events, as defined by the U.S. Department of Labor, include the birth of a child, adoption, or foster placement. To be eligible for FMLA, an employee must have worked at least 1,250 hours for their employer over the previous 12 months, and the employer must employ a minimum of 50 workers. When a medical school’s parental leave policy

aligns with FMLA provisions, additional policy features—such as those outlined in **Table 1**—were also examined.

At the time of this study, nine states and the District of Columbia mandated paid family leave (**Table 2**) [25–35]. Four more states are scheduled to implement similar laws in 2026, while two others provide optional paid leave through private insurance plans [36–41]. The scope and compensation of these programs differ by state. Most offer 12 weeks of parental leave with partial or complete wage replacement. Notable exceptions include Rhode Island, which provides six weeks, and California, which

offers up to eight weeks at a 60%–70% salary replacement rate [42].

Table 2. States with paid family leave laws

States with active paid family leave laws	States with approved paid family leave laws effective in 2026	States with voluntary paid family leave systems (via private insurance)
California	Delaware	New Hampshire*
Colorado	Maine	Vermont
Connecticut	Maryland	
District of Columbia	Minnesota	
Massachusetts		
New Jersey		
New York		
Oregon		
Rhode Island		
Washington		

*Enrollment begins December 1, 2024.

School characteristics

Medical schools were classified based on their Carnegie classification, governance type (public versus private), and the Association of American Medical Colleges (AAMC) regional designation to assess whether institutional characteristics influenced parental leave policies. Carnegie classifications included: R1 (very high research activity), R2 (high research activity), Special Focus Four-Year Research Institutions, and Special Focus Four-Year Medical Schools and Centers. Private institutions included both for-profit and not-for-profit schools. The four AAMC regions were Central, Northeast, South, and West.

Statistical analysis

Data were organized and cleaned in Microsoft Excel (Version 2306, Build 16.0.16625.42305) and analyzed using SAS version 9.4 (Cary, NC) and SPSS version 26 (Armonk, NY). Descriptive statistics were used to summarize outcomes. Pearson's chi-square tests examined differences in the availability of retrievable

parental leave policies across regions, school governance, and Carnegie classifications. One-way ANOVA was used to compare differences in paid leave duration across these categories. Partial eta-squared (η^2) was calculated to evaluate effect sizes, interpreted as small (0.01–0.05), medium (0.06–0.13), or large (≥ 0.14) [43].

Results and Discussion

Out of 156 US allopathic medical schools reviewed, 134 (85.9%) had accessible parental leave policies. Policies were distributed across AAMC regions as follows: Central (23.1%, 31/134), Northeast (26.9%, 36/134), South (34.3%, 46/134), and West (15.7%, 21/134). Chi-square analysis indicated no regional bias in policy availability ($P = 0.880$). Public schools accounted for 67.9% (91/134) of retrievable policies, significantly higher than private schools (32.1%, 43/134, $p = 0.001$), reflecting the greater number of public medical schools overall (62.6%, 97/155). Policies were more commonly obtained from R1 institutions (60.6%, 80/132) compared with other classifications ($\leq 18.2\%$, $\leq 24/132$), consistent with the fact that over half of all schools (53.3%, 80/150) are R1-affiliated.

Paid and unpaid parental leave

Among the 134 policies, the average paid leave for birthing parents was 6.72 weeks (median = 6), while non-birthing parents received 5.82 weeks (median = 6). Thirty-one percent (42/134) of schools offered at least 12 weeks of partially paid birthing leave, but only 21.6% (29/134) provided fully paid leave of 12 weeks. For non-birthing parents, 26.1% (35/134) of policies offered at least 12 weeks with partial pay, while 15.7% (21/134) provided fully paid 12-week leave.

Some schools supplemented paid leave with additional unpaid leave, available for 32.1% (43/134) of birthing parents and 29.1% (39/134) of non-birthing parents once paid leave was exhausted. **Table 3** details paid parental leave durations, and **Table 4** presents supplemental unpaid leave offerings at schools providing paid leave.

