Chapter 12
Medicine as a Family-Friendly Profession?

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Over the past 3 decades, women have poured into the US labor force. Between 1970 and 2005, the percent of adult women working for pay increased from 43.3 to 59.3%. Women not only increased their participation in the labor force, they also increased their commitment to it. While 40% of employed women worked full-time year round in 1970, approximately 60% did so in 2004 (U.S. Bureau of Labor Statistics 2006).[1]

During this period, women not only increased their attachment to the labor force overall, they also significantly increased their presence among elite workers. In particular, women made significant progress in the US medical profession. Most notably, between 1970 and 2005, women's share of seats in medical schools increased from 11 to 48.9% (American Association of Medical Colleges 2004). During the same period, women's numerical representation among practicing physicians increased nearly ninefold, from 25,000 in 1970 to 225,000 in 2002, so that in 2006 women made up nearly 30% of all practicing physicians.

Although the growth of women in medicine has been profound, it is by no means unique. As women were pouring into US medical schools, they were also entering other heretofore male-dominated elite fields like law and business. In fact, between the late 1960s and 2001, women went from less than 5% to more than 50% of US law students. Currently, 33% of practicing attorneys in the USA are female (Rhode 2001).

Some have suggested that as the presence of women in medicine and other elite occupations increases, the prevalence of family-friendly working conditions for professionals who historically dedicated themselves entirely to work will also grow (Kotkin 2007). For example, in their editorial about the increasing number of women in medicine, Levinson and Lurie maintain that "women are changing the profession itself. The effects can be seen in the work–family balance." (Levinson and Lurie 2004; Croasdale 2004a; Wardrop 2004).

Women physicians, like other elite women workers, remain unlikely to have stay-at-home or minimally employed husbands (Boulis and Jacobs 2008).[2] As a result, these women rarely have the kind of family support system that allows some male physicians to work 70 or 80 h per week. This type of

[1]This essay draws on research presented in our book, The Changing Face of Medicine. Cornell University Press, 2009.

[2]In fact, there are extremely few stay-at-home fathers. In 2006, the Census estimated that there were only 143,000 married fathers with children under 15 who remained out of the workforce primarily so they could care for 245,000 children (U.S. Bureau of Census 2006).

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single-minded devotion to a career is more challenging when both partners in a marriage are working full-time and are committed to their demanding careers. An exclusive focus on work can be even more challenging with the arrival of children, especially since evidence suggests that many women continue to feel guilty about combining paid work and mothering (Duncan et al. 2003; Jayson 2007). Consequently, the time demands of their family lives and the persistence of gendered ideas about parenting are likely to lead many women physicians to be interested in opportunities to dovetail their professional goals with their personal lives. As the number of women in medicine increases, it is reasonable to expect an increase in interest in family-friendly career options such as reduced work schedules, limited night call, and on-site child care.

Have elite professions, which have historically presumed exceptionally high levels of professional commitment, been responsive? There is some evidence of change in medicine and law. There has been growth in the number of hospitals with maternity leave policies, and the percent of physicians working part-time. In particular, results from AAMC surveys conducted in 1989 and 1994 indicated that the number of teaching hospitals with specified maternity leave policies increased from 52 to 77% in 5 years (Philibert and Bickel 1995). Further, evidence from a survey conducted by the American Academy of Pediatrics indicates that the number of practicing pediatricians who defined their position as part-time increased from 11% in 1993 to 15% in 2000 (Croasdale 2002). There is also increasing attention to the need for formalized reentry programs for physicians who take time off from medical work.[3]

In the legal profession, signs of reform are also surfacing. Most notably, in 1997, the American Bar Association adopted a resolution supporting alternative ways of working, including working from home and flexible hours (Kunde 1997). More recently, some evidence suggests that firms are abandoning billable hours in favor of flat fees that make more meaningful work–family balance possible (Belkin 1985).

In spite of the positive trends, we question the extent to which a family-friendly ethos has permeated the medical profession. In fact, the medical profession has not evolved as much as the popular and medical press suggests. Changes are clearly occurring, but they are not keeping pace with the growth of women physicians or the overall growth in demand for work–family balance. Further, in certain instances, such as the flexible tenure clock, the ultimate meaning of changes that have occurred is questionable. Moreover, the relative absence of reform in the medical profession does not stem from a lack of demand. Evidence from our research and others suggests that physicians of both genders are overworked. It also indicates that those who work reduced hours have higher professional satisfaction.

In this chapter, we examine how opportunities for work–family balance in medicine have evolved since women started entering the profession. The perspective that motivates our analysis focuses on structural change. The major idea here is that efforts to understand work–family balance must be understood within the context of a rapidly evolving profession that is confronting independent forces. This perspective suggests that although women and men physicians will continue to be affected by their gender, physicians' experiences over time will come to be defined more by the structure of the profession and less by the gender of the practitioner.

We find that women are seeking a more meaningful work–family balance for themselves, However, efforts to carve out time for personal endeavors are neither gender nor generationally

[3]The Federal Office on Women's Health convened the National Task Force on Reentry into Clinical Practice for Health Professionals in 2000 (Mark and Gupta 2002). This effort led to recommendations for a national reentry policy and to an updated compendium of physician retraining initiatives. The national task force was followed by the convening of an American Academy of Pediatrics sponsored Physician Reentry into the Workforce Project. The project is a collaborative effort that includes many medical institutions including the AMA, the VHA, the American Board of Medical Specialties, the American Academy of Family Physicians, the American Board of Surgeons, and the Council on Graduate Medical Education.

specific. Men and women in medicine are both seeking more manageable schedules. Similarly, while age and seniority is associated with enhanced control in many professions, we find that physicians of both genders at all stages of career development are finding it increasingly difficult to carve out meaningful time for family life or other personal pursuits.

