CHAPTER 6

FAMILY AND FLEXIBILITY ISSUES

Progress and Continuing Dilemmas

It is beyond the scope of this chapter to dissect the many cross-currents within Western culture regarding parenting, careers and traditional gender roles. This brief overview focuses on those currents and resources likely to be of greatest interest to academic physicians, beginning with a few recent books. In *Mother Guilt: How Our Culture Blames Mothers for What's Wrong with Society*, Eyer brings an historical perspective to bear on the pressures women experience to be the "perfect mom," debunking the possibility of achieving Supermom status. In *The Way We Never Were: American Families and the Nostalgia Trap*, Coontz reveals the extent to which most U.S. institutions are "still organized around the 1950s myth that every household has a full-time mother at home"(Coontz). Some authors reveal the desperate humor of this doublebind, e.g., *The Working Mother's Guilt Guide: Whatever You're Doing, It Isn't Enough* (Hickey and Salmans).

A new study sponsored by the Whirlpool Foundation refreshingly concluded that "it is time to end the debate about whether women who work outside the home undermine their families" (Mann). A representative sample of 1500 men and women across the country were interviewed; the main finding is that more than half of the women provide 50% or more of their household income, and most women see economic activities as part of their nurturing of their families. Also of interest is that one-third of the women and 28% of the men said they would prefer to work less than full time. The investigators recommend "replacing the debate [about whether working women undermine their families] with a realistic commitment to finding ways in which communities, employers and society in general can help men and women manage all their responsibilities effectively."

One study of how women solve work/family dilemmas found that though women with children face a number of similar dilemmas, they evidence a large range of motives, aspirations and choices (Gerson). One of the many provocative questions asked by this investigator is: "If each gender displays such a variety of orientations toward work and parenthood, why is the sexual division of parenting tasks that assigns emotional duties to women and economic duties to men so persistent?". Barnett and Rivers' study of 300 dual-career couples also demonstrated that stereotypes about women's and men's parenting roles and about what makes for happy families are misleading (Barnett and Rivers).

Compared to even ten years ago, work/family dilemmas and solutions are now much more openly discussed (Bravo; Weisberg and Buckler), and many more companies now allow job-share arrangements and greater temporal flexibility. Moreover, resources are now available to help organizations improve their culture to better support their employees' "life balance" (Kofodimos; O'Neil). However, according to the business leaders, economists and family experts who participated in a two-day conference sponsored by the Public Policy Institute at Radcliffe College, corporate and public policies have not done nearly enough to ease the work-family dilemma. The Public Policy Institute's New Economic Equation project conducted focus groups around the country with men and women on all rungs of the socio-economic ladder. Paula Rayman, the Institute's director, concluded that family-friendly policies too often remain fringe benefits that anxious employees feel too insecure to exercise (Babco).

The round-the-clock nature of patient care and the extended training period mean that medicine presents extra challenges in terms of combining family and career, and both men and women suffer under pressures that prevent

meaningful integration of their personal and professional lives. Even though child- and elder-care are not gender-specific, very few men have come forward as spokespersons on behalf of improvements here. Women are the ones decrying the paucity of less-than-full-time options during residency, fellowship and research training and the structural inflexibilities in faculty promotion and tenure policies. All of these solvable inflexibilities contribute to women's "brain drain" because at critical junctures they must choose between family and career with little hope of regaining the "academic track" (AAMC).

Support is growing for men to take paternity and family leave and "to drive a kid to soccer practice." Ironically, though, women who admit to leaving early for family reasons are still likely to be frowned upon and accused of being "unfocused" and "uncommitted." No matter how well they "juggle the candles burning at the end of each tentacle," some women physicians report that they "always seem to be in the wrong place at the wrong time." One physician describes herself and peers who also have small children as follows: "we sew Halloween costumes at midnight, worry frequently about what we are missing at home and at work, and can't recall a single thing we've done for ourselves lately" (personal communication from Mary Lou Schmidt, M.D.) .

