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Part-time medical practice: where is it headed?

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One of the fundamental tenets of medicine has been the centrality of the profession as a life calling; physicians work long hours and routinely sacrifice personal interests for professional demands. In 1993, only 13% of clinical faculty and 6% of basic science faculty members of U.S. medical schools worked part-time.[1] Historically, female physicians have been more likely than their male counterparts to work less than full time. Yet, despite increasing numbers of women in medicine and increased interest in personal time for self and family, U.S. medical workforce projections have forecast only a 3% decrease in the anticipated full-time equivalent of physicians over the next 10 years.[2]

Trends in the general workforce provide a backdrop for changes in U.S. physicians' work hours. Over the past 20 years, full-time employment of women has increased 46%, while part-time employment has increased 88%. In 1988, women were 67% of the part-time labor force and 40% of the full-time labor force in the United States.[3,4] The percentage of women in the first year classes of U.S. medical students increased nationwide throughout the 1990s. These trends would indicate that an increase in interest in part-time work is likely to occur among U.S. physicians.

The Netherlands has a health care system that includes prepaid and fee-for-service health care as well as

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private and government-sponsored health insurance. Medical specialists work in large groups within hospitals, while primary care is provided predominantly by self-employed general practitioners. The prevalence of part-time work among both men and women of all occupations is high in comparison with other western European countries. In medicine, this situation was the result of direct political activism by female, salaried, and housestaff physicians and was linked to concerns about long work hours. In 1995, 29% of the Dutch medical workforce worked part-time: 12% of male physicians and 63% of female physicians. Recently in The Netherlands, part-time medical practice has become a favorite strategy to combine work and family duties.[5]

Using data from large cross-sectional surveys of physician, we report on a culture in which part-time medical practice is uncommon and nontraditional (United States) and a medical culture in which part-time medical practice is both common and accepted (The Netherlands). These two unique datasets provide an opportunity to use physician-generated information to explore the implications of the potential increase in U.S. physicians desiring and choosing part-time careers.

Methods

The study design of the U.S. Physician Worklife Study has been described elsewhere.[6] In brief, we randomly sampled 5704 physicians, oversampling minority physicans and sampling women physicians in proportion to their prevalence in practice. Four mailings of a validated 140-item questionnaire[7] yielded an adjusted response rate of 52% (n = 2326). A "wave analysis," comparing early and late respondents, suggested little effect of late or nonresponse. The questionnaire included multiple measures of a physician's satisfaction in addition to demographic data, work hours, part-time status (less than 40 hours per week), and physician's control over work hassles, medical decision-making, and workplace issues. We also measured stress[8] and burnout[9] using previously described tools.

In the Dutch survey, "The Inventory of Part-time Work Among Medical Specialists," a random stratified sample of physicians (n = 3026) was drawn from lists of the medical associations of general practitioners and internal medicine subspecialists, psychiatrists, ophthalmologists, and anesthesiologists; the adjusted reponse rate was 66%. The survey consisted of detailed questions on work hours, family situation, part-time orientation, status as a contracted (salaried, nonpartner) or self-employed physician, and total work hours. Participants who worked less than 40 hours were designated part-time.[10] Part-time orientation was ascertained by soliciting attitudes about part-time jobs in medicine, including the consequences of working part-time on cooperation, teamwork, and intent to decrease hours. For this analysis, we included all Dutch respondents (n = 1976) still practicing medicine.

Means and proportions were obtained by adjusting for survey weights and strata. P values were obtained by chi-square and t-statistics.

Logistic regression analysis was used to determine predictors of part-time practice.

Results

Thirteen percent of U.S. respondents worked part-time; 22% of women and 9% of men ($P < 0.01$, see Table 1). Part-time women physicians were more likely to be married and have young children. 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%; $P = 0.05$). Among academic physicians, who for the most part were community-based, academically-affiliated practictioners, part-time practice was relatively uncommon (11%). Part-time physicians worked an average of 28 hours weekly, compared with an average of 58 hours for full-time physicians, and spent a greater percentage of their time working in ambulatory care (66% for part-time vs. 57% full-time; $P = 0.001$) and less time in hospital-based medicine (12% for part-time vs. 17% for full-time; $P = 0.01$).

