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Minority Female Physicians' Family and Career Experiences: A Qualitative Inquiry

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LOMA LINDA UNIVERSITY
School of Science and Technology
in conjunction with the
Faculty of Graduate Studies

Minority Female Physicians' Family and Career Experiences: A Qualitative Inquiry

by

Nishana R. Clarke

A Dissertation submitted in partial satisfaction of
the requirements for the degree of
Doctor of Philosophy in Family Studies

June 2011

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Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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CONTENTS

Approval Page.....	iii
Acknowledgements.....	iv
List of Figures.....	viii
List of Tables	ix
Abstract.....	x
Chapter	
1. Introduction.....	1
Background.....	3
Objective of the Study	5
Rationale for the Study	6
2. Review of Literature	8
Issues of Work and Family	8
Work and Family Issues of Professional Women.....	11
History & Development of Minority Physicians and Female Physicians.....	17
Work and Family Life of Female Physicians	19
Marital Relationship.....	25
Children’s Impact on Work and Family Life.....	27
Work-Family Conflict.....	30
Minority Female Physicians	32
Conclusion	37
3. Family Systems Theory	40
History and Development of Family Systems Theory.....	41
Family Systems Theory	43
Circularity	45
Boundary.....	46
Equifinality	49
Equilibrium and Homeostasis.....	50
Feedback	51

Family Systems Theory Applied to Present Study	54
4. Methodology	61
Sample and Data Creation	62
Data Analysis	64
Social Horizons of the Research	70
Methodological Issues: Reliability, Validity, and Generalizability	72
Research Questions	74
Expected Results	75
Implications	75
Implication for Research	77
Implication for Practice	80
Implication for Theory	82
5. Publishable Paper:	
Literature	84
Women and Work	85
Professional Women and Work	86
Female Physicians	87
Minority Female Physicians	88
Family Systems Theory	89
Methods	90
Sample and Interviews	90
Analytic Approach	91
Validity	93
Results	94
Work Demands	95
Multiple Role Demands	98
Role Expectations	99
Motherhood guilt	101
Couple Nurture	103
Accommodation	105
Discussion	107
Strengths and Limitations	112
Implication for Research, Theory, and Practice	113

Research.....	113
Theory.....	114
Practice.....	115
References.....	117
Dissertation References	122
Appendix	
A. Informed Consent.....	135
B. Demographic Questionnaire (Physician and Spouse)	137
C. Qualitative Interview Questionnaire	140
D. Instructions on Conducting Qualitative Interviews.....	150
E. Coding Categories with Quotes.....	152
F. Demographic_of Respondents	170

FIGURES

Figures	Page
1. Work-Family Accommodation Model	95

TABLES

Tables	Page
1. Demographic Description of Respondents	170

ABSTRACT OF THE DISSERTATION

Minority Female Physicians' Family and Career Experiences: A Qualitative Inquiry

By

Nishana R. Clarke

Doctor of Philosophy, Graduate Program in Family Studies
Loma Linda University, June 2011
Dr. Curtis A. Fox, Chairperson

This qualitative study investigated the experiences of married minority female physicians as they navigate their professional and family life. The study examined the impact of multiple roles, gender, and ethnicity on the familial and professional life of married minority female physicians. The study consisted of 21 married minority female physicians and covered issues related to marital life, family life, stressors, ethnicity, and gender. Analysis reveals the core categories of: work demands, multiple role demands, role expectations, motherhood guilt, couple nurture, and accommodation. The study found that the category work demands impact the family life of the participants'; however, when the category accommodation was present it reduced the effect of work demands on married minority female physicians. This enabled the participants to navigate between their career and family with more balance.

CHAPTER ONE

INTRODUCTION

Empirical literature shows that work and family are two important domains in the lives of many people (Schultheiss, 2006). These domains interweave and intersect in a manner that impact the quality of family life for those involved, work environments, and the larger community. The importance of understanding these effects is crucial and family scholars continue to examine the unique experiences of these on work and family (Hansen, 1991; Jacobs & Gerson, 2001; Pleck, 1999). Some of these work-family issues have become more pressing given the changes, such as blended families, taking place in family patterns and structure in the United States (Schultheiss). Moreover, these changes appear to be even more pronounced when the focus of work and family is on minority females because of the racial challenges that they face (Hebbani, 2007; Nunez-Smith et al., 2007; Post & Weddington, 1997). This is exacerbated largely on account of the increase in the number of women working longer hours outside the home and the growth of dual earner families (Balmforth & Gardner, 2006; Hansen, 1991; Jacobs & Gerson, 2001; Premeaux, Adkins, & Mossholder, 2007; Schnittker, 2007).

The rise in dual career families occurs in tandem with the persistence of traditional roles for women in the family system (Hansen, 1991; Jacobs & Gerson, 2001). Research shows that women pursuing nontraditional careers are aware of the challenges that may be present when trying to balance work and family life, but there is a continued desire to have it all despite these potential demands (O'Connell, Betz, & Kurth, 1989). Although the issue of women working is not a new phenomenon, the challenges associated with it have not abated. Specifically, the role demands for females employed

outside the home are, to a great degree, taxing. This is no less true for minority females, who, apart from the challenges of working outside the home, face a barrage of issues associated with role responsibilities and discrimination based on gender and being an ethnic minority. These issues include discrimination at work, gender role responsibilities, slowing of career, feeling have to work more than colleagues to prove self, and feeling judged by ethnic minority status instead of abilities (Corbie-Smith, Frank, Nickens, & Elon, 1999; Liebschutz et al., 2006; Nunez-Smith et al., 2007; Shrier et al., 2007). This is especially pronounced for minority females who work in professions where they are significantly underrepresented. This places minority females, who have traditionally played a central role in responding to the demands of the family, in a position that potentially questions their commitment to both work and family.

Marital status is another factor that adds to the complication of navigating the demands of a professional and family life. For example, married female physicians, continue to deal with concerns related to work and family. Additionally, married female physicians who are members of racial/ethnic minority groups have to deal with the added burden of racial discrimination. Further, it is even more important to address these concerns as the number of female physicians' increases steadily with the projection that over the next 30 years, female physicians will represent half the practicing physician populations in the United States (Salsberg & Forte, 2002). This projection suggests that more attention should be paid to the experiences of female physicians, particularly those in racial/ethnic minority groups. Liebschutz and colleagues (2006) have illustrated that the experiences of minority female physicians are unique compared to that of Caucasian female physicians. Specifically, minority physicians often feel that they have to work

harder and perform better than their peers in order to prove themselves in the professional setting (Liebschutz et al). Consequently, this dissertation will examine married minority female physicians' experiences in their professional and family lives from a qualitative perspective.

Background

Historically, women of all ethnicities have worked both inside and outside the home (Smuts, 1959; Weathers, Thompson, Robert, & Rodriguez, 1994). More recently, women have the responsibility of caring for the home, along with contributing to the family income (Weitzman & Fitzgerald, 1993). As noted earlier, minority women have engaged in paid work outside, mostly low status and low paying jobs, for many decades. Recently, however, increasing number of minority women are entering high status and high paying jobs such as medicine. In their effort to accomplish professional and family goals, women have had to make sacrifices and adjustments that sometimes put themselves last and place enormous strain on their abilities (Hinze, 2000). Often, this has led to women being caught in a bind that sometimes fosters feelings of not having enough time to accomplish the demands of work and family (Schroen, Brownstein, & Sheldon, 2003). This is inspite of the move toward a more egalitarian attitude about marriage and family as reported in the 1980s perception of families (Thornton, 1989). Research shows also that women pursuing nontraditional career fields are more likely to seek full-time employment during all stages of family life cycle, with the exception of the pre-school years for children (O'Connell, Betz, & Kurth, 1989). The requirements of full-time work

outside the home and the ongoing needs of the family at home have become increasingly arduous for some to strike balance between career and home.

The increase of women in the workforce has led to an increase in dual-earner families who are finding it necessary to negotiate their times between work and family (Haddock et al., 2006; Perrewe & Hochwarter, 2001). This contributes to the conflict experienced by professional families as they work toward balancing hours spent doing paid work and family time (Hansen, 1991; Jacobs & Gerson, 2001). At times, the spillover and inter-role conflicts impede participation in family work, and vice-versa (Balmforth & Gardner, 2006; Damiano-Teixeira, 2006). Concerns regarding work spillover, role overload, and role strain are continually experienced, since females are often expected to be the primary caretakers of the family (Bird & Melville, 1994; Damiano-Teixeira, 2006; Grey & Lynch, 1983; Haddock, Zimmerman, Ziembra, & Lyness, 2006; Perrewe & Hochwarter, 2001; Walker, 1990).

The role as primary caretakers is largely a result of gender socialization and the structure of families, and this leaves most professional females with the primary responsibility of balancing work and family (Googins & Burden, 1987; Peeters et al., 2005; Saginak & Saginak, 2005). However, at times these family responsibilities remain invisible (Bird & Melville, 1994). This can be seen in the ground-breaking work of Hochschild and Machung (2003) with their empirical finding that women often have to come home and do another shift. This second shift in the life of married minority female physicians places a lot of strain on their ability to manage their multiple role responsibilities as was demonstrated among the women in Hochschild and Machung's (2003) study.

Also, female physicians face other concerns, such as experiencing obstacles to their career advancements and disrespect in the workplace as a result of their gender (Coombs & King, 2005). These experiences have been reported to be similar for minority physicians, with the additional factor of them experiencing impediments because of their minority ethnicity (Coombs & King). This indicates that for married minority female physicians there are additional concerns that come with being a female and from a minority group, along with implications regarding how membership in those two groups impacts their professional and family lives. Thus, minority female physicians not only have to find ways to balance their roles in the family and their profession, but also have ethnic issues that influence their ability to navigate their varying roles (Liebschutz et al., 2006; Wolfinger, Mason, & Goulden, 2009).

Objectives of the Study

With the aforementioned literature in mind, the aim of this study is to understand the experiences of married minority female physicians as they navigate their professional and family lives. This research seeks to understand the experiences of minority female physicians and the impact of their multiple roles on their familial and professional lives. The study examines the perception of minority female physicians regarding their professional and family role responsibilities, and how their gender and being an ethnic minority influence the different facets of their lives. The study explores also how married minority female physicians manage work and family, and how work-family issues impact their life experiences. In their professional life, the study examines their experiences in regard to their treatment at work and their interaction with peers. In their family life, the

present study explores their relational interaction with their spouse (the couple interaction, couple relationship impact on her functioning, and experience of the couple relationship), their parenting pattern (who is doing the primary childrearing and under what circumstances), their support systems (what form is it in and how is it impacting her functioning and that of the family), and how being a member of a minority group influence how family functioning.