Table 3. Proportion of U.S. allopathic medical schools offering parental leave by duration in weeks

Allotment in weeks	Number of schools (% of 134)
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	Partially or fully paid birthing parent leave*	Unpaid birthing parent leave only	Partially or fully paid non-birthing parent leave*	Unpaid non-birthing parent leave only
0 weeks (No explicit parental leave; must use sick/vacation days or FMLA only)	–	–	–	4 (3.0%)
1–4 weeks	10 (7.5%)	0	16 (11.9%)	0
5–6 weeks	24 (17.9%)	1 (0.75%)	24 (17.9%)	1 (0.75%)
7–8 weeks	18 (13.4%)	0	16 (11.9%)	0
9–11 weeks	3 (2.2%)	0	1 (0.75%)	1 (0.75%)
≥ 12 weeks	42 (31.3%)	36 (26.9%)	35 (26.1%)	36 (26.9%)
Subtotal	97 (72.4%)	37 (27.6%)	92 (68.7%)	42 (31.3%)
Total	134 (100%)	134 (100%)		
Summary: Proportion of schools not meeting AMA and AAP recommendations for ≥ 12 weeks of fully paid parental leave				
	78.4% (105/134)	84.3% (113/134)		

*Paid leave includes any leave with full or partial compensation.

Table 4. Weeks of additional unpaid parental leave at us allopathic medical schools offering some paid parental leave

Allotment in weeks	Number (% of schools)	
	Additional unpaid birthing parent leave	Additional unpaid non-birthing parent leave
1–4 weeks	4 (3.0%)	2 (1.5%)
5–6 weeks	8 (23.5%)	9 (6.7%)
7–8 weeks	5 (3.7%)	5 (3.7%)
9–12 weeks	3 (2.2%)	1 (0.75%)
≥ 12 weeks	23 (17.2%)	22 (16.4%)
Total	97 (72.4%)	91 (67.9%)

Parental leave through FMLA and state paid family leave laws

In 59.0% of the medical schools examined (79/134), parental leave policies explicitly referenced the Family and Medical Leave Act (FMLA), providing details on how FMLA provisions were applied. A smaller group of institutions (18.7%; 25/134) relied solely on FMLA as their parental leave option, whereas others (40.3%; 54/134) offered separate parental leave policies that either complemented or ran concurrently with FMLA protections.

Although FMLA provides job-protected leave for eligible employees, institutions may implement additional conditions. Eight schools (6.0%; 8/134) required faculty to use accrued paid time off (PTO) or sick leave while on FMLA leave, whereas 45 schools

(33.6%) allowed but did not mandate the use of PTO to receive pay during leave.

Regarding state-mandated paid family leave, six states and the District of Columbia currently require at least 12 weeks of partially paid leave. Schools located in these jurisdictions remain a minority, with 43 of the 134 institutions (32.3%) situated in states offering state-level paid family leave, typically providing 60%–70% of an employee's wages. In California, which has 16 allopathic medical schools, parents are entitled to eight weeks of partially paid leave under the state program. Rhode Island, home to one medical school, offers up to six weeks of paid leave through its Temporary Caregiver Insurance program.

Policy terminology

The wording used to describe parental leave policies varied across schools. The most frequently used titles were “parental leave” (59 schools, 44.4%), “family leave” (23 schools, 17.3%), and “maternity leave” (12 schools, 9.0%). Additional terminology and their prevalence are summarized in **Table 5**.

Table 5. Parental leave policy terminology

Designation	Number of schools N (%)
Parental leave	59 (44.03%)
Family leave	23 (17.16%)
Maternity leave	12 (8.96%)
Childbearing leave	6 (4.48%)
Childrearing leave	3 (2.24%)
Primary caregiver leave	3 (2.24%)

Childbirth leave	2 (1.50%)
Child bonding leave	2 (1.50%)
Child care leave	2 (1.50%)
Baby bonding time	1 (0.75%)
Caregiving leave	1 (0.75%)
Parental workload relief plan	1 (0.75%)

Birthing vs. adoption vs. fostering

Among the 134 parental leave policies, 87 (64.9%) explicitly indicated that leave entitlements were the same for the birth of a biological child and for adoption or fostering. For the 26 policies that specified differences,

the most frequent distinction was additional leave granted to the birthing parent ($n = 17$).

