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Date :	06 – 04 - 2010	Document:	F11-025 EN
Title:	“More Physicans say NO to endless workdays “		
Authors:	New York Times		



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April 1, 2011

More Physicians Say No to Endless Workdays

By **GARDINER HARRIS**

HONESDALE, Pa. — Even as a girl, Dr. Kate Dewar seemed destined to inherit the small-town medical practice of her grandfather and father. At 4, she could explain how to insert a pulmonary catheter. At 12, she could suture a gash. And when she entered medical school, she and her father talked eagerly about practicing together.

But when she finishes residency this summer, Dr. Dewar, 31, will not be going home. Instead, she will take a job as a salaried emergency room doctor at a hospital in Elmira, N.Y., two hours away. An important reason is that she prefers the fast pace and interesting puzzles of emergency medicine, but another reason is that on Feb. 7 she gave birth to [twins](#), and she cannot imagine raising them while working as hard as her father did.

“My father tried really hard to get home, but work always got in the way,” Dr. Dewar said. “Even on Christmas morning, we would have to wait to open our presents until Dad was done rounding at the hospital.”

Dr. Dewar’s change of heart demonstrates the significant changes in American medicine that are transforming the way patients get care.

For decades, medicine has been dominated by fiercely independent doctors who owned their practices, worked night and day, had comfortable incomes and rarely saw their families.

But with two babies, Dr. Dewar wants a life different from her father’s and grandfather’s. So instead of being an entrepreneur, she will become an employee of a large corporation working 36 hours a week — half the hours her father and grandfather worked.

Indeed, emergency room and critical-care doctors work fewer hours than any other specialty, according to a 2008 [report](#) from the federal [Department of Health and Human Services](#).

Her decision is part of a sweeping cultural overhaul of medicine’s traditional ethos that along with wrenching changes in its economics is transforming the profession. Like Dr. Dewar, many other young doctors are taking salaried jobs, working fewer hours, often going part time and even choosing specialties based on family reasons. The beepers and cellphones that once leashed doctors to their patients and practices on nights, weekends and holidays are being abandoned. Metaphorically, medicine has gone from being an individual to a team sport.

For doctors, the changes mean more control of their personal lives but less of their professional ones; for patients, care that is less personal but, as studies have shown, more proficient.

Older doctors view these changes with considerable ambivalence, among them Dr. Dewar's 90-year-old grandfather and 61-year-old father, although both supported Dr. Kate Dewar's decisions and were thrilled about the birth of her twins.

"My son and I had deeper feelings for our patients than I think Kate will ever have," Dr. William Dewar II said over lunch at a diner in Honesdale, about 30 miles northeast of Scranton. Munching on a club sandwich, Dr. William Dewar III gestured toward the diner's owner, who had greeted them deferentially.

"I've had three generations of his family under my care," he said as a waitress brought his usual Diet Coke without being asked. "Kate will never have that."

In a separate interview, Dr. Kate Dewar said that treating chronic conditions like [diabetes](#) and [high cholesterol](#) — a huge part of her father's daily life — was not that interesting. She likened primary care to the movie "Groundhog Day," in which the same boring problems recur endlessly. Needing constant stimulus — she e-mails while watching TV — she realized she could not practice the medicine of her forebears.

"I like it when people get better, but I'd rather it happen right in front of my eyes and not years later," she said. "I like to fix stuff and then move on."

Her attitude is part of a gradual distancing between doctors and patients. Doctors were once revered, but a host of intermediaries — insurers, lawyers, the Internet, growing patient needs and expectations — have intervened, to the point that many patients now see doctors as interchangeable. Younger doctors are deciding that the personal price of being at their patients' beck and call is too high, while acknowledging that teams of doctors can offer a higher quality of care. So they are embracing corporate, less entrepreneurial and less intimate roles in part for the uninterrupted family time they bring.