Part-time U.S. physicians felt better able to control their work hours (3.08 vs. 2.61 on a 1 to 4 scale; $P = 0.001$), work interruptions (2.44 vs. 2.20; $P = 0.003$) and work hassles (2.29 vs. 2.05; $P = 0.001$) (Table 2). Part-time physicians were less likely to perceive competition in their work than full-time physicians. Remarkably, both part-time and full-time physicians felt similar levels of support from partners at work for the balance of home and work. 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 (2.18 vs. 2.38 on a scale from 1 to 5; $P = 0.002$). The study revealed no significant differences between the intent of part-time and full-time physicians to withdraw from clinical practice or decrease work hours.

Of 1976 Dutch respondents, 32% were part-time (74% of all women and 18% of all men). The vast majority of both part-time and full-time physicians had domestic partners and children. Full-time female physicians were significantly more likely to be single than

Table 1 Demographic and practice characteristics of U.S. part-time vs. full-time physicians

	Overall		Women		Men	
Characteristic	Part-time 13% (n = 303)	Full-time 87% (n = 1982)	Part-time 22% (n = 160)	Full-time 78% (n = 556)	Part-time 9% (n = 142)	Full-time 91% (n = 1422)
Age (years)	48	47	43	43	51	48*
Married	87%	86%	84	75*	89	89
Children <5 years	26%	20%	38	25	15	19
Children 5–12 years	40%	40%	50	35*	32	41
Children 13–18 years	26%	32%	20	18	31	36
Practice characteristics†						
HMO	22	78	34	66	13	87
Solo	11	89	17	83	10	90
Small group	12	88	26	74	8	92
Large single specialty	16	84	30	70	13	87
Large multispecialty	9*	91	13*	87	8	92
Academic	11	89	18	82	7	93
Specialty†						
Family practice	10	90	20	80	7	93
GIM	12	88	23	77	9	91
IMSS	10	90	21	79	7	93
Pediatrics	20‡	80	26	74	16*	84
Pediatric subspecialty	9	91	15	85	5	95
Worklife						
Work hours	28	58	28	54	29	60
% ambulatory	66	57‡	67	58*	65	56*
% hospital	12	17§	11	16	12	18*
% other patient care	15	15	14	15	16	15
Other work-related activities	8	11§	8	11*	8	11*
Income ($)	97,643	147,129	80,353	110,787*	111,040	157,770*

GIM = general internal medicine; HMO = health maintenance organization; IMSS = internal medicine subspecialty

*$P = 0.05$.

†Practice characteristics comparisons have HMO as comparison group. Specialty comparisons have family medicine as comparison group.

‡$P = 0.001$

§$P = 0.01$.

part-time counterparts, and were far less likely to have children (38% vs. 76%; $P = <0.001$). As in the United States, part-time status was most likely for women with children aged 0 to 4 years and 5 to 12 years. Part-time Dutch physicians were more likely than full-time physicians to be salaried (47% of part-time vs. 29% of full-time, $P <0.001$) and were more frequently non–hospital-based specialists, with 39% of all general practitioners in part-time practice (86% of women and 22% of men). Although only 13% of all internal medicine subspecialists practiced part-time, 45% of female internal medicine subspecialists practiced part-time. However, part-time practice was not limited to women physicians and generalists; for example, 27% of male psychiatrists and 33% of male opthalmologists worked part-time. In regression analyses, survey respondents most likely to work part-time were salaried physicians, female physicians with children, and physicians practicing in a nonhospital setting. For female physicians, the absence of child care assistance predicted part-time work; for male physicians, child care assistance was not related to work hours.