Paid birthing parent leave by school characteristics

Private medical schools provided significantly longer paid leave for birthing parents compared with public schools ($P < 0.001$; $\eta^2 = 0.141$, indicating a large effect) (**Figure 1**). Regionally, Northeast schools offered an average of 9.5 weeks of paid birthing leave, whereas Southern schools offered only 3.9 weeks on average ($P < 0.001$; $\eta^2 = 0.182$, large effect) (**Figure 1**). No statistically significant differences were observed in paid leave duration across Carnegie classification groups ($P=0.287$).

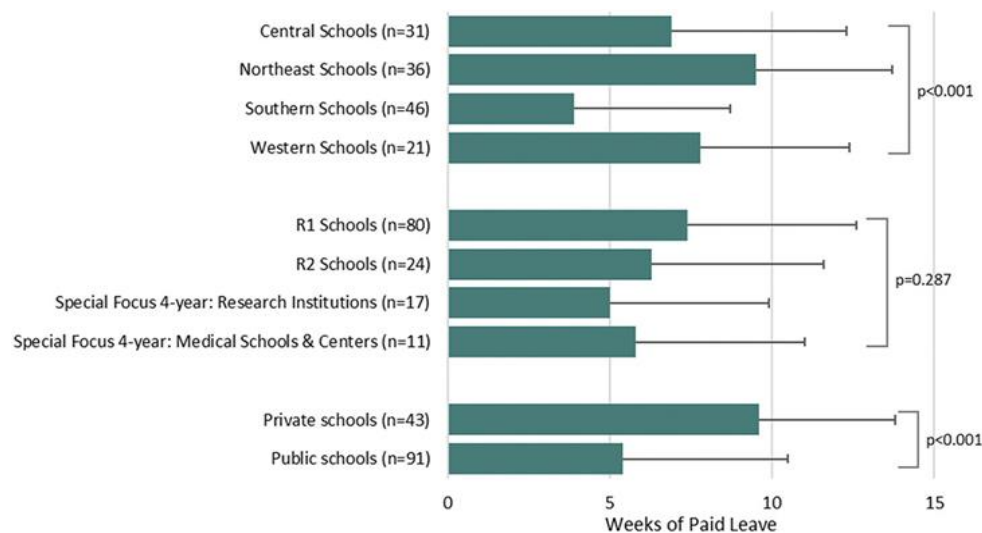


Figure 1. Mean weeks of paid birthing parent leave by school characteristics; the four Carnegie classifications sum to 132 instead of 134. One excluded school was classified as ‘doctoral/professional,’ and the second excluded school was not discoverable in the Carnegie database

This study provides a comprehensive overview of faculty parental leave policies across U.S. allopathic medical schools and evaluates the extent to which these policies meet recommendations from medical associations. The findings reveal that over three-quarters of schools do not provide 12 weeks of fully paid leave for either birthing or non-birthing parents, indicating widespread misalignment with current guidelines. Nearly one in five schools relied exclusively on FMLA, offering only unpaid leave to eligible faculty. About 65% of policies treated all family-building methods—birth, adoption, fostering, or surrogacy—equally. Institutions classified as private and those located in the Northeast offered more extended periods of paid birthing parent leave.

Limited alignment with medical association guidelines

Three significant U.S. medical associations—the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), and the American Academy of Pediatrics (AAP)—recommend 8–12 weeks of paid parental leave to support the health and well-being of parents and children [9, 10, 44, 45]. Despite these recommendations, 41% (55/97) of medical school policies offered birthing parents fewer than 12 weeks of leave with either partial or complete pay, and an additional 28% (37/134) provided unpaid leave. On average, schools offered 6.72 weeks of paid leave for birthing parents and 5.82 weeks for non-birthing parents, roughly half of the 12 weeks recommended by the AMA and AAP. Only 21.6% of

schools (29/134) provided 12 weeks of fully paid leave for parents who are birthing. The American Psychological Association notes that insufficient paid leave can result in shortened leave durations, increased depressive symptoms, interrupted breastfeeding, and financial strain for faculty [44].