We contrast our approach to three other views. The first perspective, which we refer to as personal choice, suggests that gender differences in the work-force stem primarily from differences in the choices that men and women make as they pursue education and paid employment. The most commonly cited theory encompassed by this perspective holds that gender differences in the status of male and female physicians reflect preferences and values that women bring with them into the medical profession (Hinze et al. 1997; Grant et al. 1990).

A closely related approach focuses on social change due to generational shifts among women physicians. It has been suggested that women who entered medicine during the 1990s and beyond may be seeking a fulfilling family life, along with the satisfactions of engaging professional work. As some have suggested, they may demand more flexible and part-time arrangements than did previous generations of women physicians (Bickel and Brown 2005). At the same time, it may be that work expectations are shifting for male physicians as well, as they are increasingly likely to find themselves in dual-career families.

A third perspective, which we refer to as the institutional discrimination thesis, suggests that specific industry and organizational characteristics and the behaviors of other key groups in the health services workforce are responsible for many of the disparities between male and female physicians. One of the most common theories in the discrimination group is the "structural difference" view (Kanter 1977). This theory holds that differences between men and women workers reflect gender differences in status and power in the organization or the profession.

Another aspect of the discrimination perspective is the "critical mass" hypothesis. Instead of focusing on women's presence in medical leadership, this view posits that critical change will occur in support of women's needs only after women make up a critical mass of the profession. This view would predict that part-time residencies and flexible schedules would be most common in female-dominated specialties like pediatrics and obstetrics and gynecology.

We find that although male and female physicians desire more manageable work lives, their ultimate capacity to create more workable schedules is greatly restricted by powerful countervailing pressures. These forces are evident in both the macrolevel environment, and in individual, or microlevel, decision making. That is, they permeate the broader institutional context of the profession and they also operate through the cost-benefit calculus of individual physicians. On the one hand, macro-level pressures from physicians' work environment, such as the need to pay for malpractice insurance and to meet productivity expectations, greatly limit opportunities for individual physicians and medical institutions to create work–family balance. On the other hand, concerns such as mounting educational debt also deter many physicians from taking advantage of flexible schedules when they are available. In short, reforms to date have fallen short because individuals' capacity to pursue family-friendly options is constrained.

At the same time, we suggest that many of the family-friendly reforms that are occurring in medicine stem from institutional developments that have little, if anything, to do with the representation of women in American medicine. One of the most obvious examples of such a change involves the relatively recent restrictions on resident work hours (Stanton 2007; Woodrow et al. 2006).

Family-friendly reforms in the medical profession have overall not resulted from significant organized efforts by physicians of either gender to reform their workplace. In fact, anecdotal evidence from resident union negotiations indicates that parking privileges, salaries, and access to interesting cases often takes priority over provisions for maternity leave. Our discussions also suggest that many residents are as concerned about finishing their training rapidly as they are about securing meaningful restrictions on work effort (Butterfield 2007). Although the number of organizations designed to represent female physicians is growing, reform efforts to date have not pushed an aggressive agenda

of family-friendly institutional reforms. Policy makers and medical organizations are certainly aware of the increasing representation of women in the medical workforce, and many speculate about how women will change the profession.[4] Nonetheless, relatively few in the medical community or elsewhere are actively lobbying to increase family-friendly work environments such as available child care for physicians. When speaking about the panel to develop reentry regulations for physicians who have taken time off from practicing, one of the few recent concrete efforts to create a family-friendly work environment in medicine, an official at the AAMC said, "The panel has been around for years, but it never goes anywhere because no one is willing to put the time in to make those reentry regulations happen." (American Association of Medical Colleges 2006)

Furthermore, the family-friendly initiatives remain concentrated in a few corners of the profession. For example, primary care settings have made greater strides than other specialties, most notably surgery. These disparities not only reflect the number of women in a particular specialty or work environment, but also reflect broader institutional forces such as the disproportionate tendency for hospitals to employ primary care providers. Reforms to date have not principally reflected the concerted efforts of a united contingent of women doctors. If a unified group of female physicians could mobilize around issues of changes to the medical workplace, the medical profession could rapidly evolve in a much more family-friendly direction.

In this chapter, we compare trends in part-time employment with interest in this type of flexible career option. We find that there is a sizable gap between interest in part-time work arrangements and the availability of part-time opportunities. Many physicians express interest in reducing their work schedules, while the extent of part-time work is not increasingly rapidly. We explore the reasons for this mismatch.

We ask how women and men in the medical profession are balancing their work and family life in light of their surprisingly unresponsive workplace. For the overwhelming majority of women physicians, the answer does not appear to involve either a rejection of parenting or a rejection of the medical workplace. Instead, an increasing number of women and men in medicine are attempting to combine parenting with highly demanding professional commitments and inevitably enduring the stress that accompanies such a challenging and fast-paced life style.

The Medical Workweek: Kinder and Gentler or Crazier than Ever?

As we have documented elsewhere (Boulis and Jacobs 2008), although the data indicate that women physicians work less on average than their male peers, they still typically work well in excess of 40 h in an average week regardless of their personal status. The gender gap in the workweek exists only because male physicians work extremely long hours.[5]

It may be useful to examine trends in the extremes of work schedules, not just the average. For example, Jacobs and Gerson (2004) show that while the average workweek in the United States has not changed substantially over the last 30 years, more individuals are working long workweeks (50 h or more per week). In recent years, professionals and managers have logged the longest workweeks.

[4]In fact, the increasing relative and absolute presence of women in pediatrics was listed as the second most critical concern for the American Academy of Pediatrics' Committee on Workforce issues (American Association of Pediatrics 2005).

[5]It is also worth noting that the gender gap is specialty specific. While significant gaps exist between the average male and average female pediatrician work week, male and female surgeons and obstetrician-gynecologists log equivalent hours.

