

COMMENTARY

The Gender Penalty: Reasons for Differences in Reported Weekly Work Hours Among Male and Female Family Physicians

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The *JABFM* policy brief by Wilkensen et al¹ highlights gender differences in work hours between male and female family physicians, with men reporting significantly more hours of total and direct patient care across age groups. This comes as no surprise to me as a female family physician with 3 young children who has shifted to part-time clinical work in no small part due to the competing demands of work and family. Many of my female medical school and residency classmates have followed similar paths. Some have left patient care altogether for administrative, research, or government positions, while others have transitioned to part-time clinical jobs. Traditional gender roles are still very much at play. The “invisible work” of raising children often falls on mothers, regardless of employment status. This begins with breastfeeding (and the natural carry-over to the intensive caregiving responsibilities of infancy) and evolves into scheduling doctor’s appointments, completing school forms, coordinating activities, and arranging childcare, among thousands of other small tasks that cumulatively take up hours over the course of the week.

There has been a shift in recent years toward less-than-full-time work among physicians,^{2,3} with a smaller rate of decline in work hours for male physicians, older physicians, and those with fewer

children.² Previous studies have also shown that family physicians are more likely to work part time compared with specialists. This likely reflects a cultural shift in medicine with millennial physicians placing a higher value on work-life balance over salary and career progression.⁴

Compared with previous generations, dual-career couples are more the norm, making childcare more logistically challenging.⁵ Younger male physicians are more than twice as likely as older male physicians to make career changes for their marriage and children.⁶ However, spouses of male physicians are less likely to work full-time than those of female physicians.⁷ Furthermore, female physicians in dual-physician relationships spend more time on domestic work than female physicians married to nonphysicians.⁸ The American Time Use Survey results from 2003 to 2016 showed that married female physicians spent significantly more time on household activities and childcare than male physicians, even after adjustment for respondent and spouse hours outside the home.⁹ Women physicians with children spent an additional 100.2 minutes per week than men, while female physicians without children spend 67.4 minutes.⁹ These pressures undoubtedly influence female physicians’ tendency to work part time.

This work-hour gap not only has implications for the family physician workforce and patient access, but likely contributes to the “motherhood penalty,” leading to known gender disparities in leadership positions and salary.^{10–12} While the survey sample described in the policy brief by Wilkensen et al¹ did not capture early career physicians, gender disparities in new physicians and trainees are well documented in the literature. A survey of early career physicians revealed that women physicians were significantly more likely

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than their male counterparts to report not working full time.¹³ This gap increased in women with children and as time progressed after training. Women physicians currently working full time were more likely to report considering part-time work. Predictors for considering leaving clinical practice included lack of support from colleagues and superiors, lack of performance-related feedback from supervisors, and overtime.¹³ A majority of women working part time or not at all cite family as the reason for their decision.¹⁴

Pregnant residents are inclined to deny physical and psychological limitations and compensate by overworking. For example, many work right up to delivery, take extra call to compensate for time off during maternity leave, and truncate the duration of maternity leave.^{15,16} While fellow residents and program directors are generally supportive of colleagues who are pregnant, some colleagues may express feelings of resentment and hostility.¹⁵ Several studies have shown gender differences in perceptions of pregnant colleagues, with men being generally less supportive than women.^{17,18} In a survey of residents and fellows, female physicians were more likely to feel that having a child during training would burden colleagues and negatively impact their reputation and their future career success.¹⁹ Of respondents who had children, female physicians were more likely to be the primary caregivers on weeknights and weekends. This disparity is further exacerbated by a lack of institutional resources: only 38% of academic hospitals have childcare on site, and less than 60% have lactation rooms.²⁰ Duration of breastfeeding is likely to be negatively affected by stigmatization of nursing mothers, lack of dedicated lactation rooms, and lack of time for pumping during busy clinical schedules.²¹ Despite all these challenges, reassuring data suggests that the disparity in wages and prestige of motherhood is time limited, with mothers' salaries and occupational achievement approaching those of childless women by middle age.¹⁰ In terms of wages, the majority of mothers report equivalent salaries to childless women by the time they reach their 40s. However, mothers of 3 or more children continue to experience wage penalties of 4% per child well into their 50s, a phase of life when many are facing the burden of financing multiple college tuitions and saving for their own retirement.

Wilkinson et al¹ noted that gaps in work hours were widest between the age ranges of 35 to 49 years and 60 to 69 years, surmising that caretaking may be responsible for the 60-to-69-year age-group gap. However, studies looking at the association between

age and intention to leave clinical practice show conflicting evidence, with 1 study demonstrating the greatest intention to leave for those aged 33 to 35 years with declining intention to leave after the age of 50 years,²² while 3 others showed a higher intention to leave in older compared with younger physicians.^{23–25} One explanation for a lower intention to leave in younger physicians include a greater financial burden of raising young children.²³ In addition, physicians nearing retirement may experience more burnout related to an evolving medical landscape that emphasizes quality metrics, electronic medical record documentation, condensed appointment times, and patient satisfaction scores.

Lack of acknowledgment of family responsibilities has been linked to lower job satisfaction and higher levels of stress and absenteeism.²⁶ Clearly, systemic reforms are needed to support female family physicians in their multiple roles to improve work-life balance, especially now that women comprise more than half of the US medical school population.²⁷ Reform will require the multi-level support of leaders in medicine, including clinical practitioners, administrators, academicians, and policy makers. This further underscores the need for younger female leaders in medicine who are likely to have different values about work-life balance than older male policy makers.⁶ Changes that have been proposed as “primary prevention” strategies to retain female physicians include the following: workplaces should offer affordable childcare with extended hours, dedicated lactation rooms, and parental leave coverage equivalent to that of the Family Medical Leave Act (12 weeks total, with 6 weeks' paid leave); competency-based advancement of resident trainees based on Accreditation Council for Graduate Medical Education (ACGME) milestones, with flexibility for length of training; and other measures to decrease work-related burden and increase job satisfaction, including more administrative support and time for continuing education.^{13,19,28,29}

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