In a 1995 workshop on "Setting Priorities: Balancing an Academic Career and Family Life" at the *University of Texas-Houston Health Sciences Center*, participants considered questions about balance and the importance of networks and self-care. Many participants admitted that their husbands' support was contingent on their pursuits not interfering with domestic responsibilities. Participants also realized that, rather than each woman trying to solve the balance problem on her own, they should work toward institutional solutions. But until understood as benefitting both men and women, such innovations will continue to be a "women's" issue.

Approximately 85% of women physicians marry professionals, 50% of whom are physicians (Tesch, et al.). About 60% of women *academic* physicians marry other physicians; a highly visible physician-couple conclude that "the old way of demanding single-minded dedication to medicine needs to be recast because it depended on a full-time backup for the rest of life's activities" (Fletcher and Fletcher). A recent large study of married Southern California physicians with children found that 87% of the women and 62% of men experience at least moderate levels of role conflict between family and career (Warde, et al.). Younger male physicians (49%) were nearly twice as likely as their older peers (28%) to have ever made a career change for marriage (e.g., a decrease in work hours). Nonetheless, many women physicians who are married to busy professionals acknowledge that, while they have their partner's verbal support of their careers, they need more help with managing domestic responsibilities. Women physicians have held themselves individually responsible for all the struggles involved, describing themselves as lacking sufficient commitment or seriousness to be a successful academic rather than working toward departmental and institutional improvements.

There are no easy answers in facilitating balance for physicians. In her rich book *Medicine and the Family: A Feminist Perspective*, Candib writes that, as medical director of a health center, "I found myself pitted against women with children. . .and official apologist for a sexist system. . .I used my entrenched skill at denial not to hear what my women partners and residents were trying to tell me--that full-time was too much. . .Caught by their feelings of responsibility toward each other and by their commitment to their patients, my colleagues persevered through years of insulting insinuations that because they had families they were unwilling to work hard enough. . .But a stiff upper lip is the solution neither to overwork and fatigue nor to the complexity of multiple commitments"

(Candib).

Now that many locales have an adequate supply of qualified health care providers, one might think that physicians will find it easier to combine other responsibilities and interests with their professional roles. As former president of the Association of Women Surgeons, Kim Ephgrave concludes: “People who are able to maintain a reasonable balance in their lives are more likely to maintain both their enthusiasm for their work and their self-respect better than those who risk burnout by sacrificing all else for rapid professional advancement” (Ephgrave).

Medical Students

Beginning with interviews to medical school, family-related issues take a greater toll on women than men, since some interviewers grill women applicants on their family plans with questions that make it clear there are no "right" answers (Ciesielski). Appendix 6A contains some answers to hard and common questions that medical students ask about being a parent in medicine, including how to respond to program directors’ questions about childbearing plans (Bickel).

It is impossible to know how many women have children during medical school. Of the students completing AAMC’s Matriculating Student Questionnaire in 1993, 13% of the women and 15% of the men were married; 94% of the women and 93% of the men reported no dependents (excluding their spouses). Of the 1994 Medical School Graduation Questionnaire respondents, 30% of the women and 34% of the men were married; 89% of the women and 84% of the men reported no dependents (excluding their spouses) (Bickel and Ruffin). While 11% of the women graduating from medical school does not sound substantial, that represents about 650 women seniors nationally; probably most of these dependents are children, and probably most of these women are the primary care-takers.

An assessment of the hopes and concerns of first-year medical students at *Oregon* found that family issues topped the list of concerns for both women and men, almost one third of all concerns expressed fell under this category of the effect medicine will have on marriage, children and other personal relationships (Fields and Toffler). Women and increasing numbers of men medical students eagerly question student affairs officers and physicians whom they admire and feel comfortable with about when is the best time to start a family and how to manage inevitable conflicts between family and medical responsibilities. The advice from those who know is that successfully combining parenting with medicine takes a lot of planning and a substantial support network. It may be helpful to complete a worksheet (based on the experience of physician-mothers) that encourages a self-assessment of available support relationships in the home and educational or work environments (Bernstein).