As shown in Table 3.1, female physicians are more likely to log more than 50 h per week on their jobs than was the case 20 years ago, while rates of long weeks have remained essentially constant for men. In 2000, nearly two-thirds of male physicians (64%) reported working 50 or more hours per week, down slightly from 65% in 1980. Among female physicians, nearly half (48%) worked 50 or more hours per week in 2000, up from 39% in 1980. Thus, the increased representation of women in the profession has not resulted in a general shift to more limited work schedules. Rather, both men and women in medicine have a high likelihood of working a long week.[6] Together these results suggest that the unique personal choices of female physicians are not transforming the health care system as many thought they might. They also suggest that differences in the work lives of male and female physicians which might create distinct workweeks are declining.

At the other end of the spectrum, the fraction of physicians working part-time should be revealing as well. Although many believe that the part-time medical workforce is growing in the USA (Croasdale 2002, 2004a), our findings from the US Census suggests otherwise. In fact, data from the Census suggest that rates of part-time work of 30 h or less for women has increased only slightly, from 13 to 15% between 1980 and 2000. In contrast to the 15% of female physicians who worked part-time in 2000, 8% of male physicians worked part-time, up four percentage points since 1980.[7] Thus, the vast majority of female physicians have been unable or unwilling to pursue part-time schedules.

Part-time employment is actually less common than it was during the 1970s when few physicians were women. In 1970, 20% of women physicians worked fewer than 35 h per week. Even recent research on pediatricians indicates that although the absolute numbers of women pediatricians working part-time increased during the 1990s, between 1993 and 2000 there was no change in the tendency for women pediatricians to work part-time. Further, growth in the percent of pediatricians working reduced schedules stems entirely from growth in the representation of women in the specialty (Cull et al. 2002).[8]

Data from the US Census indicate that over the last several decades, the work effort of female physicians is coming to more closely resemble the work effort of men who share their household composition. This trend is most pronounced for physicians over age 50. However, the trend toward parity does not imply a trend toward greater work–family balance. The average work effort of female physicians is increasing, while the average workweek of male physicians has remained relatively constant at a very high level. These trends fail to support either the personal choice or the social change perspectives on work–family balance. Ultimately, the trend is toward *less* work–family balance rather than more. This increase in work effort may signal increasing pressures on female physicians with regards to their lives outside of work.

How do conditions in the medical profession compare to conditions in other occupations? While all employed nonresident male physicians worked an average of 52 h per week, employed men

[6]Data from the Community Tracking Study physician surveys indicate that in 1996, 75% of men and 51% of women worked long weeks. By 2004, only 69.9% of men and 48.4% of women worked long weeks but the aging of the population between 1996 and 2004 might explain the decline in the tendency to work long weeks.

[7]Data from the 2004 CTS Physician Survey indicate that 16% of women and 6% of men physicians work less than 31 h in a normal week. Between the 1996 and the 2004 CTS Surveys, rates of part-time work increased slightly for men and women from 14.6 to 1% for women and from 4.1 to 5.9% for men. In contrast, between the 1990 and 2000 Census, the frequency of part-time work declined from 16 to 15%. The CTS survey involves only physicians who provide direct patient care at least 20 h per week and excludes radiologists, pathologists, and anesthesiologists. It also involves a survey of cities rather than a survey of the entire US population. Regardless of the data source, however, rates of part-time work for female physicians are remarkably stable.

[8]Data from the Physician Work Life Study indicates that 22% of US women respondents and 9% of US men respondents worked part-time (McMurray et al. 2005); however, this survey defines part-time as less than 40 h rather than less than 30 h.

overall work only 43.1 h per week and employed men in managerial and professional occupations work 45.6 h per week. (Jacobs and Gerson 2004: 34). The comparable numbers for employed women are 47 h for women physicians, 37.1 h overall and, 39.4 h for women in managerial and professional occupations (Jacobs and Gerson 2004: 34).

Further, according to the Census in 2000, only 26.5% of all male workers reported more than 50 h in their average workweek. Results from the 2004 American Community Survey reveal a slight decline in long workweeks for men overall. In 2004, 24.3% of male workers worked more than 48 h per week (Kuhn 2007). The comparable number for all male professional, managerial, and technical workers was 37.2%. Since 64% of male physicians work at least 50 h, on average male physicians are 1.7 times more likely then men in elite occupations overall to work long weeks.

Only 11.3% of the female workforce overall worked 50 or more hours. The comparable number for women in managerial, technical, and professional occupations was 17.1% in 2000. Since 48% of female physicians worked at least 50 h, in 2000, employed women physicians were 2.8 times more likely to work a long week than other women employed in elite occupations. Even married physician mothers were 2.5 times more likely to work a long week than their female peers in other elite occupations.

On the other hand, analysis of the 2000 Current Population Survey indicates that rates of part-time work in medicine are not too different from rates in other elite occupations. In 2000, 14.8% of women and 5.8% of men working in managerial, professional and technical fields logged less than 30 h per week (Jacobs and Gerson 2004: 34). The Hidden Brain Drain Task Force, a group of researchers and companies organized by Sylvia Hewlett helps to put conditions in medicine in perspective. As noted earlier, Hewlett's results indicate that 16% of highly qualified women work part-time. Thus, this result is very similar to results based on the Current Population Survey (Hewlett 2007). These patterns are broadly similar to the 15.1% of all employed female physicians and 7.8% of male physicians work part-time.

Today's Physicians: Workaholics or Overworked?

The growth of long workweeks and the limited expansion of part-time work are surprising in light of evidence indicating that huge portions of male and female physicians believe they work too much. While no doubt workaholics are well represented among physicians, there is a much larger and growing group that expresses interest in working fewer hours per week. For example, in the Young Physicians Survey, a nationally representative survey of physicians who finished training five or fewer years prior to the survey revealed that in 1987, 43% of male respondents and 42% of female respondents wished they could work less than they were working at the time. In 1991, 5 years after the initial survey, respondents' dissatisfaction with work hours had increased in this population such that 53% of men and 46% of women wished they could work less than their current professional schedule. After accounting for gender differences in hours worked, however, the gender gap in the desire to work less disappears. The desire to work less or to pursue part-time schedules has also been found in several studies of physicians in specific specialties including pediatrics and surgery (Fritz and Lantos 1991; Mayer et al. 2001). Interest in part-time opportunities goes well beyond physicians seeking more time for family. Many older physicians also seek reduced schedules. In fact, in 2005, 32% of physicians 50–64 years of age indicated that they were interested in part-time hours, but did not have that option in their current position (Harris 2007).