Rationale for the Study

Past studies on physicians have focused mostly on male and/or Caucasian physicians (Kaplan et al., 1996; Sobecks et al., 1999). The dominance of empirical work with White males is to be understood within the context of the fact that only recently women have reached parity in terms of the admission to medical school (Robinson, 2004). Not surprisingly, therefore, the extant literature on the experiences in family and work life of married minority female physician is sparse. Also, the majority of the limited information that is available on married minority female physicians is not based on empirical studies. This suggests a heightened need for empirical oriented studies that carefully evaluate the experiences of the aforementioned group of medical doctors, especially given that over time females will be a significant percentage of practicing physicians in the United States. Thus, this present qualitative research study will examine the experiences of married minority female physicians looking specifically at their career and family life. While this dissertation is focused on the experiences of minority female physicians within the framework of their career and family life, attention will be given also to issues of gender and race/ethnicity. Racial/ethnic groups such as African

American, Native American, mainland Puerto Rican, and Mexican American in the United States are considered under-representative minorities in the medical field (Henry, 2006; Petersdorf, Turner, Nickens, & Ready, 1990). This is in stark contrast to other racial/ethnic such as Asians who are more represented in medical field and experience less ethnic harassment (Corbie-Smith et al., 1999). In that sense, not all racial/ethnic groups are similarly represented in the medical literature. A family system perspective will be used as the conceptual framework for this study.

Therefore, the next chapter will present an overview of the literature in the following areas: work-family issues faced by professional women, history of minorities and females, work and family of female physicians, and minority female physician's work and family life. These topics will provide the background for this empirical study that seeks to understand how minority female physicians navigate their roles as family members and medical professionals.

CHAPTER TWO

REVIEW OF LITERATURE

The present literature review focuses on the work-family experiences of minority female physicians. Specifically, it examines the current state of literature on the stress and strains associated with submersion in the high demand career experiences of physician life and the unending expectations from the home sphere (Bowman & Allen, 1990; Straechley & Longo, 2006). This review of literature will consider the social context of women, specifically, minority women who are likely to have other salient experiences on account of race/ethnicity, especially when such issues influence life, health, and personal well being (Coombs & King, 2005; Liebschutz et al., 2006). This literature review attempts to unpack the work and family issues experienced by minority female physicians. This will be done by reviewing the literature on the experience of women, professional women, female physician, and minority female physicians. In addition, it will give attention to the work-family experiences of minority female physicians and how their experiences have influenced their lives.

Issues of Work and Family

Work-family issues have become an increasing part of our world and over time more females have begun working outside the home. The Health Resource and Service Administration of the U.S. Department of Health and Human Services estimated that women comprised almost half (47%) of the labor force in the United States (Whitmarsh, Brown, Cooper, Hawkins-Rodgers, & Wentworth, 2007). This situation has given rise to a number of very important issues in the lives of many families today. For example, there

are greater numbers of families in which both husbands and wives work outside the home, more work-stress issues, change in work practices, rise in worker dissatisfaction, and increase in the presence of work in the lives of many families (Balmforth & Gardner, 2006; Premeaux, Adkins, & Mossholder, 2007; Schnittker, 2007; U.S. Bureau of the Census 1996 as cited in Saginak & Saginak, 2005). Gangl and Ziefle (2009) in their cross-national longitudinal study found that for the female labor force, giving birth to a child often have broader implications because it means trying to find adequate work-family arrangements. This gives credence to previous finding that showed having young children help increase the labor force participation of women (Baunach & Barnes, 2003). This may be related to women workers experiencing strain associated with being a working mother and feeling that they have to be present both physically and financially, and often trying to work toward ensuring an adequate work-family balance.

The different aspects of work and family come with certain demands that are more likely to interfere with the ability to navigate between roles (Hansen, 1991; Jacobs & Gerson, 2001; Peeters et al., 2005; Perrewe & Hochwarter, 2001). The demands and rewards of family and work life contribute to increasing conflict with the amount of time families have to devote to paid work (Jacobs & Gerson, 2001). This conflict has been found to be related to the change in the family composition, specifically, the increased number of dual-earner families (Hansen, 1991; Jacobs & Gerson, 2001). Nonetheless, finding balance between work life and home life is of concern to the increasing number of workers being affected and experiencing this conflict (Peeters et al., 2005; Pleck, 1999). Women in particular are concerned with the tension that is experienced between

work and care-giving roles, including those of being a mother (Damiano-Teixeira, 2006; Grey & Lynch, 1983; Perrewe & Hochwarter, 2001; Walker, 1990).

The continued increase of women in the labor force has led to a rise in the number of minority females joining the workforce; however, they are not gaining more representation in the higher paying jobs (Baunach & Barnes, 2003). Reid (1998), using the 1979-1987 National Longitudinal Survey of Youth, found that a majority of minority women work in occupations that are mostly dominated by women. The study indicated that there was a degree of segregation between Caucasian women and minority women (Reid). This indicates that there may be a difference in their experiences in the workplace. Reid's analysis showed that the female minority population is subjected to discrimination in hiring, resulting in their finding work in lower paying jobs that are less desirable. Later research has elucidated also that minority women are less likely to be promoted on their jobs (Correll, Benard, & Paik, 2007). Additionally, minorities and females are often devalued in the workplace (Reid). This type of discrimination may have implications for the experiences of minority females in the work place and in the job market, and gives rise to questions regarding whether or not minority female physicians are having similar experiences.

Empirical research shows that minority women's participation in the labor force is less dependent on alternative family income and more indicative of a reduction in the tendency toward role specialization (Greenman & Xie, 2008). Review of the literature on employment inequities of minority females by Ambwani and Dyke (2007) found that inequity in the wages of minority women contributes to their experience of lower level and less attractive occupations, along with being employed in less sought after sectors of

the labor force. Further, research indicates that there are unique difficulties and challenges faced by minorities due to cultural and psychological mechanisms that are different from the experiences of the majority population (Ambwani & Dyke, 2007). Thus, as the number of minority women entering the workforce increases it becomes imperative to understand the experiences and challenges that they face. Particularly, since as a working parent, the woman plays the roles of mother, wife, and worker, which all interrelate in terms of energy, time, and commitment needed to perform these roles sufficiently (Voydanoff & Kelly, 1984). As Ambwani and Dyke states, further research is needed to examine the work and family life of minority females, in order to better understand their experiences. Moreover, these challenges of work and family are even more present in the lives of professional women and those in ethnic minority groups. Therefore, with more research there would be clarity regarding what factors may be contributing to this experience and how that experience impacts work and family demands of minority female physicians.

Work and Family Issues of Professional Women

Daily professional women experience work-family concerns related to their career and family lives. Wolfinger and colleagues' (2009) supports this finding by demonstrating that family formation contributes to the difficulties professional females face and the strain on family and professional life that it fosters. The experience of these professional women can often be illuminated in the struggle to juggle the demands of career responsibilities and family (Hebbani, 2007). Furthermore, finding balance for professional women continues to be challenging, both in their role as professionals and as

mothers (Whitmarsh et al., 2007). This is illustrated in Hoffnung's (2004) longitudinal study that consists of 118 Caucasian female and 82 minority female participants, when they were in college and seven years later, which found that women who were mothers had lower status careers than females who were non-mothers at the time of follow-up. Correll, Benard, and Paik's (2007) research of 188 participants, of which 108 were females, found that working women who were mothers are significantly more likely to be perceived as less committed and less competent, 15 and 10 % respectively, compared to females without children. This is possibly related to the perception that motherhood makes a female less productive and thus forms a barrier to women's career advancements (Gangl & Ziefle, 2009).

Sometimes, professional minority women have to contend with issues related to their career and its progression. Research indicates that minority students continue to experience under-identification and lower achievement, which impact their ability to attain their career goals (Garrison, 1993). Minority females face obstacles to their professional advancements, in addition to lower salary, which constitute two of the main reasons some minority female professionals leave their positions (Cropsey et al., 2008). There is also the perception of ethnic minority mothers being significantly less promotable and less likely to be recommended for higher positions (Correll et al., 2007). Konrad and Pfeffer's (1991) study examined the inclusion and exclusion of minority females in the professional world using 821 institutions. From the 11,412 positions examined, they found that one of the most pervasive influences in hiring minority women was whether these positions were help be those of these groups in the past (Konrad & Pfeffer). This illustrates that career positions that were once occupied by minority

females are more likely to be filled by a minority female in the future (Konrad & Pfeffer). This has negative implications for professional minority females, because they will be contending with issues related to discrimination that may limit their career possibilities.

Having a career and a family, when there are other factors impacting those parts of a professional female's life, may add strain to her ability to manage the demands on her time. Bielby and Bielby (1989), using a sample of 270 married females and 761 married males from the 1977 Quality of Employment Survey, found that women give more importance to family in their efforts to balance their many roles. As illustrated in the National Survey of Families and Households, today's woman is spending over 30 hours per week engaged in domestic work and more than 45 hours per week tending and supervising her children (Tiedje, 2004). The age of the child, number of children, and the presence of children have been shown to be associated with increase work strain for mothers (Maume, 2004). Women indicate significantly more time shortage issues, as a result of work demands and familial responsibilities (Voydanoff & Kelly, 1984). Trying to find balance can result in issues of work spillover associated with the conflict that arise in trying to navigate family and work responsibilities (Balmforth & Gardner, 2006; Berg, Kalleberg, Appelbaum, 2003). This illustrates that when work spillover and role conflict affect either the family or work domain the ability to function successfully as a professional becomes jeopardized (Balmforth & Gardner, 2006; Bielby & Bielby, 1989; Damiano-Teixeira, 2006; Greenhaus & Beutell as cited in Premeaux, Adkins, & Mossholder, 2007).

With the demands of multiple roles comes the potential concern about having time for the family. Empirical literature has illustrated this point in its finding that

working women report not having enough time with their family to interact more personally and playfully with their children (Tiedje, 2004). Schnittker's (2007) analysis of the assessment of the General Social Survey from 1974 to 2004 and National Health Interview Survey from 1997 thru 2004 found that the time bind experienced by women in their efforts to balance work and family can have adverse effects on their health, which may be experienced differently from men. However, the stress of trying to balance work and family is often reduced by the time children begins attending school (Schnittker). In order to care for their family 55 to 60 % of the working women hired outside help (Tiedje). Nonetheless, the issue of time shortage still persists for school age children because that age group still places a lot of time demands on the female parent due to school activities and the work schedule of mother (Voydanoff & Kelly, 1984).

Being involved in the work and family sphere is important for the family, but it may come with additional issues. For example, conflict continues to arise in relation to work spillover (Balmforth & Gardner, 2006). Negative spillover can lead to burnout, and women are experiencing burnout at an increased rate, which may be related to how females are socialized (Peeters et al., 2005). This socialization often comes with the message of women feeling obligated to manage the double duty of work and family more than men (Peeters et al.). This tension is shown to be associated with professional women feeling burdened as they strive toward negotiating between these two roles (Whitmarsh et al., 2007; Yogeve, 1983). However, having family support in the form of shared duties, responsibilities, recognition, and emotional support, can help in reducing the conflict that may exist between work and family responsibilities (Haddock, Zimmerman, Ziembra, & Lyness, 2006; Lee & Duxbury, 1998; Premeaux, Adkins, & Mossholder, 2007). In order

to balance the work and family life there needs to be a feedback loop that fosters a positive mood and/or environment (Balmforth & Gardner, 2006).