In 1992, *Case Western Reserve University School of Medicine* established an ad hoc committee to address the need for flexibility in the curriculum as it pertains to the unique needs of medical students (Bickel and Quinnie). The committee recommended several ways in which to allow for maximum flexibility without jeapardizing educational goals: information about the challenges of balancing personal and educational responsibilities should be made available to all students; faculty should recognize and avoid biases in evaluating those students seeking flexibility; and each department should prepare a written decelerated curriculum to allow for uniformity and clarity in implemention. The committee also suggested a revision of student leave policies to include flexible options such as extended clerkships (allowing for 50% more time) with an educationally equivalent workload, short leaves between clerkships, or an opportunity to take certain core clerkships in the fourth year.

Student leave policies at medical schools tend to allow two categories: short periods of one month to one semester, or longer periods of

one to two years. Student absences almost always require the dean's approval; however, at some institutions course directors may approve absences of 30 days or less. Leave may be granted for personal, medical, educational, or family reasons. Personal leave might be granted to a student reconsidering medicine as a career choice, but most institutions have strict guidelines about when and how students might choose this option and require students to provide a detailed justification for such. In most instances, medical leave is granted for mental or physical illness or conditions which interfere with medical school. Students returning from medical leave are usually required to present to their dean's office evidence of health clearance from the student health service. Educational leave may be granted to students pursuing research or other degree programs. Family leave is normally granted in two circumstances, for maternity or paternity responsibilities or for the death or serious illness of an immediate family member.

Residents

The largest recent study of residents found that 29% of women residents experienced at least one pregnancy during residency; 8% voluntarily terminated the pregnancy, but 78% of pregnancies resulted in live births (Klebanoff, et al.). This study found that in spite of the women residents' long hours, they were not at a significantly increased risk of spontaneous abortion compared to wives of male residents. A slightly earlier study similarly found that despite sleep deprivation and increased stress, female residents were as likely to give birth to a live, full-term newborn as the spouses of male residents (Osborn, et al.).

Baldwin and colleagues recently completed the first national examination of withdrawal and extended leave during residency training (Baldwin, et al.). During 1991-92, 2,449 residents (2.7% of 87,368) withdrew or were dismissed and 887 (1%) took extended leave. Specialty and program changes accounted for (1377) 56% of withdrawals, but 183 cited "family concerns" as the main reason. Maternity or paternity leave was involved in 32% of extended leaves, with research sabbatical (11%) the next most frequent reason. Women had higher rates of both withdrawal and extended leave than men. The authors conclude that further accommodations for childbearing and child care during residency training need to be devised.

In 1994, AAMC sent a 20-item survey to 405 AAMC Council on Teaching Hospitals and Health Systems members; 45% responded (Philibert and Bickel). A total of 77% of the respondents reported having written policies for maternity and/or parental leave. This proportion is substantial improvement from 1989 when 52% of COTH hospitals reported having policies. Forty-one percent of the 1994 responding hospitals offered dedicated paid maternity leave, with a mean of 42 days allowed. Twenty-five percent of the respondents provide paternity leave, and 15% adoption leave. While it is encouraging that the majority of the teaching hospitals have now adopted written policies, the 23% without written policies remain a source of concern. Most hospitals were not able to report how much leave was actually taken by residents, but anecdotal information suggests that few residents take the maximum days allowed by the policy.

Some more specific information is available about family medicine residents' use of maternity leave and their experience with childbearing during residency. Program directors from each of the 394 family practice residency programs listed in the 1993 Directory of Family Practice Residency Programs were asked to distribute surveys to residents who gave birth during their residency training and had returned to work. Of 199 known eligible residents, 171 (86%) completed surveys; these women represented 127 programs located in 36 states. Only 57% were aware of their program having a written maternity leave policy. The

average length of maternity leave was 8 weeks; 75% had leaves of 10 weeks or less. For many, the maternity leave was derived from multiple sources, including vacation, sick time, or a mother-child elective. Nearly all (88%) the women breast-fed and the mean duration of breast-feeding was 19 weeks. Problems frequently encountered after their return to work were sleep deprivation, difficulty arranging for child care, guilt about child care, and breast-feeding (Gjerdingen).