Like trends in work effort, data on physicians' interest in flexible or reduced work schedules belies the contention that the unique interests of female physicians are transforming the medical profession. It does not appear that the desire to work less or more flexibly is a uniquely female desire.

In fact, dissatisfaction with work hours is significantly more pervasive among physicians than among the general population. This is not surprising given the gap between physicians' work hours and those of their peers. Jacobs and Gerson report that roughly one-third of the workers in the United States labor force preferred to work fewer hours per week (2004:74).

The low rates of part-time work are even more surprising in light of recent research on the relationship between part-time work and physician satisfaction. According to analyses of the recent representative Physician Work Life Study, part-time US physicians of both genders felt better able to control their work hours, work interruptions and work hassles.

Part-time physicians were significantly more satisfied than full-time physicians with patient care issues, personal time, administrative issues, and their jobs overall, and they noted significantly less stress than full-time physicians (McMurray et al. 2005). A nationally representative study of members of the American Academy of Pediatrics found similar results. Limiting work hours enhances pediatricians' sense of work/personal balance. Part-time pediatricians are more satisfied with time for their children and other personal activities, and express similar or greater professional satisfaction (O'Connor et al. 2004).

The relationship between work effort and professional well-being is not simply about access to part-time work. Recent research reveals that the strongest predictors of whether physicians of both genders will experience burnout and career dissatisfaction are how much control they have over the total number of hours they work in a week and their work schedules.

In other words, statistics suggest that physicians of both genders are working more and feeling more overworked. Studies indicate that there is a growing belief that reduced hour work could address the problem and research suggests that such beliefs are grounded in reliable social research. Nevertheless, in spite of articles titled "Practices must cope as more physicians work part-time (Croasdale 2002)" and "Women physicians find ways to make part-time work (Croasdale 2004a)," a large scale trend toward part-time work has yet to occur.

The Culture of Unfettered Professional Commitment

What we have seen is a mismatch between the desire on the part of many physicians for more manageable work schedules and the increasingly long weeks many physicians regularly work. In seeking to understand the causes of this disconnect, it may be useful to put the dilemmas of today's physicians in historical context.

Before the large-scale entry of women, the traditional culture of the medical profession physicians expected a high degree of professional commitment. In this context, physicians worked long hours because of a culture that required total availability to patients (Adams 2004) because of a more established human connection with patients (Hobson 2005), because of a stronger association between work effort and reimbursement, because of a reluctance to rely on each other, and because of greater support at home via wives who did not work for pay outside the home.[9] Even as late as 1980, most physicians generally worked alone or with one other partner (Kletke et al. 1996), so they

[9]In 1968, Dr. Burch, then president of the American College of Cardiology, wrote in the American Journal of Cardiology: It is generally considered that there is too much to learn in medicine today. This is not true... Time is the premium, and how it is used is the important factor. The problem is not that there is too much to learn, but rather that there are too many distractions. The...physician devotes too much time to other interests...Such interests leave little time for medicine. The physician is often unable to resist these distractions and more often than not enjoys them more than he enjoys medicine...the devoted clinician obtains the greatest of pleasure from his work. He enjoys study, clinical practice and his patient more than anything else. He does not need to force himself to study and work with patients (Gerber 1983).

did not enjoy economies of scale. The small size of the average physician practice had an especially severe effect on the need to work at night and on the weekends. On-call hours have been greatly reduced as practice size has increased, and the effect of call time on physicians' lifestyles has been dramatically transformed by the development of reliable cell phones that enable physicians to take calls from where ever their lives take them.

Similarly, community-based physicians in the 1980s and earlier often established long- standing relationships with their patients. They not only knew them in the office, they also knew them in the community. This connection contributed to a larger incentive to create time for patients regardless of the physicians' schedule. During this era, it was more common for physicians to address patients' needs after hours even if they were not on call simply because their patients were members of their community. (It is worth emphasizing that our reference to time does not imply they were conducting longer visits. Instead, creating time involves the willingness to allow work to spill over into family life so that patients can see the same provider overtime rather than different members of the same group.) The obstetrician who himself delivered his pregnant patient will make a greater effort to be available to deliver his pregnant patient's child, than one who has only recently come to know his patient. This type of doctor–patient relationship is extremely rare for pregnant patients today since most obstetricians practice in a group and require patients to accept the services of whoever is on call when labor starts. Further, this type of doctor–patient relationship requires that obstetricians be completely unencumbered by family needs, an increasingly rare situation given the high numbers of women in the field. Similarly, the pediatrician, who sees his patients every time he goes to his child's sporting events, will feel a unique personal connection to them and may thus be more likely to offer medical advice when these children call the house or unexpectedly show up on the physicians' door step. Research indicates that both physician and patient enjoy greater satisfaction and trust when their relationship endures over time (Rodriguez et al. 2007). This enhanced satisfaction inevitably translated into greater physician availability and greater hours for physicians.

Finally, physicians prior to the 1980s arrived in the office early and worked late in part because they had the support at home to maintain this schedule. First, those with the support of a full-time homemaker spouse did not have to worry about being available for their children. And second, those with homemaker spouses may have felt greater responsibility to provide income to the family, so they had an extra incentive to provide additional services. Even today, male physicians with stay-at-home wives work more hours per week than do other physicians, although the difference is just a few hours per week.

