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## Parental Leave in Cardiovascular Disease Training Programs



Approaches to new parenthood in graduate medical education (GME) are under increased scrutiny. Negative perceptions exist of how pregnancy affects performance (1). Women more often view pregnancy as a career threat and are less likely to have children during training (2). They report a negative perception of compatibility of a cardiovascular disease (CVD) career with family life, which is associated with career choice (3). Because women are underrepresented in CVD (4), factors that can affect this perception, including parental leave (PL) policies, are important.

The Accreditation Council of GME only requires that PL policies comply with applicable laws. The existence of formal policies varies across GME (5), and they are unknown in CVD programs. The 2019 CVD Program Director (PD) Survey sought to address this. PDs of all 237 U.S.-based programs received the

survey and 138 (58%) responded. Of responding programs, 30% were small (1 to 10 fellows), 38% medium (11 to 17 fellows), and 32% large ( $\geq 18$  fellows).

**Table 1** shows PL time and coverage strategies of responding programs. In total, 26% and 44% of responding PDs did not know how much paid and unpaid PL is offered, respectively; 80% reported that their program's PL policy aligns with that of their institution. This survey did not assess fellow and faculty PL policy alignment within institutions. A higher percentage of small programs have had no fellows take PL in the last 3 years. In programs where fellows have taken leave, 51% of women took  $< 2$  months and 79% of men took 1 to 3 weeks. PDs believe 55% of fellows take the maximum allowed or personally desired time. Personal preference, perceived expectations or perceptions, training time constraints, and financial considerations may all impact the PL time that fellows use.

Many programs use fellows to provide coverage for PL, which may create unspoken pressure to minimize time away. Faculty cover more often in small programs. A small percentage use physician extenders for coverage. A total of 22% have no established system for coverage, developing plans as needed. When returning, programs offer fellows rotations allowing flexible scheduling (62%), reduced call (24%), or work from home (21%). Small programs may face unique challenges in implementing these strategies.

The clear priorities are for fellows to complete training requirements and become competent cardiologists. The American Board of Internal Medicine (ABIM) allows 3 months away at any point in the 3 years of training for certification examination eligibility. The ABIM permits another month if the PD attests that the fellow has met all training expectations. However, only 11% of responding PDs felt fellows should be eligible for the examination when requirements consistent with ABIM policy were met. In total, 65% felt fellows should be eligible only if they take less leave than the ABIM actually allows. The remaining respondents felt fellows should remain eligible for certification regardless of how much PL they take (12%) or were unsure (11%). It is not clear if these differences are due to variations in policy awareness, policy interpretation, or concern regarding competency achievement if fellows take the maximum permitted time.

PL can affect program and specialty culture. The Family and Medical Leave Act, institutional guidelines, and ABIM policy influence PL time and are all beyond the control of an individual program. However, our data demonstrate considerable variation in how CVD programs address PL. Although the majority

**TABLE 1** Amount of Parental Leave and Coverage Strategies for Responding Programs

PL Characteristic	All Programs	Small Programs (1-10 Fellows)	Medium Programs (11-17 Fellows)	Large Programs ( $\geq 18$ Fellows)
Average weeks of paid PL*	5.3	5.0	5.2	5.5
Average weeks of unpaid PL*	8.1	7.8	6.9	9.6
No female fellows have taken PL in last 3 yrs	28	57	19	11
No male fellows have taken PL in last 3 yrs	15	38	6	5
Use fellow coverage	49	40	52	55
Use faculty coverage	26	43	21	16
Use physician extenders	13	19	17	2

Values are average (where indicated) or %. \*Data reported as average weeks of paid or unpaid PL in responding programs aware of their PL policies.

PL = parental leave.

had a fellow recently take PL, a sizable number of PDs did not know their institutional policies. PDs play an important role in helping fellows understand PL options and supporting their individual decisions. It is important for PDs to proactively understand available options. Creatively utilizing coverage resources, allowing flexible scheduling, and creating a supportive culture can minimize pressure fellows may feel to take less PL than they would otherwise choose. Investigation into fellow experiences and the impact of various strategies will help guide the opportunity we have within CVD to clarify policies, develop shared PL models, encourage program support, and emphasize parental wellness. These require the investment of specialty societies and institutional leadership. The return on this investment will increase consistency and support for PDs and fellows nationally and ultimately improve diversity and wellness in our specialty.

\*Julie B. Damp, MD

Michael W. Cullen, MD

Victor Soukoulis, MD, PhD

Marty C. Tam, MD

Friederike K. Keating, MD

Islam Abudayyeh, MD, MPH

Atif Qasim, MD, MSCE

Paul Theriot, BSBA

Gaby Weissman, MD

\*Division of Cardiovascular Medicine

Vanderbilt University Medical Center

1215 21st Avenue South

MCE 5th Floor South Tower

Nashville, Tennessee 37232

E-mail: [Julie.boyd@vumc.org](mailto:Julie.boyd@vumc.org)

Twitter: [@BoydDamp](https://twitter.com/BoydDamp)

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The authors attest they are in compliance with human studies committees and animal welfare regulations of the authors' institutions and Food and Drug Administration guidelines, including patient consent where appropriate. For more information, visit the [JACC author instructions page](#).

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## The Devil Is in the Details When Considering the OAC Efficacy-Safety Equation in Dialysis Patients



We have read the paper by Pokorney et al. (1) on oral anticoagulation (OAC) in patients with end-stage renal disease (ESRD) and atrial fibrillation (AF). The authors concluded that, in a Medicare cohort, OAC was not associated with a reduced risk of stroke; instead, it induced significantly more bleeding events. We acknowledge the sensitive matter of OAC in dialysis, yet we have a few concerns regarding this paper.

First, >99% of the patients the authors included were on vitamin K antagonists (VKAs) (<1% direct oral anticoagulants); therefore, the title of the paper should have been changed, mentioning only VKAs and specifying this in the Conclusions section. A 2017 meta-analysis (2), including 17,380 patients from more recent dialysis cohorts, reported suboptimal anticoagulation with VKAs, demonstrating an underestimation of its true protective effect.

At the other end of the efficacy-safety equation, a recent grand Medicare cohort of patients on dialysis receiving OAC (3) found that apixaban use (in 2,351 patients) was associated with a lower risk of bleeding compared with warfarin (with similar reductions in thromboembolic and mortality risk). Therefore, one cannot use the generic term "OAC" without specifying the type of drug used.

Second, a recent statement of the Council of the European Renal Association-European Dialysis Transplant Association (ERA-EDTA) EUDIAL Working Group (4) reported on 6 trials supporting that patients with ESRD and AF on VKAs had lower rates of mortality than those not on anticoagulants, especially in the presence of a high target therapeutic range time. This could explain the contradictory results of