The workplace is more accepting, both covertly and overtly, of women scheduling work around the family because women are perceived as the caretakers of the family (Haddock et al., 2006). Saginak and Saginak (2005) found in their review of literature that perceived division of labor and allocation of responsibilities in a marriage help to increase feelings of success at balancing work and family. Additionally, being able to feel a sense of balance between family and work is influenced by the gender based perception of the couple (Googins & Burden, 1987; Saginak & Saginak, 2005). Maume (2004) illustrate that mothers were adjusting often their work responsibilities to their family demands, while men's work efforts were minimal or not at all influenced by the presence of children in the home. Likewise, it is projected that 80 % of today's employed women will have a child during the course of their professional life (Frankel & McCarty, 1993). Therefore, indicating that work-family issues may become of greater concern to the larger population as the number of females in the workforce continues to increase.

Empirical literature shows that working females who have children experience a penalty for motherhood, which is a 7.4 % reduction in their starting salary (Correll et al., 2007). Wolfinger, Mason, and Goulden's (2009) analysis of a sample of 16,049 participants from the 1983 to 1995 Survey of Earned Doctorates and explained that as a result of family conflict professional women are "mommy tracked" (p.1593) and their professional advancements are reduced and slowed. Also, minority mothers are perceived as being worth lower pay, even though they are not perceived as being less committed or less competent (Correll et al.). Altogether, there is the sense of continually being

evaluated based on being female and ethnic minority, and the balancing act that comes with having a profession and family (Hebbani, 2007). For female minorities working toward professional goals, there is an element of being covertly ignored and/or invisible in certain settings (Chavous et al., 2004). In spite of these issues, Black professional females continue to value having a balance between career and family followed by the value of attaining self fulfillment (Weathers, Thompson, Robert, & Rodriguez, 1994).

In some studies, professional women express awareness that balancing their roles takes perseverance, flexibility, and innumerable negotiations in order to facilitate some form of balance (Grey & Lynch, 1983; Premeaux et al., 2007; Tiedje, 2004). For most African American females pursuing a career, having flexibility in being able to pursue professional and family life is greatly valued (Weathers et al., 1994). In addition to the value of career and family, Weathers and colleagues found with a sample of 72 African-American females gathered from predominantly Caucasian universities in the United States showed that since some groups of minority women have always worked. Moreover, they explained that minority females have been visible excluded from literature for many years (Weathers et al.).

Research shows that female physicians and minority female physicians experience work-family conflicts, lack of support, discrimination, and obstacles to professional advancements (Balmforth & Gardner, 2006; Cropsey et al., 2008; Park et al., 2005). All these issues will impact the experience of minority female physicians in their roles in family and career (Liebschutz et al., 2006; Nunez-Smith et al., 2007). This shows that race/ethnicity and gender influence the life experiences of minority female physicians. Thus, it is important to be cognizant of the history and development of

minorities and women in medicine. The next section will explore the historical journey of minorities and women in medicine.

History and Development of Minority Physicians and Female Physicians

Several hundred years ago the presence of minorities and females was not accepted and/or present in the physician profession. It was only a few centuries ago people of African descent were perceived as being too ignorant to gain from a medical education (Johnson, 1967). The first African American to obtain a medical degree was Dr. James McCune Smith in 1837, and in 1848 the first Black American gained his medical degree from an American school (Johnson, 1967). Then in 1849 the first female, Elizabeth Blackwell, graduating from medical school and become a physician in America (Grant & Carter, 2004). Elizabeth Blackwell and minorities like James McCune Smith faced many obstacles in their effort to become physicians, and since that time minority and female physicians continue to face challenges in the medical profession. These challenges range from gender discrimination to being psychologically encouraged to choose certain specialties that are perceived as being more conducive to the responsibilities that may come in later life (Ducker, 1978). Subsequently, discrimination against female physicians and minority physicians has been documented throughout history and continues to be seen in today's research (Walsh, 1977; Coombs & King, 2005).

Minorities and females have faced many issues historically in the medical field. By the 1920s Black physicians faced challenges related to difficulty obtaining internships

and even more difficulty finding residency training facilities/institutions (Johnson, 1967). Forty-five years ago there were less than one percent of Black students enrolled in 81 of the 83 medical schools in the U.S. (Reede, 2003). Until the Civil Rights Act legislations of the 50s and 60s very few minority physicians were admitted to and/or graduated from medical institutions other than institutions such as Howard University and Meharry Medical Center, which primarily served minority students (Petersdorf, Turner, Nickens, & Ready, 1990).

In the 1960's female physicians represented 6.7 % of the physician population in the United States (Cartwright, 1972). During the 1970s the number of women entering medical school grew from less than 10 % to over 25 % by the end of the 1970s (Weisman, Levine, Steinwachs, & Chase, 1980). Over the past three decades their numbers have continued to rise. Consequently, the sex of the physician is a strong determinant in the female physicians' decision of specialty (Bowman & Allen, 1990). Issues related to lifestyle concerns regarding childbearing and child care influences the type of specialty selected by female physicians (Mayer, Ho, & Goodnight, 2001). This may be connected to female physicians' have the added duty of trying to balance work and family in terms of time and responsibilities (Gabbard, Menninger, & Coyne, 1987; Warde, Moonesinghe, Allen, & Gelberg, 1999).

In the 1960s and 70s the Association of American Medical Colleges (AAMC) made two policies to address the disparity of underrepresentation of certain minority groups in the medical profession, with an aim of increasing the representation of underrepresented minorities to 12 % representation in medical training by 1975 (Petersdorf et al., 1990). With this goal the AAMC was able to increase minority

representation to 9.8 % by 1974, which was triple the amount that was present six years previously (Petersdorf et al.). However, even by the 1990s the number of underrepresented minority physicians continued to be about 10 % despite continued efforts to reach parity with the general minority population (Petersdorf, 1990; Petersdorf et al., 1990). These challenges unique to ethnicity and gender continue to be experienced by minority female physicians and female physicians in general, even though they have become a larger part of the medical community.

Work and Family Life of Female Physicians

In 2004, Robinson estimated that by 2010 one third of the physicians in America would be female (Robinson, 2004). For this reason, it is important to understand how these female physicians are dealing with issues of career and family. The struggle between family and professional life continues to arise in the literature on female physicians, with significant stress being experienced by these women related to the demands of their professional life and the conflicting familial pressures (Straechley & Longo, 2006). One of the unique stressors that impact the experience of female physicians is their ability to manage the demands of their multiple roles (Bowman & Allen, 1990). These factors contribute to the role strain that has been seen in professional women since the 1970s and 1980s, and is of particular importance in research conducted on female physicians with children (Johnson & Johnson, 1976; Myers, 1982).

Research indicates that female physicians experience considerable role conflict due to the multiple demands and obligations to their profession and their family. There are specific gendered experiences related to issues of time pressure, role conflict, work

overload, and lack of support (Rout, 1996). This appears to be especially true for females who decide on a surgery specialty, since often they have children and their spouses work outside the home, which leaves them with the challenge of trying to balance their family and career responsibilities (Mayer, Ho, & Goodnight, 2001).

The ability of professional couples to balance work and family is influenced by the gender based structure of most families and its socialization of women (Googins & Burden, 1987; Peeters et al., 2005; Saginak & Saginak, 2005). The social expectation placed on women to be the main caregivers of the family and thus responsible for the household and childcare, contributes to the role strain being experienced by these female physicians (Bowman & Allen, 1990; Cohen et al., 1988). Research has shown that the emotional and physical effort that goes into fostering professional development and a family life adversely impact the career development of female physicians, more than male physicians (Baucum-Copeland, Copeland, & Perry, 1983, & Cohen, Woodward, & Ferrier, 1988). It should be noted that research shows also that positive experience in the family role, such as positive parental and marital experiences help to cushion the role strain experienced by professional families (Barnett, 1994).

The strain of female physicians balancing all the role responsibilities is related also to the issues of second shift and gender role attitudes of parenthood (Hochschild & Machung, 2003; Kaufman, 2005). These gendered issues continue to permeate the work-family life of female physicians (Pleck, 1977; Weisman & Teitelbaum, 1987). It contributes to some of the conflict female physicians' face when trying to function in their multiple roles, and adds to the gender based discrimination, poor parental leave support, and lack of female role models (Park et al., 2005; Yogev, 1983). Also, it adds to

the issues of reduced career opportunity, slowing of career advancement, reduced rate of pay for female physician with children, and reduction in productivity, which create concern for female physicians who are or want to become parents (Boulis, 2004; Brian, 2001; Notman & Nadelson, 1988; Schroen, Brownstein, & Sheldon, 2003; Straechley & Longo, 2006; Woodward, 2005).

The work patterns of female and male physicians reveal some significant differences in their experiences. For example, female physicians are four times more likely than male physicians in the United States to be listed as inactive, meaning that they work less than 20 hours per week (McMurray et al., 2002). Compared to female physicians of the past few decades, physicians who are at the beginning of their careers spend more time in unpaid and paid activities (Shrier et al., 2007). This cause increase in the stress of female physicians family and work environment (Shrier et al.). However, literature has shown that when female physicians are able to work the number of hours conducive to them, they are better able to reduce role conflict and more able to find a work-family balance that produces better outcomes (Barnett, Gareis, & Carr, 2005; Carr, Gareis, & Barnett, 2003; Rout, 1996; Shrier, Shrier, Rich, & Greenberg, 2006).

The work hours of female physicians show consistently that they work fewer hours than their male counterpart (McMurray et al., 2002). Shrier and Shrier's (2005) study of 136 mother-daughter physician dyads found that compared to female physicians of the past, this generation of women physicians is less satisfied with their career choice, feel the amount of work they have is too much, and worked 40 or more hours per week. Moreover, they feel less in control of their work environment and experience more stress at home and work compare to their physician mothers (Shrier & Shrier). The multiple

roles taken on contribute to the role strain experienced by married female physicians, as they try to balance the demands of their many roles on their time (Myers, 1988; Notman & Nadelson, 1988).

Some of the professional pressures present in the life of female physicians are associated with their medical specialty. Straechley and Longo (2006) examined female surgeons and found that they experience a slowing in their career development with the addition of children to the family. This increases the likelihood of female physicians without children being in a surgical specialty (Potee, Gerber, & Ickovics, 1999). On the other hand, those with children are more often in primary care specialties, specifically with female pediatricians feeling more able to have a family life and career (Potee, Gerber, & Ickovics, 1999; Shrier, Shrier, Rich, & Greenberg, 2006). Consequently, there is an understanding in the medical field that certain specialties lend themselves more readily to a more controlled life style, which has lead to specialties like emergency medicine and dermatology being sought after more often (Griffen & Schwartz, 1990).

The ability to have both a family life and practice medicine is preferred of by medical professionals. Mayer, Ho, and Goodnight's (2001) conducted a study of surgical training program graduates from the University of California, Davis that were in residency between 1989 to 2000. They collected a sample of 42 respondents, of which 20 were female and 8 of those females had children. They found that female surgeons spent a mean of 50.3 ± 60.2 hours parenting outside their regular 60 plus hours at work, while their male peers spent a mean of 24.9 ± 14.2 hours parenting. These female physicians in surgical specialties average over 40 hours per week performing household chores, while their male peers spent less that 10 hours in that role. They concluded that having children

and issues related to child care greatly impacted whether or not a physician pursued a surgical career. Mayer, Ho, and Goodnight's statistics reflect the vast differences in role responsibility experienced by female physicians, particularly those in a surgical specialty. It points also to some of the factors that may be inhibiting females from choosing specialties such as surgery because of the role strain and time constraints that appear to be present in the lives of female surgeons.