Over time, although the factors keeping physicians work-effort high before 1980 have dissipated, other forces have emerged that have maintained long workweeks. Connections between physicians and patients have weakened. Turnover is higher for patients because of insurance restrictions.[10] Access to unique physicians is more limited because practices have grown. So, even if a patient stays with one practice, they do not always see the same provider. Similarly, practice size has grown, so physicians can share responsibilities. And, physicians' spouses have begun to work at higher rates, so today's male medical professionals have somewhat less flexibility. Physicians are increasingly specialized so they are less likely to build relationships with families over time and more likely to see patients with isolated issues. As the availability of general practitioners declined, even primary physicians became less likely to handle everyone in the family and thus less likely to build relationships.

However, as the factors creating long weeks before 1980 dissipated, new structural forces have developed to take their place, and the new forces inevitably affect both male and female physicians.

[10]We suggest that as managed health care has become more common, continuity of care has declined. We base this on research by Flocke et al. (1997) who found in their analysis of 138 community-based providers that patients with IPA/PPO health insurance were four times as likely as patients with fee-for-service insurance to report a forced change in their primary care physician, and that these changes were strongly correlated with patient satisfaction and other health outcomes.

In particular, as health care technology and knowledge has improved and health care financing has evolved from a retrospective to a prospective model, the work of the average physician has become increasingly stressful and challenging (Schafermeyer and Asplin 2003). An astute observer of the medical scene, Charles Bosk has stressed the role of increased patient acuity in increasing the demands on physicians.

> Many of the changes of managed care have in essence been the operational equivalent of speeding up the assembly line. If hospital stays are shorter and if service size is constant, then those patients being treated are sicker as a group than they were twenty years ago... Sicker patients require more surveillance, more management, more worry, more coordination with nursing, more consulting with colleagues in other specialties, more scheduling of ancillary services and more communication with family members than do less sick ones. (Bosk 2003: 251)

It is important to emphasize that the increasing acuity of patients is occurring throughout the health care system rather than simply in the inpatient environment. Technological innovations have made it possible for patients with chronic illnesses like diabetes to survive significantly longer than they once did. Most of these patients need significant medical attention throughout their lives. Caring for sicker patients inevitably takes more time.

At the same time, it is no secret that the US health care delivery and financing systems are rapidly evolving. Historically, American physicians operated as a disorganized group of very independent professionals. Today, many are increasingly forced to practice within highly bureaucratized vertically integrated systems and to contend with increasingly powerful oversight from funders who often employ near monopsomy power. Together, these structural changes have resulted in declining reimbursements and increasing administrative hassles. A 2005 article in *U.S. News* entitled "Doctors Vanish from View: Harried by the bureaucracy of medicine, physicians are pulling back from patient care" captured the sentiments of many in medicine. In particular, according to Carl Getto, associate dean for hospital affairs at the University of Wisconsin Medical School:

> The hassle factors. The rewards – including satisfying relationships autonomy and high status are increasingly outweighed by... reams of time consuming paperwork, declining reimbursements and a loss of autonomy (Hobson 2005).

Bureaucratization assumes many forms. Although some enhance quality, many do not and almost all of these changes involve additional work for health care providers. For example, today, physicians must spend time seeking clearance to perform certain procedures and prescribe certain drugs. Physicians are also often expected to provide more proactive care to patients seeking relief from specific symptoms and to document all of their responses for multiple sources including private insurance and the government. So, while the average internist of past generations might simply treat a patient who presents with bronchitis symptoms for bronchitis, today's physicians are expected to offer that bronchitis patient care for his diabetes and counseling for his obesity. Yet, the visit is reimbursed at the same or even at a lower rate than it was in the past. In addition to providing more holistic care, they must also document these reforms more fully and more often for agencies attempting to enhance quality. Since this work is not reimbursed and since physicians' ability to set prices for their services has been severely restricted, these administrative hassles must either reduce physicians' pay or increase their work effort.

Further, physicians' stress is not limited to the increased acuity of their patients and the increased expectations of their bureaucracies. It also stems from increasing demands and knowledge of their clientele. David Mechanic tracks changes in patients' expectations in his 2003 article "Physician Discontent Challenges and Opportunities," He cites a 1957 study of ambulatory clinics that found patients to be poorly informed about their own illnesses and about common diseases and notes that they showed little evidence of demanding information. He then suggests that by the mid-1980s, as many as two-fifths of persons studied were behaving to some extent in a consumerist manner – seeking information exercising some independent judgment, showing cost consciousness, and

were on average better educated and reported less faith in and dependence on physicians (Roter and Hall 1992). Finally, mechanic cites a Community tracking Study by Tu and Hargraves (2003) which found that 38% of those surveyed in 2000–2001 had "looked for or obtained information about a personal health concern" from a source other than their physician. Those with a college education or higher were most likely to seek independent information and use the Internet. In addition to coping with better-informed patients, physicians also find themselves treating a growing population of misinformed patients. Since 1998, when the FDA relaxed guidelines surrounding direct to consumer pharmaceutical advertising, doctors have had to confront a growing population of patients who seek specific prescriptions after seeing pharmaceutical advertisements on television. Physicians complain that they must spend inordinate amounts of time negotiating with this population or provide the prescription inappropriately (Maguire 1999). Given changes in patients' knowledge and expectations, the average time a doctor spends per patient has actually been increasing (Mechanic et al. 2001). The increase in time per patient and the reductions in reimbursements together have contributed to the growing medical workweek.

Do these currents affect women as much as men? In general, the structural changes facing male physicians are also facing their female colleagues.[11] One female physician we interviewed who had achieved tenure at an elite medical school reflected on how things had changed in medicine. She said that when she finished one of her rotations as a resident, the patients had a going away party for her. Then she commented that such a party would be impossible today because patients who are healthy enough to have a party are not in the hospital.