The Family Medical Leave Act of 1993 (FMLA) applies to most residents. The FMLA requires employers having fifty or more workers to grant up to 12 weeks of unpaid leave each year to new fathers and mothers (including adoptive parents) who have worked for at least one year. The same amount of leave is permitted for employees to seek medical care themselves or to care for a spouse, child or parent with a serious health condition. Guides to interpreting the FMLA have become available, e.g., from the Women's Legal Defense Fund (see "Resources" below).

A pediatrics program director mailed a two-page questionnaire to all 214 accredited residency programs in pediatrics to learn what impact the FMLA was having on these programs (Bradford). The author reported that most responding programs were "insensitive to family issues as evidenced by a lack of adoption, paternity, or liberal childbirth policies." In addition, he noted that "subliminal pressure on housestaff to perform and not disrupt colleagues often leads to shorter leaves than programs permit." This survey also showed that the majority of program directors did not notify their residents of the Act's provisions despite the federal requirement to do so, and most did not anticipate its utilization.

For a number of years more than half of the *University of California - San Francisco* pediatric residents have been women; many have children during their training. The program discourages childbearing during the first year of residency; but residents planning to have children during their second or third years may work 8 rather than 12 months each year and extend their residency by one year (i.e., residents may train for 24 months over three rather than two years). Several residents have selected this approach; however, it has not been as popular as was anticipated (personal communication from Diane Wara, M.D.).

With regard to shared residency positions, the only source of data is the American Medical Association. In 1994 there were 7,509 residency programs in the U.S.; of which 1062 (or 14%) offered part-time/shared positions. Of the 97,832 residents, 292 residents (or 0.29%) were in such a position. Of these 292, 40% were men. The residency areas with the largest numbers of part-time residents are pediatrics followed by psychiatry, internal medicine and family medicine. There are many reasons why such a small number of residents are part-time, e.g., difficulty in finding a person with whom to share a position, worries over compromising training quality, educational debts.

Other developments of interest to residents include:

• Specific provisions for parental leave and unpaid leave are now available to trainees and fellows supported by the NIH National Research Services Awards. Specifically, trainees/fellows may continue to receive stipends for up to 30 days of parental leave per year for the adoption or the birth of a child when those in comparable training positions at the grantee or sponsoring institution have access to paid leave for this purpose *(NIH Guide for Grants and Contracts*, Volume 22, #38, October 22, 1993.)

• The *American College of Gastroenterology* approved a position paper which consists of seven specific guidelines, including that parental leave of six weeks should be allowed with pay and all benefits (Riely).

• The *American Board of Surgery* has changed the rules regarding time off during residency. In order to complete a year of residency, previously residents had to finish 48 weeks in a given year. Now, the rules allow an accumulation of an *average* of 48 weeks per

year. A total of 144 weeks are required during the three junior years, and 96 weeks are required during the two chief/senior years.

• The *American College of Surgeons* published a statement on "Surgical Residencies and the Educational Environment" (*Bulletin of the American College of Surgeons*, 79:89-93, 1994) which includes recommendations in four areas: 1) that maternal, parental, and personal leave policies should be specified at the beginning of the resident's employment; 2) that institutions should be encouraged to provide adequate day-care services; 3) that sexual harassment policies should be consistent with institutional policies and the law, and should be strictly enforced; and 4) that support services should be adequate enough to avoid overburdening residents with non-educational activities.