Use of FMLA in medical schools

While state-level paid family leave policies establish minimum requirements, 18.7% of schools (25/134) relied solely on the FMLA, which provides 12 weeks of unpaid leave for employees who have worked at least one year (or 1,250 hours). Research has demonstrated that paid leave reduces adverse outcomes: a 2018 study reported a 47% decrease in infant re-hospitalizations and a 51% reduction in parental re-hospitalizations in the first year postpartum compared with unpaid leave or no leave [46]. These benefits are attributed to timely medical care, on-schedule vaccinations, and improved parental mental health [46, 47].

Additionally, eight schools required faculty to exhaust all accrued vacation, PTO, and sick leave during FMLA leave, limiting flexibility for new parents and reducing their available time for personal or child-related needs after returning to work. By relying solely on federal or state frameworks rather than developing institution-specific parental leave benefits, some schools may miss an opportunity to foster a culture of wellness that acknowledges faculty health as integral to overall institutional well-being.

Parental leave disparities

Ensuring equitable parental leave between female and male faculty has important implications for both workforce equality and the health of the birthing parent and child [48]. In academic medicine, insufficient parental leave is associated with increased career dissatisfaction, higher burnout rates, and lower retention among female faculty members [49, 50]. Women frequently shoulder a larger share of domestic and childcare responsibilities than their male counterparts, even when professional obligations are equivalent or greater [51–53]. Equal parental leave for birthing and non-birthing parents encourages greater involvement of male faculty in childcare. It ensures fair access to benefits for families formed through adoption, fostering, or surrogacy [54, 55].

Providing fair and paid parental leave may also help narrow the gender pay gap. Despite gains in female

faculty representation at U.S. medical schools over the past two decades, women continue to experience lower retention, slower career advancement, and reduced compensation compared to their male colleagues [56, 57]. A major contributing factor is that women are more likely to take time off for childcare [58]. Offering adequate paid leave to both birthing and non-birthing parents, protected from penalties, could reduce these disparities [14]. Research shows that up to 86% of non-birthing parents limit or forgo leave when it is unpaid, while birthing parents require leave for physical recovery [59]. Consequently, female faculty may be compelled to take unpaid leave, reducing income, whereas male faculty continue working, maintaining wages and potentially gaining leadership opportunities [50]. Longer paid leave for non-birthing parents has been shown to increase male involvement in childcare and household duties during and after leave, while positively affecting female workforce participation and earnings [21]. While nearly all medical school employers (96.3%) provided some parental leave for both birthing and non-birthing parents, only 31.3% offered unpaid non-birthing parent leave, and 3% (4/134) lacked a clear policy beyond FMLA.

Inclusivity across family-building methods

Most parental leave policies (65%; 87/134) explicitly stated that leave duration did not differ by method of family building. However, this is mainly attributable to schools relying on FMLA. Recognizing alternative family-building pathways is particularly important for female physicians, who face infertility rates up to 25%, double that of the general population [60], and typically delay childbearing by seven years [61]. Factors such as stress, sleep deprivation, poor diet, and limited exercise may further contribute to fertility challenges and increased pregnancy risks among female physicians [62]. To promote inclusivity, many policies used gender-neutral terminology, with “parental leave” (44.4%; 59/134) and “family leave” (17.3%; 23/134) being most common, while only 9% of schools used “maternity leave.” Careful attention to language helps ensure that parental leave policies are accessible and welcoming to all types of families.

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References

1. Livingston G, Thomas D. Among 41 countries, only U.S. lacks paid parental leave. Pew Research Center. 2019 Dec 16. Available from: <https://www.pewresearch.org/short-reads/2019/12/16/u-s-lacks-mandated-paid-parental-leave/>
2. United Nations Development Programme. Human development index. Human Development Reports — Data Center. 2024. Available from: <https://hdr.undp.org/data-center/human-development-index#/indicies/HDI>
3. Watson J. Countries with paid maternity leave: how the U.S. compares. Justworks. 2023. Available from: <https://www.justworks.com/blog/countries-with-paid-maternity-leave#parental-leave-and-paternity-leave>
4. Kaufman G, Petts RJ. Gendered parental leave policies among Fortune 500 companies. Community Work Fam. 2022;25(5):603–10.
5. JUST Capital. Only 9% of America’s largest companies provide parity in paid parental leave of 12+ weeks for primary and secondary caregivers. JUST Capital report. 2023. Available from: <https://justcapital.com/reports/only-9-percent-of-largest-us-companies-offer-at-least-12-weeks-of-paid-parental-leave-parity/>
6. Kraus MB, Khan A, Strand N, Mukkamala SG, McMullen KB, Sharperson CM, et al. Parental leave