The increasing representation of women in specialty fields that demand long workweeks is another contributing factor. As we have documented elsewhere (Boulis and Jacobs 2008), the level of gender differentiation across specialties has remained roughly constant since 1985. However, given the growing numbers of women in medicine, this means that the absolute numbers of women in fields that involve long and unpredictable hours like general surgery are increasing (see also Croasdale 2007).

Ultimately, the disconnect between the desire for work–family balance and the reality of medical work stems largely from structural pressures beyond the control of individual physicians. In some instances, those forces reside in the general labor market. As we suggest, our economy is constructed in a way that is increasing pressures on elite workers to work long weeks, and limiting meaningful part-time opportunities. In other respects, medicine remains unique. Pressures on modern physicians are creating work environments that are increasingly difficult to manage. While technological advances like personal computers, cell phones, and the internet have inevitably heightened expectations on professional workers overall, we suggest that technological and financial change has been even more pronounced in medicine. Thus, it is not surprising that physicians endure longer weeks than their professional peers. Although female physicians are more likely to seek and find part-time positions, their ultimate effect on the availability of part-time work within the profession will be greatly restricted by independent trends in American medicine.

Obstacles to Part-Time Work

Women entered a medical profession which took long workweeks for granted, and in recent years, powerful forces have contributed to an expansion of work commitment on the part of most physicians. The pursuit of part-time opportunities thus runs counter to these historical patterns.

[11] Under some circumstances, changes facing female physicians might be more severe since patients seeking specific drugs might expect female providers to be more accommodating of their requests.

Overall, there is a lack of viable part-time opportunities in many medical contexts. There are multiple barriers to part-time work in medicine. Some of these factors are unique to the profession but others occur in many elite occupations. In general, part-time work is lacking in the USA for professionals. Further, the part-time work that is available is clustered disproportionately in the lower tiers of the profession.

Barriers to part-time work include cultural and organizational obstacles. Many of these types of obstacles are not unique to medicine. In fact, they pervade professional work in the USA and may even be stronger in other professions (The Hidden Brain drain task force found that although rates of part-time work are limited for all elite women, it is lowest for women in business). However, there are also financial and patient-related factors that limit demand for part-time medical work, and in this arena obstacles are often unique to medical work. Many physicians who want to work less do not seek part-time schedules because such positions involve major sacrifices. Although many of the barriers to reduced schedules appear immutable, other barriers can be removed or reduced.

Cultural and Organizational Factors

Women physicians seeking reduced work hours have often encountered superiors who are willing to reduce their salaries and rewards but reluctant to reduce work-related expectations. This problem is evident throughout the profession, reflecting a long-standing view that devotion to medicine takes precedence over all other commitments (Adams 2004), but it is especially prominent in academic medicine. As the following quote from the MomMD Website suggests, those with authority in academic medicine can be reluctant to embrace part-time schedules for staff physicians and academic faculty.

> I have a similar experience in academic medicine (pathology). I asked my chair (a man) almost a year ago to be part-time. He was willing to cut my salary, but this did not come with a decrease in the work load. About a month ago, I informed him that I was not going to renew my contract as of July 1. I basically had to entirely quit my job to get more time for my family. There was no flexibility. Posted doski 04-24-2007

> I just have not figured out how to make it in my job only working 4 days. My boss has told me that in my area (mostly research) that women who "cut back" still wind up doing the same amount of work – they just get paid less for it. So she opposes part-time or "less time." She thinks that is made up for by the amazing flexibility that my job provides. All she says is "I don't care when or where you work, just get the job done." But really, I would like to just do 80% of the job for 80% of the money. 08-24-2006 *Conflicted*

The failure to reduce work-related expectations for part-time workers coexists with a trend to increasing expectations for full-time professional workers that is in part responsible for increases in the average workweek of the highly educated labor force.

This pattern is evident for many professional women outside the medical context as well. In a qualitative study of highly educated women who were out of the labor force, Stone and Lovejoy find that "upon becoming mothers, about half of the women in our sample expressed a desire to cut back on their work hours and/or to increase the flexibility of their schedules (Stone and Lovejoy 2004: 68)." Their efforts met with mixed results. However, one-third of the study sample cited workplace inflexibility as a major factor in their decision to interrupt their careers. The authors note that women spoke repeatedly about having full-time responsibilities on a part-time schedule, of doing a "job and half" when they were supposed to be doing half a job.

While workplace inflexibility is real in medicine, evidence suggests that women physicians are somewhat more likely than women in other elite careers to cope with the demands of family life by reducing their hours without accepting a formal part-time position. Results from the Hidden Brain Drain Task Force survey indicate that 38% of female physicians and 25% of elite workers in other

occupations worked a reduced but nevertheless full-time job schedule (Hewlett and Luce 2005). Ultimately, the meaning of a reduced but full-time schedule is unclear, since physicians work so much more on average than others professionals.

The other side of this situation involves physicians who accept part-time positions and end up working full-time hours. One part-time internist we interviewed abandoned her position in favor of an oncology fellowship because she ultimately concluded that part-time work was not possible and that if she was going to work full-time, she preferred the type of work and the type of pay enjoyed by specialists.

Another critical problem limiting part-time work among professional workers overall involves the uniquely high sacrifices that part-time workers in elite occupations must endure. Physicians report facing both short-term disapproval and longer term career sacrifices for challenging time norms that expect them to work far more than 40 h a week so that they can spend time with their families.