Finally, it is of interest here that some the ethical issues that childbearing raises during training have received attention in a case study in *Hastings Center Report:* Jane becomes pregnant while completing a fellowship in high-risk obstetrics and misses four weeks of work due to complications in her third trimester. In addition to the six weeks maternity leave allowed by her department, Jane asks for four additional weeks of leave as vacation time. Her chair (and mentor) denies her request with advice to postpone her vacation until the summer, when an additional fellow would join the program. Her mentor told her: "You've already missed too much in the fellowship. Pregnancy, after all, is elective." The case study asks: "Was this a fair way to respond to Jane's request? Would it be fair to consider her experience of a high-risk pregnancy relevant to the training in a high-risk specialty? What are the moral implications of considering pregnancy elective?". In their commentary, Geilker and Geilker conclude that it is "robbing Peter to pay Paul" to allow Jane time at home when the other fellows who also have families would need to split Jane's responsibilities. At the same time, they take issue with the mentor's statement that pregnancy is "elective". The mentor, though justified in denying Jane's request, has "muddied the issue of responsibility with his glib comments" (Geilker and Geilker). In another commentary, Mahowald concludes that the experience of a high-risk pregnancy is relevant and has the potential of contributing uniquely to the clinician's understanding of patients with whom she will interact throughout her professional life. "Nonetheless. . .fairness, after all, involves balancing harms and benefits among all those affected by a decision. While vacation is a benefit to which all of the fellows are entitled, its timing may infringe on the plans and needs of others, both patients and colleagues" (Mahowald).

Faculty

The only relevant study of U.S. medical schools is from 1989, when 22% reported no written guidelines for maternity leave for faculty; 34% had specific maternity leave policies, and the remainder categorized this leave as a form of sick or disability leave (Grisso, et al.). Examples of schools with specific policies covering childbearing are *Yale University School of Medicine*, *SUNY-Syracuse*, and the *University of California-San Francisco*. For instance, at Yale a pregnant faculty member may have a total maternity leave of six weeks, with pay and fringe benefits. Some schools revised their policies in response to the FMLA in 1993. For instance, *University of Texas Medical Branch* now grants up to 12 weeks in a 12-month period for one or more of the following reasons: birth of a son/daughter and care after such birth; placement with an employee of a son/daughter for adoption or foster care; serious health condition of spouse, child or parent of employee, or serious health condition of employee; and employees are required to use all accumulated vacation and sick leave, if applicable, when taking leave under the FMLA.

With regard to parental or child *rearing* leave, the 1989 study found that 32% had guidelines, usually stipulating leave without

pay (Grisso, et al.). In addition to guidelines for parental leaves, which usually cover adoption and to both sexes of parents, some schools have also defined a category of "family" or of "caregiver" leave. For instance, at *Yale University School of Medicine*, caregiver leave is defined as follows: "A member of the faculty may take an unpaid leave of absence to care for a seriously ill spouse, parent, or child for up to sixteen weeks in any two-year period. Except in cases of emergency, two weeks notice is required, and all requests must be accompanied by written notice from a physician or other health care provider verifying the need for a leave and the probable duration. Serious illness is considered to be a disabling physical or mental condition that requires in-patient care or continuing treatment by a licensed health care provider. During the period of this leave, the University will continue to pay its share of health and any non-contributory insurance premiums for the caregiver on leave."

At *McMaster University* as the result of a 1991 Workplace Climate Survey undertaken through the auspices of the Employment Equity Office, an ad hoc committee conducted a survey of employees to obtain information to assist in developing cost-effective ways of helping to balance work and family responsibilities. The survey was sent to 3,200 full and part time employees; 1,166 (36%) responded. Of these, 771 respondents or 66% indicated they were responsible for dependent care, and 102 respondents noted responsibilities for both children and elderly dependents. The most common conflicts related to time pressure, particularly with illness of dependent. In describing how the stress of coping with these conflicts affect their work, respondents listed most frequently difficulty in concentrating, reduction of efficiency, fatigue and time spent worrying. Half of the McMaster respondents with dependent care responsibilities had missed work in the last 6 months (approximately 900 days in total). In terms of flexibility on the job, 26% of the clerical/secretarial group stated they had no flexibility. Most tellingly, this study found that although flexibility did not eliminate conflict, stress or lost of time, those with the least amount of flexibility accounted for more days taken from work and the greatest amount of conflict and stress (*McMaster University*).