"Look, I'm as committed to being a doctor as anyone. I went back to work six weeks after my boys were born. I love my job," said Dr. Kate Dewar. "But I was in tears walking out of the house that first day. I'm the mother of twins, and I want to be there to feed them, play games with them or open presents with them on Christmas morning. Or at least I want the option to do those things without fearing I'll be called back to the hospital."

The pain of that first week's separation was lessened somewhat because she worked in the hospital's new pediatric emergency department. "I felt better knowing that at least I was taking care of somebody else's babies even if I couldn't be with mine," she said.

Three Generations of M.D.'s

The story of the Dewars demonstrates how these trends have played out over nearly seven decades.

Dr. William Dewar II opened his practice 67 years ago at his home in Catasauqua, Pa., an Allentown suburb, with his wife, Thelma, as his lone nurse and assistant. He delivered babies and set broken bones. Sick patients showed up on his doorstep at all hours, with some sleeping over. When they needed to be hospitalized, Dr. Dewar oversaw their care. Patients paid cash — \$2 for an office visit and \$3 for a house call, fees that covered most needed medicines.

Thelma Dewar handled the bills and laboratory tests, often by cooking urine samples on the stove before analysis.

“I loved my practice. Totally loved it,” Dr. Dewar said. “You were in touch with the patients. They were part of your family.”

The culture of medicine at the time was decidedly macho. Residents routinely worked 120 hours a week, often staying at the hospital for days at a time. Indeed, the term “residency” comes from the first such program at [Johns Hopkins University](#), established around the start of the 20th century, where doctors lived in a dormitory next to the hospital, a monastic life inimical to women who wanted children. As the residency requirement took hold nationally, the share of female doctors, already low, fell further. Dr. William Osler, the founder of the residency program, celebrated such sacrifices.

“What about the wife and babies if you have them? Leave them,” Dr. Osler wrote. “Heavy are the responsibilities to yourself, to the profession and to the public. Your wife will be glad to bear her share of the sacrifices you make.”

After 25 years in Catasauqua, the Dewars moved to the Honesdale area, and their oldest son joined the practice — which by then had moved to an office building. But working outside the home meant that Dr. William Dewar III saw less of his children than his father had seen of his — though he attended more of their sporting events. He tried to make a point of eating dinner with the family, but often failed because his sickest patients spent more time in the hospital as fewer people died at home. Even when he did make it home for the meal, he often left afterward. He was on call seven days a week, limiting vacations.

“We always joked that as soon as Dad’s butt hit the chair for dinner, his beeper would go off,” Dr. Kate Dewar said.

A Changing Field

But even as the two men tried to keep their practice the same, the world around them kept shifting. Their patients’ medical needs grew steadily, and specialists began to take over the more complicated procedures.

After his father retired at 75, Dr. Dewar merged his practice with those of four other doctors,

eventually moving into a large building that once housed the town's bowling alley. Thousands of paper records occupy much of the building's space, and 35 employees handle the billing and other clerical functions.

And the burden of trying to be all things to all of his patients became unmanageable. In 2006, after Wayne Memorial Hospital hired hospitalists — doctors who specialize in taking care of hospitalized patients — Dr. Dewar finally gave up hospital rounds.

For his hospitalized patients, the change meant putting their trust in a doctor who knew them less intimately but was more available and more adept at hospital care. "My patients are getting better care now in the hospital," Dr. Dewar said.

And the change saved him hours of work each week. "It meant getting off the hamster wheel," he said.

In her third year of medical school, Kate Dewar shadowed clinic doctors treating patients with everyday illnesses. It was just the kind of medicine her father practices: advising the obese to lose weight and the smokers to quit, and prescribing cholesterol and [hypertension](#) medicines again and again. "I hated it, and I felt terribly guilty," she said. She called her father and broke the news that she wanted to work in a hospital. He was very supportive, she said.

Her father also remembered being both envious and disappointed. "On the one hand, it bothers me that the generation of doctors that my daughter is in doesn't work as many hours and isn't willing to do the stuff that I did," he said. "On the other hand, I'm almost a little jealous."