Feeling pulled between work and family may influence the life satisfaction of female physicians. McMurray and colleagues' (2000) sample of 735 female physician illustrated that female physicians rated a number of factors highly: being able to control their time away from work, recognition of their work's importance, and good peer relationships. A later survey conducted on 68 female physicians at Mayo Clinic in Arizona examined underlying causes of dissatisfaction experienced by female physicians (Mayer, Blair, & Files, 2006). The study found that for 93 % of the female physicians' issues related to work and family demands, which affected their satisfaction (Mayer, Blair, & Files). A follow-up surveys of 47 participants in the Mayer and colleagues study indicated that 41 % of the female physicians working full-time wanted to reduce their work hours. Lack of control of workplace and work hours were also predictive of burnout in women physicians (McMurray et al.). However, having support from colleagues and spouse in balancing work and family helped to protect against burnout (McMurray et al.). This demonstrate that for female physicians work and family role demands impact their level of satisfaction and influence their sense of control. Therefore that impacts their long term functioning in their career and family.

Within the medical field, female physicians not only face issues related to dissatisfaction and potential burnout, but at times they experience obstacles to their career advancement. Shrier and colleagues' (2007) study of the 136 physician daughter and physician mother participants found that few reported increase in career opportunities due to race and/or gender. This was seen also in Coombs and King's (2005) statistical analysis that found females were five times more likely to experience obstacles to their career advancement compared to their male peers. This has been reported to be similar for minority physicians, who also experience disrespect in the work environments (Coombs & King). Shrier and colleagues' study found that for minority physician mothers (22%) and daughters (24%), the mothers had more experiences of being left out of career advancement opportunities due to gender and being non-Caucasian. However, physician daughters continue to experience a significant amount of gender discrimination, though racial/ethnic discrimination in their sample had reduced from mother to daughter's generation.

Female physicians are faced also with harassment in their workplace in addition to discrimination. Shrier and colleagues' (2007) study found that both mother and daughter physicians experienced incidents of sexual harassment. Using mailed surveys, Coombs and King (2005) with a sample of 445 practicing Massachusetts physicians, of whom 46.4 % were females, found that when female physicians brought up issues of discrimination to their organization, 26.7 % of those women were more likely to report an increase in the harassment. Female physicians employed in academia or historically male-dominated specialties (i.e. surgery) also experience higher rates of sexual harassment (Frank, Brogan, & Schiffman, 1998). However, having a female role model

was helpful in younger physician women being able to deal with gender biases more effectively (Shrier et al.). For some women encouragement from others often helped to motivate them to go into medicine (Cartwright, 1972). Further, research shows that after controlling for work hours, status, specialty, age, and ethnicity, female physicians were at an increased likelihood of being satisfied with their relationships in the workplace and less likely to be satisfied with their pay, autonomy, and relationship with community (McMurray et al., 2000). These concerns related to harassment, discrimination, specialty, being the primary caretaker, and multiple role demands of female physicians impacts their marital relationship, relationship with children, and contributes to work-family conflict.

Marital Relationship

The numerous roles and responsibilities that female physicians have can bring with it personal satisfaction; however, if there is difficulty in one role, other areas of their life will be affected (Warde, Moonesinghe, Allen, & Gelberg, 1999). These issues may be even more pronounced in dual career physician families, since a high percentage of female physicians are married to men who are of the same status level, with 50% of these marriages creating dual-physician unions (Brotherton & LeBailly, 1993; Nadelson & Notman, 1988; Sotile & Sotile, 1997; Woodward, 2005). Female physicians are more likely to be married to another physician compared to male physicians (Schroen, Brownstein, & Sheldon, 2004; Sobecks et al., 1999; Woodward, 2005). Further, empirical literature shows that two-thirds of the physicians who are married, are married to

individuals who are employed outside the home, which implies that a large majority of physician families are professional families (Sobecks et al., 1999).

Sobecks and colleagues (1999) studied 1208 physicians from the 1980 to 1990 classes from two medical schools in Ohio. In that study, 44% of female physicians in dual-physician marriages reported they had primary and/or equal responsibility for the care of their children. Also, their partners tried to arrange their work schedules around the care of the children (Sobecks et al.). When compared to female physicians married to non-physicians, females in dual-physician marriages reported family reasons as contributing to the limitations in their professional life. Also, the study showed that female physicians married to non-physicians worked more hours per week than were in dual physician marriages. This contributes to issues related to time constraints and pressure in the numerous roles the female physicians encompass, along with reduced time for self, which may be affecting marital relationship, family, and professional development (Beiser & Roberts, 1994). It would seem that female physicians married to non-physicians may have spouses who take a more active role in childcare and household responsibility, which may be imply the desire of the male in a less prestigious and remunerative career to compensate in the context of the wife's career and earning that superior on both counts (Almeida, Maggs, & Galambos, 1993). Additionally, research has indicated that African American husbands participate in household responsibilities regardless of the employment status of their spouse (Orbuch & Custer, 1995).

Physician marriages experience issues related to being overworked and having a lack of time for the family, which affects the quality and quantity of their relational interaction with their family (Myers, 2004; Smith, Boulger, & Beattie, 2002). Research

illustrate that female students felt that certain specialties, specifically general surgery was not conducive to raising children and having a happy marriage (Park et al., 2005).

Nonetheless, female physicians were more likely than men to recommend parenting (Cujec, Oancia, Bohm, & Johnson, 2000).

Examination of female physicians showed that those who were academic surgeons were more likely to have never been married compared to their male counterparts, 23 % and 4 % respectively (Schroen, Brownstein, & Sheldon, 2004). For married female physicians, Carnes (1996) indicated that it was important to choose a spouse that had shared goals and who was willing to share and negotiate the responsibilities, because that may enable the women to achieve their professional and personal goals. Research suggested that selecting and having a spouse who is supportive and committed to nurturing the partnership was helpful in integrating career and family life, and leads to increased family satisfaction (Shrier et al., 2006; Warde et al., 1999). Furthermore, having a supportive spouse during pregnancy was reported by a majority of female physicians to be very helpful, particularly if little support is received from their training program or workplace (Sinal, Weavil, & Camp, 1988). Consequently, a balance may be found between the demands of career and parenting because of the support present from their spouse as well as their support network (Carnes).

Children's Impact on Work and Family Life

For professional families, like medical doctors, when there is a child present the number of hours worked per week changes, which sometimes leads to a discrepancy between the male and female work hours (Grant, Simpson, Rong, & Peters-Golden,

1990). In spite of the potential slowing of career with the presence of children, female physicians are more likely to be married and involved with child-rearing, and less likely to be divorced in comparison to women in the general population (Boulis, 2004; Cooney & Uhlenberg, 1989). Compared to 20 years earlier, female physicians in the 21st century are less likely to be married (Boulis). However, women in the general population had a decreased chance of being married compared to female physicians (Boulis). Also, female physicians are more likely to have their first child during their early 30s (Shrier & Shrier, 2005; Potee, Gerber, & Ickovics, 1999). Study by Sinal and colleagues' (1988) illustrated similar timing of the female physicians having children, with 56% of their participants having their first child during residency. Seventy percent recommended that fellow female physicians' best timing for first pregnancy would be after completing residency and about one-third of the female physicians who had children taking six week or less off for the birth of their child (Potee, Gerber, & Ickovics, 1999; Sinal, Weavil, & Camp, 1988). While a decade before 60% of the female physicians took about the same amount of time off (Sinal, Weavil, & Camp, 1988).

Female physicians have a reduction in their productivity because of social expectations, children, dual-career marriages, and stress (Bowman & Allen, 1990; Cohen et al., 1988; Phillips, 2000; Sobecks et. al., 1999). It appears that female physicians often feel they have to sacrifice career productivity when they take on the parenting role, while their male peers often increase productivity as their family size increases (Phillips, 2000). More than 60% of the women physicians with children have experienced a noticeable slowing in their careers and impediments to their professional advancement (Potee, Gerber, & Ickovics, 1999). Thirty five percent of female physicians without children and

not planning on having children felt they had to choose between medicine and motherhood, while more than forty percent felt they would not be able to be both a good doctor and a good mother (Potee, Gerber, & Ickovics). This demonstrates that for some female physicians there is a feeling that they have to choose between their career and parenthood. Furthermore, this may contribute to the role strain experienced, which is seen in the research on professional women and their children, and may have some implications for multiple role issues experienced by female physicians (Johnson & Johnson, 1976; Myers, 1982).

Although female physicians face impediments, research shows that more than 50% of the female physicians with children reported satisfaction with the amount of time they have available for their children (Sinal, Weavil, & Camp, 1988). Those with children were more satisfied with their family life in comparison to those female physicians without children (Potee, Gerber, & Ickovics, 1999). This illustrates that while having children may negatively impact the career advancement of female physicians, those with children experience satisfaction in that relational role. However, Cujec and colleagues (2000) found that female physicians were less likely to recommend parenting to their peers.

Female physicians with preschool age children experience more strains on their time which can impact their ability to find a balance between career and family. For example, Grant and colleagues (1990) found that female physicians with young children had a reduction in work hours, while physician fathers with small children do not reflect this reduction in practice hours. Instead, male physicians are more likely to increase their work hours per week while the woman physicians are more apt to reduce their weekly

hours when pre-school age children are in the family (Barnett, Gareis, & Carr, 2005; Carr et al., 1998; Haddock, Zimmerman, & Ziemba, 2006). The reduction in the female physicians' work hours was seen also when compared to women physicians who do not have any children in the home (Grant et al., 1990; Woodward, 2005). This may be related to gender socialization parenting practices in our society of women being expected to be the primary caretakers (Grant et al.; Woodward). However, in dual-physician marriages there appears to be more movement towards both partners working less hours and a sense that this form of marriage is more conducive to balancing between work and family (Browning et al., 2000; Sobecks et al., 1999).

Work-family Conflict

The experience of having limited time factors into the issues related to work-family conflict that is often seen in professional families. This issue of time is particularly pervasive in physician families as often they are trying to coordinate the schedules of two professionals (Smith, Boulger, & Beattie 2002). Sometimes, there is lack of time that can be a source of conflict for physician families (Gabbard, Menninger, & Coyne, 1987). This can impact the marital and parental satisfaction because of the strain experienced in trying to function in these multiple roles effectively (Warde, Moonesinghe, Allen, & Gelberg, 1999).

The struggle regarding timing of children is related to trying to time child birth in the context of their demanding medical career. As Shrier and colleagues (2006) indicated in their research article, the timing of children based on age of female physician and stage of career comes with differing advantages and disadvantages that need to be assessed.