Many physicians who seek better work and family balance share these experiences. As the following quotes from the MomMD Website suggests part-timers often feel they have to give up respect and a sense of professionalism:

> as a part-timer, i have had to continually advocate for myself. kpzr/9145 Plus Member Member # 4520 02-05-2007

> I have been part-time for 5 years now, and am probably quitting, mostly due to the treatment I get as a part-timer. I get considered last for the work schedule, don't get my name on the group prescription pads, don't get invited to any company social functions – all due to my part-time status. I have no benefits at all. I made it clear to my employer that I was limited to part-time due to family but that I was planning to commit to working there for the future as I live in that area and would even consider going full-time there when my kids were older. I am getting no credit toward partnership for these years. **Carole** 07-01-2005 08:39 AMJuly 01, 2005 08:39 AM Member # 3851

Physicians seeking better work–family balance sacrifice more than professional rewards like pay and promotion. They also incur the criticism of their colleagues. One survey of internal medicine specialists indicates that even in the Netherlands where rates of part-time work are generally high, physicians view part-time colleagues with suspicion (Lugtenberg et al. 2006). In the *Part-time Paradox*, Cynthia Epstein and her colleagues report a similar pattern among lawyers who sought out part-time work (Epstein et al., 1998). Further, the available part-time work is clustered disproportionately in the less prestigious aspects of the profession. According to the Physician Work Life Study, the highest proportions of part-time physicians were found in general pediatrics (20%) and in health maintenance organizations (22%). Although these results are in part related to the number of women in pediatrics and in health maintenance organizations, male pediatricians were significantly more likely to choose part-time practice than their family practice counterparts (16 vs. 7%; $P=0.05$) (McMurray et al. 2005). Here again, this pattern is reflected in other settings outside of medicine. Those professionals who do secure reduced schedules are often in the lower tiers of their industries (NALP 2006).[12]

One set of organizational constraints involves scheduling bottlenecks in hospital settings. Many physicians who desire flexible schedules must rely on hospitals and other institutions to provide their services. Hospitals have historically had a very difficult time allocating operating room time because assessing the length of an operation is very difficult. (Jarnberg et al. 2001). In an effort to cut costs and maintain fiscal solvency, hospitals are limiting staff anesthesiologists and operating

[12]In 2006, nearly all offices, 96%, allowed part-time schedules, either as an affirmative policy or on a case-by-case basis, but as has been the case since NALP first compiled this information in 1994, very few lawyers are working on a part-time basis, just 5% overall. Associates are more likely to work part-time (4.7%) than partners (2.8%), but other lawyers, such as counsel and staff attorneys, show the highest rate of part-time work, over 16% (NALP 2006).

room nurses, thus forcing surgeons and other providers who perform procedures with "add on" cases to wait until after the standard business day has ended in order to perform procedures that could theoretically be done during the standard workday if operating room staff were available (Matthias 1997). This is an especially prominent problem for cases that need prompt attention but are not life-threatening emergencies, like kidney stones.

Economic Constraints

Many physicians who would like to work less do not attempt to negotiate or find reduced work because of the inevitable financial penalty that part-time work involves.[13] Although physicians have high earnings prospects, there are several financial considerations that hit physicians harder than many other workers.

Like other Americans, physicians are increasingly too strapped financially to consider part-time work. Increasing tuition costs often leave medical students with considerable debt. Median debt in 2003 was 4.5 times median debt in 1984. By 2003, the median debt was $100,000 and $135,000 for public school and private school graduates, respectively (Croasdale 2004b).

As a result, part-time work is financially unrealistic for a growing portion of newly minted physicians. As mentioned earlier in the essay, research on pediatricians indicates that loans are a major obstacle to part-time work (Cull et al. 2002). Financial barriers are especially pronounced if, like the author of this MomMD post, physicians attempt to start their own practice:

> As far as payback, it is tough. I always wanted to work part-time, but I can't see cutting back at all anytime in the next several years. Right now, between my husband and myself, we are just barely covering our expenses, living paycheck to paycheck. We have no savings at all and have significant credit card debt because of all of those "emergencies" that pop up–like the cars breaking down, etc. At the moment one of our cars may be broken beyond repair and if that happens we'll have to take out yet another loan to buy a new (used) one. I'm not sure where we will come up with the money for that. 12-05-2006 06:35 AMDecember 05, 2006 06:35 AM rydys

However, it is misleading to think that financial stress is limited to those in the initial stages of establishing a practice. As this Mom MD quote suggests, reimbursements and overhead and making it increasingly difficult to make ends meet in some specialties:

> "One Family Practice physician recently complained that her net take-home pay after all expenses (including malpractice and student loans) is approximately $37,000 per year, less than her husband's salary as a Chief Petty Officer in the Navy." Now I really want to be a Dr bcuz I want to help people and I am challenged and interested by the field but the money part is somewhat important too. I mean, 11 years of school and tons of hard, hard work to make 37K/yr is ridiculous!! Is this realistic?!?!?! posted 04-07-2007 08:08 PM April 07, 2007 08:08 PM ALLALLY

> Yes, I personally know docs who have taken home less than 50K in a year. It has become extremely difficult to make a good living in private practice. 04-07-2007 09:40 PM AnnaM

Physicians' financial struggles are also seen in the general population. Although many workers indicated that they want to work less in general, answers shift markedly when issues of wages are added. When options are posed as trade-offs between time and money, working less becomes less attractive.

The fixed costs associated with a medical practice tend to encourage long workweeks. In other words, if there are costs that are present no matter how much work is done, the physician must

[13]Some have suggested that physicians dropping to part-time must be willing to take more than a proportional cut in take-home pay to make up for fixed expenses like overhead costs and health and malpractice insurance (Walpert 2002).

devote a considerable portion of the workweek recouping these unavoidable expenses. Malpractice insurance is an example of a large and growing cost of practicing medicine that endures whether the physician is employed 30 h per week or 60 h per week.

The limited availability of part-time work in medicine reflects these types of pressures, especially in those specialties of medicine and regions of the country where malpractice costs are high.[14] The experiences of one academic obstetrician capture this phenomenon:

> Creative options for balancing work and family are few. The recent escalation in the cost of malpractice insurance coverage has largely precluded options for part-time practice; the physician who delivers one patient per month pays just as high a rate as everyone else. At my academic medical center, premiums in my department increased by 68% last year, which brought the base rate to $100 000 per physician per year. (Some of my colleagues were assessed twice that.) A number of senior men, but interestingly enough, none of the women, promptly gave up obstetrics altogether and switched to a predominantly surgical gynecology practice. When I asked to cut back to a 4-day work week, I was told I couldn't possibly generate enough revenue to cover the expense of keeping me, what with salary, overhead, and liability insurance (Plante, 2004).