The majority of Dutch physicians surveyed were positively inclined towards part-time medical practice (55% positive, 36% negative, 9% neutral), although full-time physicians had reservations concerning the continuity of patient care and the ability of part-time physicians to maintain communication with colleagues (Table 3). By comparison, part-time physicians felt that part-time practice did not affect continuity of care, quality of professional life, or communication with colleagues. Only in the area of practice autonomy did part-time physicians perceive more difficulties than full-time physicians.

Discussion

In the United States, part-time work is relatively uncommon; the majority of part-time physicians are younger women with children, and the highest prevalence is in general pediatrics and in health maintenance organizations. In The Netherlands, part-time practice is highly prevalent among female physicians; the majority of these

Table 2 Comparison of job, satisfaction, work control, and perceived support of part-time and full-time U.S. physicians

Variable	Part-time (n = 303)	Full-time (n = 1982)	*P* Value
Satisfaction*			
Autonomy	3.51	3.33	0.017
Patient care issues	3.44	3.08	<0.001
Patient relationships	3.74	3.87	0.12
Administration	2.95	2.55	<0.001
Colleague relationships	3.61	3.66	0.37
Personal time	3.32	2.81	<0.001
Resources	3.69	3.69	0.46
Global job satisfaction	3.83	3.68	0.034
Career satisfaction	3.72	3.71	0.89
Specialty satisfaction	3.53	3.51	0.80
Work control†			
Ability to control work hours	3.08	2.61	0.001
Ability to control work interruptions	2.44	2.20	0.003
Ability to control work hassles	2.29	2.05	0.001
Colleague support for work family balance	3.54	3.48	NS
Stress	2.18	2.38	0.002
Burnout‡	18%	24%	0.09
Intent to decrease work hours	24%	28%	0.40
Intent to leave the practice	21%	14%	0.08
Intent to leave patient care	16%	14%	0.48

*Satisfaction and colleague support scored from 1 to 5, with 5 = strongly agree.
†Control variables scored from 1 to 4, with 4 = very often.
‡Scored from 1 to 5, with 5 = higher score. Burnout = score of 3 or higher on single item question.

women have children, and close to half work as salaried employees.

Workforce and organizational implications

The practical and attitudinal differences in part-time practice between the United States and The Netherlands raise an important question facing the United States with regard to the physician workforce: "Who will do this job?" As the role of being a physician becomes increasingly less satisfying and less remunerative, U.S. medical leaders wrestle with the challenge of ensuring a high quality physician workforce. To the extent that practicing part-time allows for increased satisfaction among physicians,

Table 3 Attitude toward part-time work*: comparison of full-time and part-time Dutch physicians (n = 1977)

	Full-time	Part-time	
Variable	Mean		*t*-Value†
A part-time doctor invests as much in *overhead-tasks* (e.g., administration) as full-time doctors	2.82	3.18	4.17
Part-time working is *restrictive towards autonomy*	2.62	3.75	10.78
A small part-time job (0.3 FTE) at the start of a career is disastrous for *building up an independent position* as a doctor	3.84	3.32	6.37
Working part-time is threatening to the *continuity of patient care*	3.16	2.17	12.41
For professionalism, working part-time or full-time is not important	3.15	3.81	7.95
Part-time working is negative for *communication and contact with colleagues*	3.21	2.50	9.59
For a part-time doctor it is not possible to *build up a network* with other health care partners	2.70	1.81	13.22
The lesser hours worked the *lesser efficiency* will be reached	3.23	2.43	9.69
If the proportion part-time doctors increases, the *flexibility of task-division* will be higher	2.62	3.30	8.64
The *numbers* of part-time doctors in our speciality have reached a ceiling	2.12	1.63	7.49

FTE = full-time equivalent
*Attitude was scored from 1 to 5; 1 = *I do not agree at all,* 5 = *I fully agree*.
†*P* <0.001 for all comparisons, with *t* test.