There appears to be greater flexibility, if female physicians choose to have children during medical school (Brian, 2001). However, choosing to begin a family during residency comes with issues related to the physical and emotional demands of training along with finding a program with flexible and accommodating schedule (Brian, 2001). These issues surrounding timing are reflected in the research showing that female physicians are delaying childbirth and usually deciding to have children and become pregnant near the end of their residency training (Boulis, 2004; Brian, 2001; Schroen, Brownstein, & Sheldon, 2003; Smith, Boulger, & Beattie, 2002; Tinsley, 2000). From 569 medical female respondents, at varying points of their medical training and/or career, it was found that after the completion of medical training was perceived as being the most optimal time to embark on parenthood (Cujec et al., 2000).

In becoming parents, female physicians indicate that their professional schedule left little time for family life (Schroen, Brownstein, & Sheldon, 2003). Many female physicians have concerns about being present in their children's lives, specifically being able to have time for their children. Shrier and colleagues (2006) propose more flexible hours for physicians during the period they are raising their children because it appears that physicians often regret not having enough time with their family. This may impact their experience of life, their relationship with their child, and thus their balance between work and family.

Research shows that physicians who have children find their life challenges more manageable and joyful when their primary relationship is happy (Myers, 2004). The literature points to the fact that being able to be flexible with their time during childrearing ages might help to reduce the role conflict sometimes experienced by female

physicians (Barnett, Gareis, & Carr, 2005; Rout, 1996; Shrier, Shrier, Rich, & Greenberg, 2006). A study has shown lower career satisfaction for female physicians who experience a high number of hours doing childcare compared to hours spent on professional work (Frank, McMurray, Linzer, & Elon, 1999). This seems to indicate that flexible or reduce hours in career and family life may be adaptive positively and satisfactorily.

The multiple role responsibilities of female physicians contribute to the role strain experienced as they try to negotiate the demands of their roles on their time (Myers, 1988; Notman & Nadelson, 1988). These issues are associated with lack of clear demarcation between the boundaries of work and family (Myers, 2004; Shaw & Lee, 2004). Nonetheless, despite of these concerns this generation of female physicians is making a greater effort towards pushing for a balance between family and career (Boulis, 2004). Furthermore, these issues may be even more pronounced for minority female physicians, who feel they have to prove themselves because they are an ethnic minority (Liebschutz et al., 2006).

Minority Female Physicians

Ethnic minority physicians are faced with substantial challenges as a result of their race (Nunez-Smith et al., 2007). A recent qualitative study by Liebschutz and colleagues (2006) examining 10 Black male physicians and nine Black female physicians found the core themes of discrimination, consequences, differing expectation, and social isolation, present in the experiences of these minority participants. Specifically, the research found male and female Black physicians experienced inconsistent expectations and unequal treatment in the work environment, with the Black physician being more

harshly punished for mistakes made compared to their Caucasian colleagues (Liebschutz et al.).

In an earlier quantitative analysis of discrimination, Coombs and King (2005) using logistic regression analysis on the 115 non-White male and 70 female non-White physician respondents, found that oftentimes discrimination in the workplace results in minority physicians experiencing obstacles to their career advancement, in addition to disrespect or punitive actions. Nunez-Smith and colleagues (2007) postulate that due to racial fatigue and racial silence, the experience of some minority physicians is even more stressful and arduous. As such, minority physicians in today's world are experiencing discrimination and this has an impact on their functioning. Therefore, it is important to understand what that impact is on the professional and family life of minority female physicians.

There needs to be a consciousness of the history of women and minority because as recently as the 1960s more than ninety percent of the U.S. medical students were Caucasian males (Nickens, Ready, & Petersdorf, 1994). However, by the 1990s female represented 40 % of the medical school populations, with 31 % being from ethnic minority groups (Nickens, Ready, & Petersdorf). Some minority physicians have expressed that race sometimes pervades their experiences and identity as they function in their roles at work, leading to feelings of being perceived as a minority before being seen as a physician (Nunez-Smith et al., 2007).

A study found that over fifty percent of the minority physicians experience obstacles and biases due to being minority and this has had negative impact on their satisfaction in their work environment and career (Peterson et al., 2004). In addition,

minority physicians face stressors in the workplace related to feeling overloaded, specifically, in regards to issues of time demands in their varying relationships (Post & Weddington, 1997). Moreover, physician mothers of color tend to report more incidents of being omitted from opportunities for career advancements compared to their Caucasian peers (Shrier et al., 2007). Some minority physicians have had the experience of being perceived as not being well prepared or capable (Liebschutz et al., 2006). This has left them with a sense of having to prove themselves in the workplace (Liebschutz et al.). Also, minority health professional feels isolated and disempowered in their professional life (Betancourt, 2007). The work environment contributes to these issues and magnifies the physician “minority” status (Betancourt). This has resulted in minority physicians believing that they have to work harder and perform at a higher standard than their Caucasian counterparts in order to succeed and avoid reprimand (Liebschutz et al.).

Research shows that ethnic minority groups and foreign-born physicians experience and report a high rate of harassment during their medical training and practice (Corbie-Smith, Frank, Nickens, & Elon, 1999). This may have foreseeable impact on their experience and perception of their work environment. Research on discrimination in the workplace setting of physicians in Massachusetts found that 48.1% experienced racial discrimination in their work environment and 43.2% expressed feeling the presence of gender discrimination in their place of work (Coombs & King, 2005). Consistently, gender-based discrimination/harassment seems to be present for most ethnic minority female physicians, however for those female physicians of Asian descent or foreign born, there appears to be a reduced rate in the harassment experienced (Frank, Brogan, &

Schiffman, 1998). Corbie-Smith and colleagues report similar finding with over sixty percent of the Black female physicians in their study experiencing ethnic harassment in medical setting, with female physicians from Asian decent reporting about thirty percent and Hispanic female physicians reporting three times less incidents compare to their Black colleagues. This may indicate that for some female physicians of color there is an even higher level of discrimination.

Some physicians experience direct discriminations because of their minority status, but a more common covert discrimination that they experience is being perceived as a non-physician at first glance (Liebschutz et al., 2006). A study conducted by Nunez-Smith and colleagues (2007) found that physicians of African descent experienced and were aware of race issues in varying degrees present in the workplace that impact the climate of the workplace and the experience of the physician. Multivariate analysis of minority physicians in academia demonstrated that minority faculty physicians had a decreased likelihood to be promoted to full professor compare to their Caucasian colleagues, with underrepresented minority (Black, Mexican-American, American Indian, mainland Puerto Rican) physician faculty being significantly less likely to be promoted to senior academic ranks (Palepu et al., 1998). The discrimination experienced by some minority physicians have lead to feelings of inadequacy, lack of confidence in professional roles, and damage sense of self, with some going as far as contemplating leaving medicine completely because of the strain on their personhood (Liebschutz et al.). However, research shows that having a strong support system in the work environment and in their personal life has helped to reduce the effect of the discrimination they experience in regards to their ethnicity and gender (Liebschutz et al.).

Coombs and King (2005) found that 65.4% of the minority physicians who were being discriminated against brought this issue to their organization's attention but it did not bring about any change to the situation. In an earlier study by Corbie-Smith and colleagues (1999), it was found that twenty five percent of the Black women physicians reported harassment experiences in at least three setting (before medical school, during medical school, during training, and/or during practice), compare to the six percent, two percent, and zero point five percent of Hispanic, Asian, and Caucasian colleagues respectively. As such, one may conclude that minority and female professionals are more likely to experience and report sexual harassment and discrimination during their career (Cropsey et al., 2008).

Despite some of the adverse realities that minority physicians face, particularly when there is the added element of being a female, there are positive experiences as well. For some minority physicians these positives can be seen in the context of a supportive environment of colleagues and other supportive individuals in the work environment (Nunez-Smith et al., 2007). This support can be seen in the mentorship received from minority colleagues which helps the minority physicians feel support during time of uncertainty and having a peer to look up to that is successful (Liebschutz et al., 2006). Also, there is the added benefit of their personal influence on the community in the form of being able to help reduce racism, provide care for minority patients, and being a role model to minority youth (Gartland et al., 2003).

In order to work towards a more positive interaction and experience, the American Association of Medical Colleges (AAMC) has been working on increasing the representation of underrepresented minority physicians (Nickens, Ready, & Petersdorf,

1994). To work toward this goal more effectively, they came up with Project 3000 by 2000 (Nickens, Ready, & Petersdorf). This project aim to enroll 3000 medical students from underrepresented minority groups each year beginning in the year 2000 (Nickens, Ready, & Petersdorf). However, even by the year 2000 the number of underrepresented minorities in medical school was still less than 12%, which has been the goal for several decades (Salsberg & Forte, 2002). This indicates that physicians in minority groups of African American, Hispanic American (Mexican-American and mainland Puerto Ricans), and Native American continue to be underrepresented in the U.S. physician workforce (Salsberg & Forte). Also, there is a constant awareness of the racial/ethnic status of the physician in the workplace when she/he belongs to a minority group (Nunez-Smith et al., 2007). Minority female physicians are at times mistaken for nurses because of their ethnicity and gender (Liebschutz et al., 2006). So, when minority physicians are not able to discuss issues related to race in the work environment it can lead to their feeling overburdened and stressed (Nunez-Smith et al.).

Conclusion

The empirical literature on female physicians has shed light on the systems in which they interact and the work-family issues that they face. However, literature specific to ethnic minority female physicians has been limited in comparison, and the systemic impact of their experiences has not been fully explored. The literature showed female physicians as experiencing stress and strain related to the demands of their career and family responsibilities (Bowman & Allen, 1990, Straechley & Longo, 2006). According to the research, this can lead to role conflict for the female physicians (Myers, 1988;

Notman & Nadelson, 1988). Additionally, this present review of the literature has shown often that female physicians have the responsibility of being the primary caretaker and spend more time than male physicians parenting and doing household chores (Mayer, Ho, & Goodnight, 2001). So further, having positive marital and parental interactions reduced the strain experienced by female physicians (Barnett, 1994). Even so, some specialties were easier to manage along with family demands (Griffen & Schwarts, 1990).

Research on female physicians elucidated several core issues, however, for minority female physicians two of the core issues present were related to being discriminated against and feel that they have to do more to prove self (Liebschutz et al., 2006). Additionally, minority physicians were often under-acknowledged by patients and others in their work environments (Liebschutz et al.; Nunez-Smith et al., 2007).

Furthermore, the literature illustrated that being an ethnic minority seriously impacting minority female physicians because in addition to gender they have to deal with issues related to having to work harder, not being perceived as the physician at first glance, being disrespected, and being harassed (Coombs & King; Liebschutz et al.; Peterson et al., 2004). As Liebschutz and colleagues' study found, minority female physicians experience lack of confidence in their professional abilities and feelings of not being good enough due to discrimination.

In order to examine the experiences of married minority female physicians, this present dissertation explored four research questions: what are the experiences of married minority female physicians in the home and in their profession; how do they experience their roles as mother and professional, in relationship to their race/ethnicity and how does it impact their life and their functioning within their professional and familial roles; how

do issues of gender impact their experience of their roles and responsibilities at home and in their career; and how does the act of balancing between work and family contribute to the life experience of married minority female physician. These questions are important because some issues specific to minority female physicians have not yet been fully examined, such as minority female physicians' family life and the impact their experiences at work have on their familial roles.

