



Factors in Considering and Adopting Part-Time Work Schedules Among Early-Career Physicians

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Introduction

Projections from the Association of American Medical Colleges (AAMC) estimate a shortage of approximately 86 000 physicians by 2036, underscoring the importance of physician workforce retention.^{1,2} The prevalence of physicians who may be considering part-time work but are not currently working part-time has not been well-characterized and may indicate an early sign of attrition or departure from the workforce. Gender, specialty, parental status, and time may uniquely influence one's ability to transition to part-time work. We examined factors of considering and working part-time among early-career physicians across a 10-year follow-up period.

Methods

This cohort study included US physicians enrolled in the Intern Health Study who participated in longitudinal follow-up surveys after completion of residency training between 2015 and 2024 (eFigure in Supplement 1). Participants provided written informed consent and were compensated \$25 per survey. The study was approved by the University of Michigan institutional review board. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline was followed.

Work status was categorized as: (1) working full-time and not considering part-time; (2) working full-time and considering part-time; and (3) working part-time (eMethods in Supplement 1). There were 32 respondents who reported not working at 1 or more points of follow-up. When they reported not working, their responses were excluded from analyses at that follow-up time point. Generalized estimating equation (GEE) models examined longitudinal associations of gender, specialty, and parenthood with employment, adjusting for age, race, marital status, and years out of training (eMethods in Supplement 1). Two models were fit, each with a different reference category (Table).³ Results are reported as aORs with 95% CIs. We applied poststratification weights derived from the AAMC national distributions of physician gender, race, and specialty (eMethods in Supplement 1).⁴ SAS/STAT version 9.4 (SAS Institute Inc) was used for all analyses.

+ Supplemental content

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Table. Factors of Work-Status Categories Among Early-Career Physicians^a

Factors	Working FT but considering PT, OR (95% CI)	P value	Working PT after considering PT, OR (95% CI)	P value
Female	4.12 (2.85-5.95)	<.001	12.33 (6.41-23.72)	<.001
Surgeon	0.62 (0.40-0.98)	.043	0.55 (0.28-1.11)	.10
Parent	1.06 (0.81-1.39)	.68	2.20 (1.38-3.51)	.001
Years out of training	1.04 (1.002-1.07)	.04	1.07 (1.02-1.12)	.004

Abbreviations: FT, full-time; OR, odds ratio; PT, part-time.

^a Adjusted for age, race, marital status, and years out of training. Race was self-reported in the survey data and was categorized as Asian or Pacific Islander, Black or African American, Hispanic or Latinx, non-Hispanic White, and other (including Native American, Arab or Middle Eastern, multiple races, other, or no response).

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Results

Overall, 710 participants completed 1 or more postresidency survey. Median (IQR) follow-up was 8.3 (5.5-12.0) years; 370 participants (52.1%) were women, 270 (38.0%) were in a surgical specialty, and 356 (50.1%) were parents at baseline. Baseline characteristics did not differ significantly by gender.

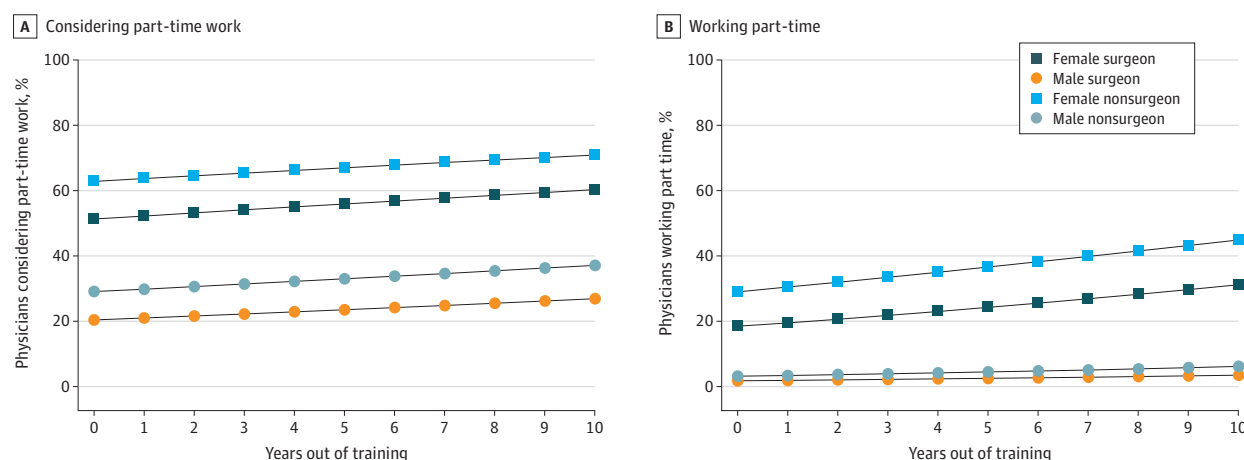
Consideration of part-time work increased steadily across all groups (**Figure, A**). Across follow-up, there were higher levels of considering part-time work among female nonsurgeons (10-year follow-up: 70.9% [95% CI, 62.9%-77.7%]) and surgeons (60.3% [95% CI, 50.0%-69.7%]), than male nonsurgeons (37.1% [95% CI, 29.7%-45.2%]), and surgeons (26.9% [95% CI, 18.4%-37.6%]). Among those considering part-time work, the proportion who had transitioned to working part-time also rose over time but was strikingly lower for male physicians regardless of specialty (Figure, panel B).