- policies in the top 20 U.S. hospitals: a call for inclusivity and improvement. *Womens Health Rep* (New Rochelle). 2023;4(1):162-8.
7. Burtle A, Bezruchka S. Population health and paid parental leave: what the United States can learn from two decades of research. *Healthcare* (Basel). 2016;4(2):30.
 8. Dodson NA, Talib HJ. Paid parental leave for mothers and fathers can improve physician wellness. *AAP News*. 2020 Jul 1. Available from: <https://publications.aap.org/aapnews/news/12432?autologincheck=redirected>
 9. American Medical Association. PolicyFinder — family leave / parental leave policy statements. AMA PolicyFinder. Available from: <https://policysearch.ama-assn.org/policyfinder/detail/family%20leave?url=%2FAMADoc%2FHOD.xml-0-3580.xml>
 10. The American College of Obstetricians and Gynecologists (ACOG). Paid parental leave — Statement of Policy. 2020. Available from: <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/paid-parental-leave#:~:text=Paid%20parental%20leave%20for%20at>
 11. Feld LD, Oxentenko AS, Sears D, Charabaty A, Rabinowitz LG, Silver JK. Parental leave and return-to-work policies: a practical model for implementation in gastroenterology. *Gastroenterology*. 2023;165(4):813–8.
 12. Aitken Z, Garrett CC, Hewitt B, Keogh L, Hocking JS, Kavanagh A, et al. The maternal health outcomes of paid maternity leave: a systematic review. *Soc Sci Med*. 2015;130:32–41.
 13. Ruhm CJ. Parental leave and child health. *J Health Econ*. 2000;19(6):931-60.
 14. Berger LM, Hill J, Waldfogel J. Maternity leave, early maternal employment and child health and development in the U.S. *Econ J*. 2005;115(501):F29–47.
 15. Gault B, Hartmann H, Hegewisch A, Milli J, Reichlin L. Paid parental leave in the United States: what the data tell us about access, usage, and economic and health benefits. Institute for Women's Policy Research (IWPR) report. 2014.
 16. Rossin M. The effects of maternity leave on children's birth and infant health outcomes in the United States. *J Health Econ*. 2011;30(2):221–39.
 17. The American College of Obstetricians and Gynecologists. Optimizing postpartum care — Committee Opinion (ACOG). [cited 2018 May]. Available from: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care>
 18. Perry MF, Trasatti E, Yee LM, Feinglass JM. State paid family and medical leave and postpartum outcomes. *Am J Obstet Gynecol*. 2023;228(1):S39–40.
 19. Mandal B. The effect of paid leave on maternal mental health. *Matern Child Health J*. 2018;22(10):1470–6.
 20. Van Niel MS, Bhatia R, Riano NS, de Faria L, Catapano-Friedman L, Ravven S, et al. The impact of paid maternity leave on the mental and physical health of mothers and children: a review of the literature and policy implications. *Harv Rev Psychiatry*. 2020;28(2):113-26. doi:10.1097/HRP.0000000000000246
 21. U.S. Department of Labor. DOL policy brief — Paternity leave: Why parental leave for fathers is so important for working families. United States Department of Labor.
 22. Slostad J, Jain S, McKinnon M, Chokkara S, Laiteerapong N. Evaluation of faculty parental leave policies at medical schools ranked by US news & world report in 2020. *JAMA Netw Open*. 2023;6(1):e2250954. doi:10.1001/jamanetworkopen.2022.50954
 23. Riano NS, Linos E, Accurso EC, Sung D, Linos E, Simard JF, et al. Paid family and childbearing leave policies at top US medical schools. *JAMA*. 2018;319(6):611-4. doi:10.1001/jama.2017.19519
 24. U.S. Department of Labor, Wage and Hour Division. Family and Medical Leave Act (FMLA). U.S. Dept. of Labor. Available from: <https://www.dol.gov/agencies/whd/fmla>
 25. California Employment Development Department. Helping Californians be there for the moments that matter. Sacramento (CA): California Employment Development Department; 2022. Available from:

- https://edd.ca.gov/siteassets/files/pdf_pub_ctr/de8520.pdf
26. Connecticut General Assembly. Employment regulation. Conn Gen Stat. 2014. Available from: https://www.cga.ct.gov/current/pub/chap_557.htm#sec_31-49e
 27. Commonwealth of Massachusetts. An act relative to minimum wage, paid family medical leave and the sales tax holiday. Session Laws — Acts of 2018, chapter 121. Boston (MA): Commonwealth of Massachusetts; 2018 Jun 28. Available from: <https://malegislature.gov/Laws/SessionLaws/Acts/2018/Chapter121>
 28. State of New Jersey. The New Jersey Family Leave Act. 2020 Apr 15. Available from: <https://www.nj.gov/oag/dcr/downloads/Family-Leave-Act.pdf>
 29. New York State. Paid Family Leave. Albany (NY): State of New York; 2018. Available from: <https://paidfamilyleave.ny.gov/>
 30. State of Rhode Island. Labor and labor relations — R.I. Gen. Laws. 2014. Available from: <http://webserver.rilin.state.ri.us/Statutes/TITLE28/28-41/28-41-35.HTM>
 31. Virginia General Assembly. Paid Family and Medical Leave program — SB1101 summary. Richmond (VA): Virginia Legislature; 2023. Available from: <https://lis.virginia.gov/cgi-bin/legp604.exe?231+sum+SB1101>
 32. Washington State Department of Labor & Industries. Paid Family & Medical Leave. Olympia (WA): WA Dept of Labor & Industries; 2018 Jan 1. Available from: <https://www.lni.wa.gov/workers-rights/leave/paid-family-and-medical-leave#:~:text=Paid%20Family%20%26%20Medical%20Leave>
 33. District of Columbia, Department of Employment Services. DC Paid Family Leave. Washington (DC): DOES. [cited 2020 Jul 1]. Available from: <https://does.dc.gov/page/dc-paid-family-leave#:~:text=As%20of%20October%201%2C%202022>
 34. Oregon Paid Leave Authority. Paid Leave Oregon. Salem (OR): Oregon Paid Leave Authority. Available from: <https://paidleave.oregon.gov/>
 35. State of Colorado. Family and Medical Leave Insurance (FAMLI). Denver (CO): Colorado Department of Labor & Employment. Available from: <https://famli.colorado.gov/>
 36. State of Minnesota. Minnesota Paid Leave. Saint Paul (MN): Minnesota Department of Labor & Industry; 2024. Available from: <https://paidleave.mn.gov/>
 37. Delaware Department of Labor. Delaware Paid Leave Is Coming. Dover (DE): Delaware Dept of Labor. Available from: <https://labor.delaware.gov/delaware-paid-leave-is-coming/>
 38. Maryland Department of Labor. Paid Family and Medical Leave. Baltimore (MD): Maryland Dept of Labor; 2024. Available from: <https://paidleave.maryland.gov/Pages/default.aspx>
 39. Maine Department of Labor. Paid Family and Medical Leave. Augusta (ME): Maine Dept of Labor; 2023. Available from: <https://www.maine.gov/paidleave/>
 40. State of New Hampshire. Paid Family Medical Leave. Concord (NH): New Hampshire state website. Available from: <https://www.paidfamilymedicalleave.nh.gov/>
 41. Office of the Governor — Vermont (Phil Scott). Vermont Family and Medical Leave Plan. Montpelier (VT): Office of the Governor; 2024. Available from: <https://governor.vermont.gov/vtfmli>
 42. Bipartisan Policy Center. State paid family leave laws across the U.S. Washington (DC): Bipartisan Policy Center; [cited 2022 Jan 13]. Available from: <https://bipartisanpolicy.org/explainer/state-paid-family-leave-laws-across-the-u-s/>
 43. Lakens D. Calculating and reporting effect sizes to facilitate cumulative science: a practical primer for t-tests and ANOVAs. *Front Psychol.* 2013;4:863.
 44. Abrams Z. The urgent necessity for paid parental leave. *Monitor on Psychology.* [cited 2022 Apr 1]. Available from: <https://www.apa.org/monitor/2022/04/feature-parental-leave>
 45. D'Arrigo T. Paid maternity leave improves health, mental health for both mothers and infants. *Psychiatric News.* 2020;55(13).
 46. Jou J, Kozhimannil KB, Abraham JM, Blewett LA, McGovern PM. Paid Maternity Leave in the United States: Associations with Maternal and Infant Health. *Matern Child Health J.* 2018;22(2):216-25. doi:10.1007/s10995-017-2393-x