There have been both qualitative and quantitative research conducted on female physicians but very few on the specific experiences in the professional and family life of minority female physicians. The studies that examined minority female physicians did not examine their family life in relationship to their experiences in the workplace. It is possible that with their experiences in the workplace, the home life is being impacted as well because of issues related to discrimination and experiences of disempowerment in their work life. Furthermore, in the larger studies, such as Sobecks and colleagues' (1999) quantitative study of 1208 participants, the focus was not on minority female physicians, but female physicians in general, so may not have explored some of the important issues that maybe pertinent to minority female physicians. Therefore, there is need for empirical investigation of these experiences of married minority female physicians, not just in their professional lives but in their family environment. This would allow a more in-depth analysis of the professional and family life experiences of physicians who are married, female, and ethnic minority, in order to better understand their experiences in their larger context.

CHAPTER THREE

FAMILY SYSTEMS THEORY

This dissertation research frames the examination, analysis, and interpretation of the present research in a family systems theoretical framework. Family systems theory allows for an investigation of the married minority female physicians' experiences within their family and professional life from a perspective that is sensitive to the varying facets of family life that daily impacts their functioning. Through the family systems theoretical lens, issues related to family life, professional functioning, gender, and ethnicity are examined. The family systems theoretical orientation fosters a systemic understanding of married minority female physicians' functioning in their multiple roles, gender role issues, and ethnicity, thus offering a holistic exploration of their experiences. This is done with the awareness that an understanding of married minority female physicians' experience cannot be understood in isolation due to the interconnectedness with her family and the environment (Smith et al., 2009).

An exploration of married minority female physicians within the family systems framework will enable an examination of the complexities that are present in their career and family lives in a systemic manner. Also, it examines these issues in relation to the core family systems concepts of equilibrium, boundaries, circular causality, feedback, and equifinality. Towards understanding this theoretical framework more clearly, this paper will first explore the history and development of family systems theory, discuss family systems theory and its key concepts, and explore how this theoretical orientation apply's to the present study.

History and Development of Family Systems Theory

Family systems theory emerged in the 1960s from the grand theory of general systems, and began to be widely applied in family science (Broderick & Pulliam-Krager, 1979; Kreppner, 2002). It developed from the work of family scientists from the Palo Alto group, National Institute of Mental Health, and Family Mental Health Clinic, many of these were major contributors to its development (Smith, Hamon, Ingoldsby, & Miller, 2009). Therefore, in order to fully comprehend family systems theory it is important to frame it in the historical context in which it began and to put forth some information about the grand theoretical framework from which it evolved.

General systems theory emerged in the 1920s through the work of biologist, Ludwig von Bertalanffy (Broderick, 1993; Skyttner, 2001; Skyttner, 2005; Smith et al., 2009; von Bertalanffy, 1968). It arose with the goal of trying to unify science because the different disciplines had drifted apart and it was thought that the unity of science was being lost (Whitchurch & Constantine, 1993). General systems theory emerged as an interdisciplinary and holistic approach to understanding what was being observed in the world (Skyttner, 2001; Skyttner, 2005). From this theoretical perspective came an epistemology that influenced and structured people thinking about thinking, and their thinking about reality (Skyttner, 2001; Skyttner, 2005). Also, it contributed to the fundamental understanding that systems are wholes and are derived from the interactions of their parts because meaning can only be comprehended based on the whole (Skyttner, 2005; Whitchurch & Constantine).

As general systems theory developed, the idea that everything in the universe was connected and interlinked began to take root (Skyttner, 2001; Skyttner, 2005). The theory

asked questions of “what” instead of “why” and focused on the main task of examining the system instead of worrying about smaller things occurring within the system (Skyttner, 2001; Skyttner, 2005). By general systems theory focusing on the question of “what”, it helped to focus the theory in the here and now (Becvar & Becvar, 1982; Becvar & Becvar, 1999). This greatly contributed to family systems theory’s perception of family interaction and allowed researchers to focus on the family’s ongoing interaction at the present time instead of its origin (Becvar & Becvar, 1982; Becvar & Becvar, 1999).

Along with general systems theory, cybernetics greatly influenced family systems theory. Cybernetics was developed from the work of mathematician, Norbert Wiener, in his study of living systems (Broderick, 1993; Skyttner, 2001; Skyttner, 2005; von Bertalanffy, 1968). Cybernetics came from research on information theory, development in computer technology, and self regulating machines in the 1940s (von Bertalanffy, 1968; Whitchurch & Constantine, 1993). Cybernetic is an important part of understanding general systems theory and emerged from the concepts of feedback and information (von Bertalanffy, 1968; Whitchurch & Constantine, 1993). Through the cybernetic concept of self steering, the human behavior of self reflexivity was seen because the human system has the ability to reflect on its self worth as perceived by its group membership (Hanson, 1995). More specifically, cybernetics study self regulating patterns of systems (Hanson).

Cybernetics is a theory of control systems and is based on communication or transfer of information within the system, and between the environment and the system (von Bertalanffy, 1968). This communication provides controls or feedback to the environment as part of the system’s functioning (von Bertalanffy). The theory of control

and communication, along with some core concepts from general systems theory are very present within family system theory (Skyttner, 2001; Skyttner, 2005).

After the Second World War, the Palo Alto group and other family scientists began applying systems theory and cybernetics to the family, and until then the family remained unexplored and the science of family functioning was seen as part of structural functionalism (Smith et al., 2009; Whitchurch & Constantine, 1993). Together, general systems theory and cybernetics merged and fed into the development of family systems theory (Broderick, 1993). This systemic perspective of examining the world plays a dominant role in a variety of fields, and family research is one of such field that it has impacted in the form of family systems theory (von Bertalanffy, 1968).

Family Systems Theory

It was von Bertalanffy (1968) who illustrated that social phenomenon is best comprehended as a system. He sought to show that social phenomena such as interactions and the impact of family members on each others functioning can only truly be understood in the context of systems thinking. Minority female physicians cannot be understood in isolation or separate from the systems they interact with and in. Therefore, this dissertation research examines the qualitative data of this present study from a family systems theoretical framework. In order to fully understand this perspective it is necessary to study the process and the parts in the system because this helps to illustrate the dynamic interaction of the parts (von Bertalanffy, 1968).

Systems theory is a science of wholeness, and wholeness is an important way of understanding how families interact in a family system because any variation in any

element of the system brings about change or variation in the whole systems (Becvar & Becvar, 1982; Becvar & Becvar, 1999; Skyttner, 2001; Skyttner, 2005; von Bertalanffy, 1968). So, any change in one family member will bring about change in the whole family (Becvar & Becvar, 1982). As a result minority female physicians cannot be understood separate from their family system and the environment outside the system that impacts that system. As Roberts (1994) explained, the family cannot be understood by only describing its individual members. The family is tied together in such a way that individual behavior cannot be explained (Roberts, 1994). Even within the smallest family system that would consist of two members, there are the two individuals in the relationship plus the relationship itself (Roberts, 1994). The emotional functioning of a member of the family creates always an atmosphere or field, and that atmosphere influences the whole family (Skyttner, 2001; Skyttner, 2005). This is a reflection of wholeness and the interconnectedness present within a system.

Family systems theory comes from an interpersonal perspective that is interactive, consider all ongoing parts of the behavior, and have recursive events, instead of an intrapsychic perspective, thus illustrating that this theoretical perspective has no beginning or end because its circularity makes it continuous (Smith et al., 2009). This theory has the basic assumption that the whole is greater than the sum of its parts, meaning that a family has a holistic quality that makes it more than its individual members being related to each other (Smith et al.; Whitchurch & Constantine, 1993). Therefore, demonstrating that all parts of the family system is interconnected and understanding can only be gained by examining the whole (Klein & White, 1996). Family system theory use the concepts of circular causality, boundary, equifinality,

equilibrium, and feedback, to show wholeness and interconnectedness of a family system, which will be explored further below (Skyttner, 2001; Skyttner, 2005).

Circularity

Due to the interconnectedness of systems theory, cause and effect are circular in logic as oppose to linear, because change in one part of the system results in change occurring in the entire system (Hanson, 1995; Skyttner, 2001; Skyttner, 2005; von Bertalanffy, 1968). When viewing phenomena from a system perspective any change or interaction in one part of the system impacts or changes the other parts of the system (Hanson, 1995). Therefore, if minority female physicians are being impacted by their multiple roles in their family and professional lives this will impact, their experience in the system and will affect the whole system, which in turn will feedback into the system and influence all members. This is indicative of variables in systems theory having the possibility of being both cause and effect (Skyttner, 2001; Skyttner, 2005). For example, a minority female physician may have experienced harassment at work and this harassment caused her to feel strained, leading to her being short in her interaction with her spouse, causing her spouse to react in anger towards her, resulting in her feeling even more strained, and creating a cycle of conflict and strain that affects the whole system.

Circularity can be seen in recursion which refers to the shared responsibilities and mutual influence present between members of a family or system (Becvar & Becvar, 1999). This help to reduce blame when dealing with relational interaction in a system because the shared responsibility help to illustrate that whatever relationship is created between family members was created together by the family (Becvar & Becvar). This

shows the circular nature of systems thinking because anything occurring in the system is recursive and thus a product of the interaction between the members, therefore it was created together. For example, the minority female physician's family experiencing conflict due to work intruding on family life and this conflict is further created by the family members' reaction to the physician mother's work influence on the family's life, thus together the family members creates the conflict. In circular thinking this conflict is occurring and created not only by work but by the family members' reaction to the situation, in addition to their reaction to each other about the conflict being experienced. This illustrates that the conflict felt within the family was created together by the family members and is circular in nature.

Boundary

Boundary in family systems theory is a key concept. It is the rules that define how and who participate in the family subsystems (Broderick & Pulliam-Krager, 1979). There are layers of subsystems within the family system (Chibucos, Leite, & Weis, 2005). Each subsystem has its own boundary with a certain degree of permeability (Chibucos, Leite, & Weis, 2005). For example, within the married minority physician family may be the parental subsystem, marital subsystem, and the sibling subsystem and these subsystems have boundaries with a certain degrees of permeability between each other, and between the family system and the environment.

The nature of the boundary a family has between its members, around the family, and between itself and other systems can be seen in the degree of openness or closedness in the family (Becvar & Becvar, 1982; Becvar & Becvar, 1999). Openness can be seen

when a family is more receptive to and allows input from outside systems and from its family members (Becvar & Becvar, 1999). On the other hand, a system is perceived as having closed boundaries when the boundaries between systems are impermeable (Whitchurch & Constantine, 1993). For example, the parental subsystem of the married minority female physician family can decide how the sibling subsystem interacts and how much it connects with the parental subsystem based on the degree of openness and closedness between the subsystems and within that family system.