Such mixed feelings are common among older doctors, many of whom have been unable to sell or even give away their practices because younger doctors are not willing to work the hours required. Indeed, Dr. William Dewar III's practice has hired [nurse practitioners](#) recently, in part because it cannot recruit doctors.

Merritt Hawkins, a top doctor recruitment firm, reported that 51 percent of the positions it filled in the past year were for [hospitals](#), up from 14 percent eight years ago. And even a growing share of the jobs the company filled in private practices included income guarantees from hospitals. Young doctors surveyed by Merritt Hawkins listed quality of life well above finances as the most important factor in their job searches, and just 1 percent said they were willing to practice alone. Many young doctors will not take jobs that require them to be on call.

Almost every hospital in the country has vastly expanded its medical staff. Lehigh Valley Health Network in Allentown, where Dr. Kate Dewar currently works, has gone in seven years from 100 to 500 employed doctors.

A Different Pace

A day spent with Dr. Dewar in the emergency room of Lehigh Valley Hospital-Cedar Crest had the

feel of an episode of “E.R.,” far different from “Marcus Welby, M.D.,” which her father grew up with. The attending physician was Dr. Rezarta Lloyd. The two women had complete control over a section of the emergency room reserved for the most serious cases, and there were many that day: a young woman with a deep gash on her hand that Dr. Dewar stitched closed, an older woman with suffocating fluid around her heart, and a 35-year-old man with a high fever, abdominal pains and an altered mental state.

The two doctors ordered a CT scan of the man’s midsection, and they stood next to a computer terminal and toggled through images of his internal organs, deeply concerned.

“Everything looks so inflamed,” Dr. Dewar said as Dr. Lloyd nodded. “Look at the stomach. Look at the wall there. What is wrong with this guy?”

The more challenging the case, the better the women liked it. Each tended to collect rare and difficult interventions like merit badges. Standing beside the display screen, Dr. Dewar told a story about having a patient whom she thought might need a tracheotomy, a rarely done procedure in which a tube is put into a patient’s throat to prevent suffocation. She had a “trach kit” placed in the patient’s room just in case.

While attending to another patient, Dr. Dewar noticed a commotion outside the patient’s room and yelled at her colleague on duty, playfully threatening bodily harm to anyone else daring to do “her” tracheotomy.

The tracheotomy story was interrupted by another phone call from one of the hospital’s radiology technologists, whom Drs. Dewar and Lloyd had sparred with all day. The two had sent a patient whose damaged eye was bleeding, leaking fluid and bulging. The doctors had described the patient’s condition in the order they submitted for the CT scan, but the technologists rarely seemed to read those instructions closely, Dr. Dewar complained.

“No,” she said. “We’re looking for a globe rupture.”

Then a 22-year-old man showed up with flu symptoms. Dr. Dewar, pregnant at the time, kept her distance while Dr. Lloyd went to his bedside and, later in the day, prescribed antivirals.

“My big fear is patients with the flu,” Dr. Dewar explained. “Pregnant women were the ones who died from H1N1, so Dr. Lloyd protects me by seeing them herself. I had my flu shot and all that, but if I don’t have to risk it, I won’t.”

Pregnant residents are another sign of medicine’s shifting culture. Residency hours and practices were once so grueling that few doctors deliberately became parents during those years. But in an effort to reduce fatigue-related errors, residency hours were reduced in 2003 to 80 per week. Last year at Johns Hopkins, the birthplace of the residency program, more than a third of the women in one internal medicine residency program became pregnant or were the mothers of young children — an outcome that would have been unimaginable to William Osler.

Still, carrying twins on a job that requires hours of walking between rooms was not easy. On a nine-hour shift in her 29th week, she drank three liters of water and snacked constantly on cheese crackers.

But when her shift ended, Dr. Dewar went home and put up her feet. And no pager threatened her rest — something her father has rarely experienced.