part-time work may well be a key mechanism for maintaining a highly motivated cadre of young physicians, especially in general internal medicine where satisfaction is relatively low.[11]

The concept of part-time medical practice challenges long-established traditions in medicine. The worth of a physician has often been measured according to productivity, indefatigability, and selfless dedication (e.g., "A great resident; he/she never leaves the hospital.") However, the practice and ethos of medicine have evolved. Traits such as humanism, the ability to balance work and home, compassion, and collegiality are now more readily recognized as important components of "the good physician." For many physicians making their way through the complex matrix of U.S. medical practice, part-time work is attractive precisely because it allows better opportunities for developing and maintaining these professional qualities.

In both the United States and The Netherlands, part-time practice is predominant among young women with children. In the United States, part-time practice is also more common among older men, presumably as they move toward retirement. Thus, part-time practice is fulfilling two key objectives: providing a mechanism for female physicians to balance professional and personal lives, and allowing older (predominantly male) physicians a means of staying active within their practices. Both of these situations enrich the physician workforce and can be an efficient way to provide sufficient staffing for patient care.

Although full-time Dutch physicians expressed reservations about part-time practice, recent articles from the United States suggest that patients of part-time physicians are as satisfied as patients of full-time physicians in virtually all domains, including continuity of care,[10,12] although one study showed a significant increase in patient satisfaction with continuity for patients of physicians who worked "overtime (>65 hours per week) compared with full-time physicians.[10] Fein and colleagues found no difference in case mix, severity of illness, or length of stay when comparing inpatients of part-time versus full-time academic internists; furthermore, patient satisfaction ratings were similar for all physicians.[13] Thus, there is little evidence that part-time practice compromises quality of care. Whether part-time practice is feasible in complex medical specialties, such as medical oncology or renal transplantation, remains to be determined.

Part-time practice and academia

Many U.S. academic health centers are now experimenting with allowing faculty to work part-time. Although part-time faculty status does not inherently prevent effective functioning as a physician, teacher, mentor, or scholar, academic medicine is daunting to those who wish to work less than a typical 55- to 60-hour work week. Nevertheless, academic institutions are likely to benefit from a more flexible approach to faculty work hours if it values faculty and wants to nurture and protect them. Otherwise, academic medicine is in danger of losing some of its most talented and dedicated people, who may choose more welcoming environments for part-time careers.

As part-time practice grows in academic medicine, challenges include concerns about continuity, networking, and communication between part-time physicians and their full-time counterparts. Issues of workforce size and the additional cost of benefits are also of concern. Part-time physicians in academia will need to decide with their colleagues how available they can be when not in the office, and departmental leaders will need to pay attention to issues of career trajectories, including promotional clocks, as well as how to avoid any sense of second-class citizenship. Increasing pressures to pay for clinical time may be especially salient for part-time faculty, who have traditionally chosen clinical practice as the predominant mode of participation.

One mechanism to ensure that leaders are both cognizant and supportive of part-time physician issues is to incorporate part-time physicians into the leadership structure of practice organizations. For example, at the University of Wisconsin, two clinic medical directors worked part-time. In answer to the question, "How can a part-time physician take a leadership role?", we posit that a part-time person with excellent leadership skills and work control can have as much presence and accountability as a full-time physician who is potentially overcommitted and less able to control his or her workplace.

The potential for increasing numbers of physicians seeking part-time careers has implications for the physician workforce in academic departments.[14] Academic centers can play a positive role by creating systems in which part-time faculty are productive and valued and can serve as role models for trainees who are preparing for practice outside academia. Indeed, at a time when trainees place a growing emphasis on work-family balance, a core group of satisfied part-time physicians could improve the recruitment of medical students into internal medicine. It will therefore be beneficial for institutions to consider and study their strategies for accommodating larger numbers of part-time physicians—strategies that could ultimately result in highly functioning health care teams and the highest quality care for patients.

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