Boundary maintenance is present also and it has two parts that keep disruptive or harmful influences out of the family and keeping an open and active connection to parts of the external world that has nurturing and supportive elements (Becvar & Becvar, 1999; Broderick & Pulliam-Krager, 1979). Family member place a lot of importance on joining with other members of the family in order to maneuver for mutual protection (Broderick & Pulliam-Krager). This usually involves a fixed style of collective and rapid consensus about how the environment is patterned (Broderick & Pulliam-Krager). When a system has an appropriate degree of closedness and openness depending on the context, it is perceived as functioning well (Becvar & Becvar).

Boundaries are delineated by family rules, which are redundant patterns of interaction that occurs between and among members of a family, and this pattern of interaction makes their relationship system unique from other families (Becvar & Becvar, 1982; Becvar & Becvar, 1999; Chibucos, Leite, & Weis, 2005). The family system has rules and these family rules are part of the process for maintaining the balance between change and stability (Becvar & Becvar, 1999). Family rules arise from the redundancy principles and makes family members aware of what is expected within the family, along

with helping to define the family (Smith et al., 2009). The rules within a family are passed on from generation to generation, often with minimal modification, and these rules make up the boundary of the family (Roberts, 1994). Family rules change little over the generations and may contribute to minority female physicians feeling the strain between their work and family life, particularly if there is a family rule being fostered that the female should be the primary caretaker.

Rules within the family are both covert and overt, with covert rules being the most powerful rules (Smith et al., 2009). Rules that are covert, such as the female being expected to be the primary caretaker, can negatively impact the married minority female physician experience within her family and career. Also, family rules help to differentiate one family from another and marks the family boundaries (Smith et al., 2009). These boundaries are brought about by the family members' communication and interaction (Becvar & Becvar, 1999). Boundary is set in place to help family member learn how to communicate with each other, how to interact, and how to make decisions in the family (Becvar & Becvar; Chibucos, Leite, & Weis, 2005). For example, in a minority female physician family there may be the rule that mommy gets to miss some recitals because of her work, or daddy does the morning routine with the children because mother has early morning rounds.

Family boundaries regulate the amount and type of emotional and physical contact that occurs between family members (Roberts, 1994; Minuchin, 2002). Family rules regulate and clarify the interaction between family members (Chibucos, Leite, & Weis, 2005; Roberts, 1994). In order to understand a family there has to be an analysis

and understanding of the family rules that govern the interactional patterns of the family (Roberts, 1994).

Equifinality

Another core concept in the family systems theoretical framework is equifinality. It means that complex systems can be examined from varying perspectives that are perceived as complimentary rather than competitive (Hanson, 1995; Skyttner, 2001; Skyttner, 2005). The concept of equifinality helps to demonstrate that the same results can occur from different initial conditions and these final results can be reached in a variety of ways (Hanson; von Bertalanffy, 1968). Stated differently, regardless of the beginning point, the end result will be the same (Becvar & Becvar, 1982; Becvar & Becvar, 1999).

Equifinality is goal seeking and helps to show that within a family system, acting upon one part of the system may not bring about the result that was initially intended (Becvar & Becvar, 1982; Hanson, 1995). This can be seen in many families, when family members or parts of the family system, have one intention for their action but it results in something different or unexpected. This shows that the effects of an act upon the interrelated parts of a system cannot be gauged based on the input because acting on a system from multiple ends can result in the same end and multiple results from a system can come from one stimuli (Hanson).

The family system has goals that it seeks to achieve and these goals change over time as the family grows and changes (Chibucos, Leite, & Weis, 2005). Goal seeking in general systems theory means that interaction in the systems must lead to some result or

final state or equilibrium (Skyttner, 2001; Skyttner, 2005). Goal seeking and purposive are ways to describe systems (Becvar & Becvar, 1982). However, it is difficult to identify the primary goal of a system because life changes affect the goals (Broderick, 1993). Moreover, in order for all systems to attain their goals and maintain a steady state they must transform input into output (Skyttner, 2001; Skyttner, 2005).

Equilibrium and Homeostasis

Another key concept in family systems theory is equilibrium, which came out of cybernetics (Skyttner, 2001; Skyttner, 2005). Through equilibrium, the system tries to balance between change and stability (Smith et al., 2009). Equilibrium is a tendency to maintain order in a system and, by it seeks to hold and seeks to limit system deviation, often refer to as homeostasis (Skyttner, 2001; Skyttner, 2005; von Bertalanffy, 1968). Homeostasis works to maintain stability in the face of system changes, internally and externally (Roberts, 1994). However, it has a natural inclination to resist change and maintain the status quo (Ackerman, 1984; Broderick, 1993; Minuchin, 2002; Smith et al.). Managing the changes and information from the environment without causing too much distress to the system is how the process of homeostasis function (Roberts; Smith et al.). An example of homeostasis in a family is when the work hours of one of the parents increases, this may lead to the parent coming home later then the family is use to, resulting in the family reacting to the increase work hours negatively and showing their dissatisfaction by the child subsystem getting into trouble at school or arguing occurring in the parental subsystems more frequently, and this continuing until the parent gets back to the work hours the family likes or the family reaches a new equilibrium.

Closely related to homeostasis is morphostasis which is the ability of a system to maintain a steady state in the context of change, thus demonstrating that the system must be able to change as needed (Becvar & Becvar, 1999). While its counterpart, morphogenesis is change in the context of stability (Becvar & Becvar). It is also considered to be the changes within the system (Robert, 1994). The pattern of morphogenesis is seen in the family system when the basic structure and function of the family system changes over time (Chibucos, Leite, & Weis, 2005). Through morphogenesis the family system changes and adapt to new patterns of interaction based on information received from inside or outside the family (Chibucos, Leite, & Weis). Morphogenesis and morphostasis function to help the family system to change and maintain a steady state interchangeably. According to Becvar and Becvar, in a healthy family system it is necessary to have both morphogenesis and morphostasis. The family being able to change is an important part of their being able to function well. Change is necessary for the family to develop and grow (Becvar & Becvar, 1982).

Feedback

Working to maintain equilibrium in a system, such as the family, is called feedback (Skyttner, 2001). Feedback is related to the general systems theory concept of regulation, which states that a system must be regulated in some manner in order for the system to reach its goals (Skyttner, 2001; Skyttner, 2005). It helps to provide balance within the system and this balance can be called homeostasis (von Bertalanffy, 1968; Hanson, 1995). Feedback is a strategy that allows the system to compensate when there

are disturbances that affect the equilibrium or homeostasis (Skyttner, 2001; Skyttner, 2005).

The behavior of the system impacts the environment and in turn the environment affects the systems, which is the basic understanding of feedback (Klein & White, 1996). Feedback has been likened to a thermostat sending information back to the A/C indicating whether it needs more or less hot or cold air, all with the goal of reaching and/or maintaining a desired temperature. Feedback helps in understanding the interaction between members in a family, the family's equilibrium, and how information is transmitted (Roberts, 1994). It is through feedback that the system communicates and controls things within the family.

Through feedback, the family system is able to steer itself by its ability to continuously transfer information back and forth within the system about things occurring inside and outside the system in order to adjust in a manner that is advantageous to the family (Becvar & Becvar, 1999; Hanson, 1995; Roberts, 1994; Smith et al., 2009). It allows the system to self-regulate and self-correct (Broderick, 1993). Individual family members' interactions are shaped by their interaction within the family and this shapes the environment in a manner that affects change in both (Roberts). Further, feedback moves the family system and it plays a role in the pattern of behavior between and among family members (Hanson).

There is positive and negative feedback and these two help to compensate for disruptions or disturbances in the system (Skyttner, 2001; Skyttner, 2005). The two feedback loops have the function of one facilitating change and the other maintaining equilibrium for the family (Robert, 1994). Feedback within a family is crucial because it

allows for the visibility of patterns, and it allows the family system to see these patterns in the form of long-term interactional processes and tries to get into the culture specificity of the family context (Hanson, 1995).

Within a family system, positive feedback message indicates that change has occurred and that the family system has accommodated to the change (Becvar & Becvar, 1999). Positive feedback results in change within the system (Becvar & Becvar, 1982; Hanson, 1995). It functions as a deviation amplification mechanism, while, negative feedback opposes what the system is doing and acts as a deviation correction (Becvar & Becvar, 1999; Roberts, 1994; Skyttner, 2001; Skyttner, 2005). Negative feedback within a family system is there to maintain the homeostasis and this is done through communication (Becvar & Becvar, 1999; Smith et al., 2009).

Communication is very important to family systems theory and it is seen in positive and negative feedback that occurs within the family unit. Within the family system, communication, which is the flow of information, is the way energy is input and output (Becvar & Becvar, 1982; Becvar & Becvar, 1999). There are several types of communication: nonverbal and context level communication, verbal communication, and digital and analog modes of communication (Becvar & Becvar, 1982; Becvar & Becvar, 1999). It is through the differing modes of communication that feedback occurs and fluctuation within the system is enabled in order to adjust as needed (Becvar & Becvar, 1999). Since communication is done through feedback, it is impossible for human being to not communicate because even saying nothing is communicating something (Broderick, 1993). For example, the child of a minority female physician may come home from school and give the physician parent a big huge, after the physician had been

at the hospital every evening for the past week, communicating to the physician parent that the child is happy to have the physician parent home after not being able to see her during the evening for the past week. Feedback or communication is continuously occurring within the family system, if not verbally then non-verbally (Becvar & Becvar, 1982; Becvar & Becvar, 1999).

Communication is also a regulatory tool used by the family to socialize the next generation (Kreppner, 2002). Family members expect and want other family members to behave and act according to the feedback being given, and this communication is model based on how the family members think and believe (Becvar & Becvar, 1982; Becvar & Becvar, 1999). The interaction and dialogue between family members create shared meaning and expectation about how each family member should behave or act within the family system, thus it creates the expected roles of the individual family members (Smith et al., 2009). If a family member diverges or does not play the expected role assigned to him/her, this may upset the family equilibrium and may result in negative feedback (Smith et al.). The quality of the communication among family members is one of the main foci of the systems framework (Smith et al.). This is particularly important since it is one way that understanding of the whole family can be attained.

Family Systems Theory Applied to Present Study

In family systems theory, the human system is what is being examined and that examination is based on the interaction between and among the members of the family (Becvar & Becvar, 1999). Within a family system, the family is goal seeking, a social system, self-regulating, open, and ongoing (Broderick, 1993). In this research, the

examination of the married minority female physician and her interactions within the family and with the outside environment will be examined. Understanding married minority female physicians' experience from a family systems perspective will enable the researcher to gain a better comprehension of their experiences and their family system. Family systems theory aims to understand each family member in relation to other members of the family because each has an impact on the other (Becvar & Becvar, 1982). From this perspective the aim is towards understanding human beings and their environment as part of an interacting system and to understand the system that human beings interact in from multiple perspectives (Skyttner, 2001; Skyttner, 2005).

Systems theory is representative of a shift in paradigm in terms of how we understand human behavior because it is a unifying theory (Becvar & Becvar, 1982). A system can only be distinguished from its parts by its organization (Skyttner, 2005). This indicates that organization, being goal oriented, and continuity of identity must be present in order to be perceived as a system (Skyttner, 2001; Skyttner, 2005). Previous studies have illustrated that these elements are present in families of professional females and can be seen in their family life, marital relationship, interacting with their children, and their move towards attaining goals in their career (Hebbani 2007; Straechley & Longo, 2006).