Female gender (aOR, 4.12; 95% CI, 2.85-5.95), and years out of training (aOR, 1.04; 95% CI, 1.002-1.07) were associated with higher odds of considering part-time work, while surgical specialty (aOR, 0.62; 95% CI, 0.40-0.98) was associated with lower odds (Table). Female gender (aOR, 12.33; 95% CI, 6.41-23.72), parenthood (aOR, 2.20; 95% CI, 1.38-3.51), and years out of training (aOR, 1.07; 95% CI, 1.02-1.12) were all associated with higher odds of working part-time compared with working full-time, while considering part-time (Table). Among those considering part-time work, the surgical specialty was not associated with a transition to part-time work (Table).

Discussion

Female gender was associated with considering part-time work and, among those considering it, with much higher odds of working part-time. Our data further highlight that, among surgeons and nonsurgeons alike, there is a significant gap between considering part-time work and working part-time (Figure). For example, by year 10 of follow-up, 60.3% of female surgeons were considering part-time work, compared with just 31.2% working part-time. This gap suggests that barriers may prevent physicians from realizing their desire to work part-time, including physician shortages, high levels of debt from medical training, or cultural stigma attached to reduced work effort. Creating pathways to part-time work, in addition to improving working conditions to support a more diverse workforce with increasing demands outside of work, may serve as a complementary strategy to curb workforce attrition and lost productivity.⁵ Although not captured by our data, structural features of surgical

Figure. Proportion Considering and Adopting Part-Time Work Schedules, by Gender-Specialty Groups



Estimated proportions of physicians considering part-time work and working part-time over 10 years after training, stratified by gender and specialty. Points represent model-estimated percentages from generalized estimating equation (GEE) models. A,

Reference for considering part-time was full-time and not considering part-time; B, reference was working full-time and considering part-time.

practices, including call responsibilities, continuity-of-care demands, long operative hours, and limited precedent for reduced schedules, have been implicated as barriers to part-time work for surgeons.⁶⁻⁸ Female surgeons experience competing pressures: a desire for reduced hours (like women physicians broadly) alongside structural and professional barriers to achieving them that are specific to surgical practice.

Our findings reinforce a growing body of research highlighting workforce issues, including reduced effort and attrition, particularly among female physicians. The majority of female physicians in this cohort report considering part-time work, suggesting the scope of this challenge may be larger than previously appreciated. The significance of parenthood in association with part-time work may highlight that societal inequity in domestic roles has a significant impact on female physicians' consideration of reduced effort. Our results are observational, limiting causal inference, and the survey design limits generalizability due to responder bias. Equitable parental leave and childcare support, as well as institutional efforts to support flexible scheduling or reduced-hour arrangements and normalization of such arrangements within professional culture, are all intervention targets.

ARTICLE INFORMATION

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Author Contributions: Drs Hughes and Bohnert had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: Kim, Sinco, Bohnert, Hughes.

Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: Kim, Sinco.

Critical review of the manuscript for important intellectual content: All authors.

Statistical analysis: Sinco, Zhao.

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Administrative, technical, or material support: Zhao, Fang, Hughes.

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SUPPLEMENT 1.

eFigure. Flow diagram of included participants
eMethods.

SUPPLEMENT 2.

Data Sharing Statement