47. Roy Choudhury A, Polachek SW. The impact of paid family leave on the timely vaccination of infants. *Vaccine*. 2021;39(21):2886-93.
48. Almqvist AL, Duvander ÅZ. Changes in gender equality? Swedish fathers' parental leave, division of childcare and housework. *J Fam Stud*. 2014;20(1):19–27.
49. Dandar VM, Grigsby RK, Bunton SA. Burnout among U.S. medical school faculty. Association of American Medical Colleges (AAMC). 2019;19(1):1. Available from: <https://www.aamc.org/media/9921/download?attachment>
50. Rupp NG, Zeager LA. Paid parental leave and female faculty retention. *East Econ J*. 2017;44(3):475-88.
51. Matulevicius SA, Kho KA, Reisch J, Yin H. Academic medicine faculty perceptions of work-life balance before and since the COVID-19 Pandemic. *JAMA Netw Open*. 2021;4(6):e2113539. doi:10.1001/jamanetworkopen.2021.13539
52. Spector ND, Overholser B. COVID-19 and the slide backward for women in academic medicine. *JAMA Netw Open*. 2020;3(9):e2021061.
53. Lufler RS, McNulty MA. The glass ceiling thickens: the impact of COVID-19 on academic medicine faculty in the United States. *Med Educ Online*. 2022;27(1):2058314.
54. Misra J, Strader E. Gender pay equity in advanced countries: the role of parenthood and policies. *J Int Aff*. 2013;67(1):27–41.
55. Cabeza MF, Johnson JB, Tyner LJ. Glass ceiling and maternity leave as important contributors to the gender wage gap. *South J Bus Ethics*. 2011;3:73.
56. Bennett CL, Salinas RY, Locascio JJ, Boyer EW. Two decades of little change: an analysis of U.S. medical school basic science faculty by sex, race/ethnicity, and academic rank. *PLoS One*. 2020;15(7):e0235190. doi:10.1371/journal.pone.0235190
57. Carr PL, Raj A, Kaplan SE, Terrin N, Breeze JL, Freund KM. Gender differences in academic medicine: retention, rank, and leadership comparisons from the national faculty survey. *Acad Med*. 2018;93(11):1694-9. doi:10.1097/ACM.0000000000002146
58. Freund KM, Raj A, Kaplan SE, Terrin N, Breeze JL, Urech TH, et al. Inequities in academic compensation by gender: a follow-up to the national faculty survey cohort study. *Acad Med*. 2016;91(8):1068-73. doi:10.1097/ACM.0000000000001250
59. Harrington B, Van Deusen F, Fraone JS, Eddy S, Haas L. The New Dad: Take Your Leave — perspectives on paternity leave from fathers, leading organizations, and global policies. Boston (MA): Boston College Center for Work & Family; 2014. Available from: https://www.bc.edu/content/dam/files/centers/cwf/research/publications3/researchreports/The%20New%20Dad%202014_Take%20Your%20Leave
60. Stentz NC, Griffith KA, Perkins E, Jones RD, Jagsi R. Fertility and childbearing among American female physicians. *J Womens Health (Larchmt)*. 2016;25(10):1059-65. doi:10.1089/jwh.2015.5638
61. Armijo PR, Flores L, Huynh L, Strong S, Mukkamala S, Shillcutt S. Fertility and reproductive health in women physicians. *J Womens Health (Larchmt)*. 2021;30(12):1713-9. doi:10.1089/jwh.2020.8671
62. ASH Clinical News. Female physicians face higher rates of infertility and pregnancy complications. ASH Clinical News. 2021 Nov 24. Available from: <https://ashpublications.org/ashclinicalnews/news/1426/Female-Physicians-Face-Higher-Rates-of-Infertility>