Though certainly not without their own limitations, one approach to adding flexibility to faculty appointments is via part-time options (Gappa). In 1991 a study of part-time faculty in internal medicine found that women's choice of the part-time option was geared to childrearing, whereas men part-timers tended to also have a private practice commitment (Levinson, et al.). Sixty-four percent of women versus 37% of men reported developing the part-time faculty position themselves. In the written comments relative to disadvantages, both sexes indicated lack of respect from colleagues and limited benefits/salary. Building on an AAMC survey of faculty appointment and tenure policies, in 1994 Froom and Bickel surveyed 102 U.S. and Canadian medical schools that had answered yes to the question, "does the medical school provide for faculty who choose to work less than full-time but whose full professional effort is directed towards the institution?". Seventy-one U.S. and Canadian medical schools reported provisions for "full professional effort" (FPE) faculty; and 32 of these had developed specific procedures for such faculty. Other nomenclatures in use for FPE faculty include "limited full-time," "full status/partial load," and "reduced period of responsibility." Almost half of the 71 survey respondents reported that FPE faculty could be appointed to, or remain on, a tenure track; more than half of these schools said that they lengthened the probationary period on a prorated basis (Froom and Bickel).

At *Medical College of Wisconsin*, FPE faculty have renewable contracts, have their malpractice coverage paid, can be part-time indefinitely and can purchase health insurance. At *Yale University School of Medicine*, if tenure-track faculty choose to assume a less-than-full-time position, they may have up to 13

instead of 10 years to gain tenure. Such faculty have a prorated adjustment of salary, paid leave eligibility, maximum permissible time-in-rank, and some fringe benefits. The *George Washington University School of Medicine* recently approved an FPE option: FPE faculty are eligible for all incentive income and may be on the tenure track, showing the probationary process according to a specific algorithm based on their percent of full time and length of time spent in FPE status.

As a sign of increasing interest in this subject, a session on "Developing Flexibility in Faculty Careers: Reduced Time Options" was well attended at AAMC's Conference on Tenure Compensation and Career Pathways (February 5, 1996 in Leesburg, VA). Panelist Merle Waxman, Yale's associate dean for academic development commented that, although Yale has had a policy for less-than-full-time faculty for several decades, it has been used most during the last 5 to 10 years. She also stated that FPE faculty have generally been promoted at the same rate as full-time faculty; two FPE faculty have thus far received tenure. Linda Salamon, Ph.D., Dean, College of Arts and Sciences, *George Washington University*, noted that medical schools were ahead of the rest of the university culture in providing flexible options for faculty. She recommended the following steps as important to the success of any FPE program: 1) set clear expectations for performance; 2) protect faculty time for research and writing and minimize time spent on committee work and administration; and 3) FPE faculty must take responsibility for preventing a "mommy track" mentality.

As medical schools adapt their classifying practices to the need to "capture more patient lives," the definition of "full-time medical school faculty" is becoming increasingly blurred. But faculty who wish to work less than full-time and simultaneously build a career clearly do face extra difficulties in protecting time for academic goals and in convincing cost-conscious department heads that they pull their weight. And certainly there are logistical issues defining benefits and departmental responsibilities. But the greatest barriers to expanding temporal flexibility in faculty pathways may be conceptual. Even though the country now has an adequate overall supply of physicians and though increasing percentages work for a managed care company, the "full-time" ethos in medicine has such a hold, that "less-than-full-time" continues to be equated with "uncommitted." Also, so few current physicians ever had a role model who practiced part-time to combine family and career responsibilities. New voices are being heard, however. For example, a woman physician who shares a practice with three others who are also part-time relates: "My skills haven't suffered for having worked part-time. If anything I think I'm fresher" (Cleary).