Although malpractice is a particularly severe barrier for high-risk specialists seeking work–family balance, malpractice premiums present a significant obstacle to any physicians seeking part-time work (Walpert 2002).

Practice ownership similarly tends to induce proprietors to put in long workweeks. Incentives among self-employed professionals involve a tradeoff between autonomy and control and the burden of fixed operating costs. On one hand, the self-employed ostensibly have more control over their work lives and should therefore be better able to strike a satisfying work and family balance. And there are instances when such control has actually helped women in medicine. For example, when Sandra Adamson Fryhofer, FACP, a general internist in Atlanta and the College's President-elect, gave birth to her twins, there was no maternity leave. But because she was in solo practice, she could choose not to schedule patients when she had a parent-teacher conference or another home-work conflict. The result may have been that she earned less that day, but it was her choice (Gesensway 1999).

On the other hand, the self-employed in medicine and other professions encounter severe pressures to work long hours both because they must personally shoulder all of the fixed costs associated with their businesses and because they often reap the financial rewards of additional work more directly than their professional peers who work for others and are often reimbursed with a fixed salary.

Ultimately, the pressures to pay the bills and earn the money appear to be winning out for self-employed physicians. Data from the 2000 Census indicate that male and female employed physicians between 30 and 50 who are self-employed owners or coowners of incorporated businesses work significantly longer hours than their peers. While women physicians work an average of 46.9 h per week, self-employed women physicians with incorporated businesses work 51 h per week. While men physicians work an average of 55.1 h per week, self-employed men physicians with incorporated businesses work 58 h per week.

The pressures on self-employed physicians to work long hours are inevitably stronger when physicians are part-owners rather than sole proprietors. Physicians who have partners must balance their desire for flexible schedules with their need to pay their share of the overhead. Since changes in health care are making solo practice increasingly difficult and unprofitable, fewer physicians are considering it as an option (Cook 2007), and those who do attempt private practice may have less control than Dr. Fryhofer because of the increasing bureaucratic demands on private practice physicians. Thus, while Dr. Fryhofer's solo practice seems like an ideal situation for a working mother, it is increasingly unrealistic to expect physicians of either gender to pursue self employment as an option (Cook 2007). Further, as we discussed above, today's young medical graduates may simply

[14]Not only do malpractice premiums vary by state and specialty, they also vary within state. In 2002, a family practitioner in Cincinnati is $12,650, according to insurer ProAssurance, whereas the rate is $21,375 in Cleveland (Hawkins 2002).

be unable to make the choice that Dr. Fryhofer made because of a radically different financial horizon. The odds are that they have loans which Dr. Fryhofer did not have, and the reality is that they will not be paid as well as Dr. Fryhofer was paid (Dolan 2006).

Practice Considerations

Cultural, organizational, and financial considerations are not the only barriers to flexible professional schedules. Physicians are often expected to be continuously available to their clients. While systematic data on client expectations are not readily available, we suspect that patients are even more likely than other types of clients to expect continuous access to services because of the essential nature of health problems. As this post on the MomMD Website suggests, some patients, including physician–patients, do not react well to part-time physicians:

> I know for one (and I hope that this does not piss anyone off) that if I had a pediatrician and my kid was sick and needed to see her/him and she was part-time and not available until X day…that would tick me off and we would chose someone else. I know this sounds bad and it is probably not the PC thing to say but it "is" how I feel for now. 08-27-2005 06:45 PM August 27, 2005 06:45 PM efex101.

In fact, studies of patient satisfaction with primary care suggest that satisfaction depends on access to care and care continuity, among a list of seven factors (Anderson et al. 2007; Fan et al. 2005). Thus, the perception that patients want their physicians to be available is grounded in some degree of reality.[15]

The need to be persistently available is equally present for specialists. However, as this MomMD quote indicates, for specialists, the issue often involves being available for referrals:

> I've been reading with interest about how physicians work part-time or job share, but I don't know how to cut back on my work hours. I am a general surgeon (with 2 young children) in a group practice, taking call every 4th weekend. Over the past 8 years, I have tried to limit my work hours and numbers of patients seen, but in a field where my business depends on *my availability for referrals* [emphasis added] as well as my desire to follow my patients postoperatively, I don't know how I can cut back any more without going out of business. I love surgery, especially the laparoscopy, and I want to "stay in the game" while still raising a family. http://www.mommd.com/ubb/ultimatebb.php/ubb/get_topic/f/2/t/000475

The issue involved with "availability for referrals" involves more than the absolute number of hours a specialist works. Ideally, specialist physicians must court primary care physicians in order to maintain referrals. This networking is normally done in the off hours and thus conflicts with the needs of physicians seeking a more realistic family life.

An additional force may pressure physicians to work long weeks in the near future. Health policy makers have suggested that there are not sufficient physicians to treat aging baby boomers and that access to care will be increasingly restricted because there are not enough physicians. Evidence from Massachusetts, the first state to adopt universal health insurance, indicates that the current supply of primary care physicians is already insufficient to meet demand (Ruiz 2008). Now that nearly all Massachusetts residents have health insurance, there is now a 3–4 week delay to see many specialists and a 10% increase in the number of family physicians who have closed their practices because they are so busy (Ruiz 2008). Although systematic evidence is lacking, it is reasonable to suspect that as the shortage persists and grows, many physicians will work more than they want to work because they do not want to turn sick or needy patients away.

[15]There is also limited evidence that continuity relates to positive health outcomes. In particular, research indicates that patients who see the same provider consistently are less likely to be hospitalized, are less likely to use emergency services, and are more likely to receive preventive services (Cabana and Jee, 2004).