Finally, to be noted here is emerging help for the "trailing partner" challenge which often interferes with the recruitment of women to positions. At least two universities have created formal programs which provide assistance to dual-career couples:

• The Women's Resource Office at *Purdue University* offers a Relocation Assistance Program (RAP) for spouses of recruited faculty and staff, and a special Bridge Program for couples seeking faculty appointments in the same discipline. RAP was designed to strengthen recruitment potential, increase likelihood that employment offers will be accepted, facilitate the relocation and employment process, and retain employees. RAP personnel serve as advocates in identifying resources, making referrals, generating contacts, and developing search strategies. Services are offered from the point of recruitment and may continue up to one year after employment of recruited faculty or staff (for information, tel 317/494-9879).

•The *University of California-Davis'* Office of Faculty Relations established the Partner Opportunities Program (POP) to attract and retain talented faculty in dual career couples, with special attention to women and minorities.

POP offers assistance with searches for academic and non-academic positions and employment interviewing, coordinates partner contacts with a variety of potential employers, and provides information related to real estate, schools, and day care opportunities. Ongoing privileges for partners of tenure-track faculty include access to library and other faculty support services, parking facilities, and tickets to campus events. Partners seeking academic positions at UC-D are eligible for a number of possibilities: 1) a small pool of FTE is set aside to assist in partner hiring; 2) a bridging position of one or two years or an “adjunct” title may be created; and 3) faculty fellowships of $15,000 or an appropriate FTE fraction may be available to serve as a base from which to network and pursue employment. For more information, contact Marge Steward, Ph.D., Associate Dean, Women’s Affairs, tel 916/752-4802.

Child Care

A commitment to families should go beyond token adjustments. The best example in academic medicine of a comprehensive approach is Beth Israel Hospital in Boston. Its "Commitment to Working Parents" includes:

* on-site childcare, accommodating ages 6 weeks to 5 yrs, open between 6:30 am and 6:00 pm;
* dependent care referral service;
* flexible benefits (and part-time are eligible for most of them);
* earned time program (combines traditional sick, vacation and holiday hours into one bank to provide maximum flexibility in determining how to use paid-time off);
* flexible scheduling and job sharing;
* breastfeeding support program;
* piloting a work-at-home program for some clerical staff; and
* lunchtime programs of special interest to parents (contact *Laura Avakian*, Vice President, Human Resources [and WLO], tel 617/735-2800).

The creation of child care resources in academic medical centers is not keeping up with demand, but there are a few signs of progress. At *Yale University*, there is an on-site day care center at the School of Medicine for children, six weeks through pre-school age, which is open to the community. First priority is given to children of parents who are faculty, students, or postdoctoral fellows at the School of Medicine, with second priority given either to faculty or staff in another department at the University or to house officers at Yale-New Haven Hospital or the VA Hospital. This priority scale is also used in administering the center’s Scholarship Fund which consists of money from the Dean’s office and other funds raised by the center.

In 1995, *Hackensack Medical Center* in New Jersey opened its Child Care and Learning Center, one of the largest in-house child care centers in the country (Black). The Center was developed as a tool for recruiting and retaining employees and serves over 360 children (ages three months through first grade) of employees and medical staff. The Center has an infirmary for mildly ill children and private rooms for speech, occupational and physical therapists to work with special needs children. Disabled children are mainstreamed into the Center programs which are under the direction of the Department of Pediatrics. Another successful in-house program is *Bowman Gray School of Medicine’s* child care facility (open since 1991) which enrolls over 280 children with a waiting list for newborns.

In 1993, the *University of Texas-San Antonio’s* Women’s Faculty Association (WFA) conducted an internal survey of 1,000 men and women faculty regarding the feasibility of an on-campus or near-campus child care facility. Of 400 respondents, 59% reported being absent from work or class 1-5 times because of problems with child care arrangements; 92% indicated that a nearby facility would have eased their return to work and class. WFA’s Early Childhood Development Committee offers informational

sessions for faculty to learn more about available and appropriate resources, and the WFA office compiles child care information packets for distribution through human resources to new employees and upon request (for information, tel 210/567-3855). In addition, San Antonio's Corporate Child Care Collaborative is a community-based project in which local corporations and community leaders joined in 1993 to develop strategies to improve the quality and quantity of area child care services. In conjunction with this project, the San Antonio Area Foundation manages an endowment program for annual distribution of fund donations to various child care programs.

An investment in child care is an investment in women's health because employed women are better able to stay out of poverty and reduce all the health risks associated with poverty. Therefore, physicians ought to be taking the lead in improvements in this area. A great new resource here is *Developing A Child Care Program: A Health System Decision-Making Guide, Women Physicians -- Champions for Child Care* (1995). Published by the Lutheran General Hospital and AMWA in collaboration with many experts, the *Guide* is a resource for developing, implementing and maintaining quality child care in any organization. Appendices include sample needs assessment questionnaires and budget worksheets, a list of resources for planning and establishing a center, a risk management checklist, and profiles of organizations participating as program examples.

Resources

Catalyst is a national, nonprofit firm dedicated to enhancing the role of women in business and the professions. For over 30 years Catalyst has assisted organizations in adding flexibility to the workplace. In 1994, it studied 16 corporations and 15 professional firms with nationally recognized experience with flex-time and other full-time options and with reduced-time options. The report *Making Work Flexible: Policy to Practice* discusses the building blocks for integrating flexibility into an organization, including structural, systems and evaluation issues. For a list of publications and more information: tel 292/777-8900; <info@catalystwomen.org>.

College and University Personnel Association (CUPA), 1233 20th St., Ste 301, Washington DC 20036, tel 202/429-0311, <http:\\cupa.org>:
•The results of a 1995 *College and University Personnel Association* study on how universities are supporting members of their communities in balancing family responsibilities will be available in November 1996.
•The Fall 1995 *CUPA Journal* is devoted to the interrelationship of work and family. Articles cover establishing an infant/toddler day care center, the effects of child care arrangements on absenteeism, campus work and family programs, elder care, and the use of the college and university summer campus as a form of child care.
•Contact the electronic discussion group *Women, Work and Family in the 20th Century*, <ws238-l@ubvm>.

Conference Board Work and Family Information Center, 845 Third Avenue, New York, NY 10022, tel 212/339-0234.

Families and Work Institute Inc., 330 Seventh Avenue, New York, NY 10001, tel 212/465-2044 (ext. 229).

Guide to the Family and Medical Leave Act is 30 pages of questions and answers about these 1993 regulations ($10).

National Association for the Education of Young Children, 1834 Connecticut Avenue, NW, Washington, DC 20009, tel 800/424-2460.

National Coalition for Campus Child Care

(NCCCC), an educational and professional organization whose Governing Board consists primarily of university personnel across the U.S. The purpose of NCCCC is to promote quality in child care programs on campus and to advocate for the needs of children and families in the field of education and public policy. NCCCC offers its members workshops, publications, opportunities for extensive peer networking and support, as well as an annual conference (April 6-19, 1997 in Washington, DC). Membership is $35 for individuals and $90 for institutions and includes a subscription to the NCCCC newsletter, *Campus Child Care News*. For more information: Sherry Fuchs, Child Care Coordinator, Catonsville Community College, 800 S Rolling Road, Catonsville, MD 21228.

Resources for Child Care Management, 261 Springfield Avenue, Suite 201, Berkeley Heights, NJ 07922, tel 201/665-9070.

Women's Bureau Department of Labor, 201 Varick Street, Room 601, New York, NY 10014, tel 212/337-2390.

Women's Legal Defense Fund, 1875 Connecticut Ave., #710, Washington, DC 20009, tel 202/986-2600.

Work and Family Connection, 5197 Beachside Drive, Minnetonka, MN 55343, tel 612/936-7898.

Work/Family Directions, 930 Commonwealth Avenue, South, Boston, MA 02115-1212, tel 617/566-1800.

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