A systemic perspective of the family, views issues facing the families as being the communication pattern between the members (Smith et al., 2009). It looks from a circular perspective to understand the family and its interactions, instead of from a linear perspective, because at the heart of family systems theory is continuous circular interaction (Smith et al.). This continuous circular interaction is the interaction between

each family member and each responding to the perceptions of the other (Ackerman, 1984; Smith et al.).

Communication between human being, particularly in families is very complex. The systems theoretical perspective is one of the best approaches to understand the intimacy and complexities of human interaction (Smith et al., 2009). Communication patterns within the family are input within the family and it defines the relationship of each family member and makes the relationship distinctive (Becvar & Becvar, 1999). Additionally, communication is one of the ways in which feedback occurs. For example, positive feedback can be seen in female professionals like minority female physicians when their family system pushes for more family time and they are able to rearrange their work schedule to include more time that can be used for the family. On the other hand, negative feedback is a process that tells the system to maintain its current state of functioning, meaning it tells the system that no change is necessary presently (Hanson, 1995). An example of negative feedback with a minority female physician family may be her professional community telling her that in order to succeed she needs to spend more time at work and her family unit is countering this message by stating that being a professional is important but spending time with family is even more important; however, the family understands the importance of her time at work and therefore, do not push for more time as much as they could resulting in the family system maintaining the status quo. Through this process of feedback the minority female physician family will continue receiving this information from within and outside the family system until equilibrium is attained again. After which a message will be sent to the system that a steady state of being has been reached and no more input is necessary because the stable state is being

maintained (Becvar & Becvar, 1999). The pattern of communication within the system of the family helps to move the system towards a stable state when there is a problem (Becvar & Becvar, 1982).

Family systems theory attends to the processes that exist within and between families and the environment, and elements that make up the family (Chibucos, Leite, & Weis, 2005). The system perspective views problems as being an issue for the system as oppose to one specific family member (Smith et al., 2009). Problems experienced by individuals are perceived to be a function of recursive feedback loops between the society and the family (Roberts, 1994). For minority female physicians, their work, which is outside the family system, affects their interaction within their family and in their career. Research has shown that there is an important effect on the type and quality of family relationships and behaviors based on the involvement of family members in social networks (Lee, 1979). Additionally, human groups, such as families and friendships, are apart of the social force outcome along with being apart of the universe created by human beings called culture (von Bertalanffy, 1968).

Lee (1979) studied the effects of family members' participation in differing types of social network and found that when husband and wife have a greater network connectedness there is a greater chance that the husband and wife roles are more rigidly defined by gender roles in regards to labor and more often pursue leisure activity separately. Findings have shown that employed wives are less involved in household task resulting in the possibility that: the husband takes up more of the household responsibilities, the child does more around the house, the level of household work goes down all together, someone is hired to help with the home, or a combination of the above

(Rallings & Nye, 1979). The wife's career may impact the family system resulting in change within the family and the rules that govern the family. For instance, it is possible that with minority female physicians requiring long hours their spouse may be more inclined to share in the familial responsibilities (Almeida, Maggs, & Galambos, 1993). Research has shown employment of wife to be positively related to husband being influenced to perform more tasks that are sometimes considered traditional female tasks (Rallings & Nye, 1979). Under the established family pattern of connectedness and separateness are the family's established congruence of images and the evolving family themes among the family members (Broderick & Pulliam-Krager, 1979).

From a family systems perspective an individual cannot be truly understood separate from their interaction with members of the system (Becvar & Becvar, 1999). Thus the person can only be understood in the context of the whole (Chibucos, Leite, & Weis, 2005). Also, the individual family members have different functioning and positions within the family unit and reciprocal relationships (Skyttner, 2001; Skyttner, 2005). The operation of the emotional system in the family reflects individuality and connectedness interplaying within the family (Skyttner, 2001; Skyttner, 2005). This may be observed in the minority female physician family interaction and how her roles and functioning is fulfilled. Qualitative study by Post & Weddington (1997) found also that physicians of African descent demonstrate a strong emphasis on family, with decisions regarding their career being addressed in a family oriented manner.

Using the family systems lens will be valuable in this research. It is a theory that cuts across the many disciplines and links closely to communication and information (Skyttner, 2001; Skyttner, 2005). As von Bertalanffy (1968) states "social science is the

science of social systems” (p.195). The principles of systems operations are grounded in nature and the family operates in ways consistent with it being a system thus making it a coherent unit (Skyttner, 2001; Skyttner, 2005). Family systems or family process is interested in ongoing and observable patterns of interaction between individual families (Broderick & Pulliam-Krager, 1979). System adjusts to change and restores its balance by changing the operating rules of the feedback within the system (Skyttner, 2001; Skyttner, 2005).

Research on minority female physicians is presently limited and even more so when the focus of the study is their family life. As a result, this present study trying to examine the work and family life experience of married minority female physicians’ is important because few research studies have been conducted on the experiences and/or perceptions of married minority female physicians and even fewer taking a family systems approach to understanding their experience. An understanding of the experience of the married minority female physician is needed towards better comprehension of her experience of her role responsibilities in her family and career, how these roles impact her functioning, how issues of gender and ethnicity affects her career and family life, and how each of these factors impact her ability to balance career and family.

This study does not have transcripts that include all family members, though from a system perspective that would be best (Becvar & Becvar, 1982). However, this present dissertation study examines minority female physicians in the context of their family relationship and work environment. Their relational interaction with the family will be used to understand their family system and its impact on their functioning. In this way this study does not consider the married minority female physician in isolation, but in

context of her interaction with her family and her work environment. This is because “all events in a family must be considered simultaneously as subsequent and antecedent behaviors” (Becvar & Becvar, 1982 p. 6).

CHAPTER FOUR

METHODOLOGY

The qualitative methodology of grounded theory was used to examine the experience of married minority female physicians in the home and at work, exploring how gender and ethnicity affects lived experiences in these spheres. Consideration was given to examining how their multiple roles within the family and how their career affects their functioning. There was sensitivity and understanding regarding the impact of their historical past, gender, ethnicity, and their experiences and perception of how they are negotiating their work-family roles within the family system. This research method is concerned with process and meaning rather than specific outcomes (Creswell, 1994).

Present research is a part of a larger research project on physicians and their families that has been approved by the Institutional Review Board (IRB) at Loma Linda University. The larger study group consists of two male graduate students and six female graduate students. All the graduate students in the research group have taken graduate level classes on qualitative research methodology and went through training on collecting qualitative research data. The research group is supervised by three professors, two from the counseling and family sciences department and one from the School of Medicine. The larger study is focused on understanding the marital life, family life, stressors, spirituality, and gender issues in physician families. This dissertation study takes a more focused look at the data collected from married minority female physicians in regards to their experiences in their family life and career.

Sample and Data Creation

For this present study, purposive sampling was used. As such, the researcher found participants who were likely to have information relevant to the topic being studied (Pattern, 2005). The research continued collecting data from additional participants and determined the cut off point when the data being collected began showing similar information, thus indicating to the researcher that theoretical saturation was reached on the data being collected (Strauss & Corbin, 1998).

Theoretical saturation in qualitative research is when the research has gotten to the point that the data being gathering, analyzed, and placed in categories appear to be showing no additional new categories emerging from the coding (Strauss & Corbin, 1998). Additionally, when the categories are well developed and have variation in their properties and dimensions, along with the relationships between the categories being well established, theoretical saturation has been attained (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Theoretical saturation is crucial in qualitative research according to Strauss & Corbin, because when theoretical saturation is reached the data being gathered have categories that have been saturated and the theory emerging from the data will be precise and evenly developed. This determination of appropriate sample size is different from quantitative research which determines sample size based on power analysis (Gravetter & Wallnau, 2007). However, for qualitative research, sample determination is based on reaching saturation (Strauss & Corbin). Some have critiqued qualitative research as not being a valid research methodology due to this issue, however, it has been able to demonstrate that this methodology and manner of sampling adds to the empirical

literature in the field and is valid in its technique, with its data collection process being sensitive and able to capture the nuances of human life (Strauss & Corbin).

With regard to the inclusion criteria for this proposed study, participants were: minority female physician, married for at least two years, and out of residency for at least one year. Once these inclusion criteria were met the married minority female physician was interviewed, preferably with her spouse. The study aimed to get the married minority female physicians to participate in the interview and when possible have her spouse participate as well. However, in some circumstances the married minority female physician spouse could not be present and therefore, the physician was interviewed by herself, as the key informant. The interviews were semi-structured with probes throughout to ensure that more detail will be derived. This style allows participants space to speak in more detail about their experiences and allow the interviewer the latitude to follow certain conversation threads.

Participants were gained through the use of recruitment flyers, referrals from participants, and word of mouth. Once participants were contacted and they verbally agreed to be a part of the study, the interview was scheduled. For every interview audio-tape was used to record the entire interview. The interviewer had also a back-up audio tape present in case of technical difficulty. For those times when the married minority female physician was the key informant, the interviewer asked questions regarding the spousal relationship. At the beginning of the interview the participants were given informed consent form to read and sign if they agree to participate in the study, after which point the interview began.

The interviews were conducted by doctoral students from Loma Linda University that are a part of the physician and their family research group. The interviewers were observant regarding what was being said as well as how the information was being expressed verbally and physically, with memo writing being done after each interview to reflect on what was seen and experienced in the interview. The interview could be stopped at any point by the participant and if the participant becomes uncomfortable with a question they could chose to skip that question. After each interview the audio-tape was transcribed and initial analysis of the data completed. Analysis was on-going process throughout the collection of the data with interviews being transcribed, and coding being done simultaneously as data were being collected.

Data Analysis

The analysis for this research followed the guidelines for developing grounded theory that has been put forth by Strauss and Corbin (1998). Once transcription starts the researcher begins initial coding and interpretation (Creswell, 1994). Coding and interpretation were continuously occurring, along with memo/reflective writing. Specifically, the researcher began by doing open coding through line by line analysis, followed by axial coding, and lead to development of core categories through selective coding (Patten, 2005; Strauss & Corbin, 1998).

For this research study open coding was done in the form of line by line coding. In line by line coding the researcher closely examines the interview transcripts, going phrase by phrase and sentence by sentence (Strauss & Corbin, 1998). In this part of the analysis the researcher closely examining the phrases and sentences expressed by the

respondent, in doing this the researcher is doing open coding by providing labels or names for what is being seen in the sentence or phrase expressed by the respondent in the transcript. For example, if a respondent answer a question regarding family life by stating “My family often do their own activities and I am usually in my room”, the phrase “often do their own activities” may be labeled “separation” and the phrase “I am usually in my room” may be labeled “isolated or detached”. The focus in the line by line analysis of the data is to carefully label through coding what is being seen in the transcripts and putting initial name to the respondents words, and this process is done with all the data.

Throughout the process of line by line coding the researcher keeps in mind the meaning and context of what the participants say in the interview to ensure that coding is contextually accurate. It is in open coding that the researcher begins to get an initial view of some of the experiences of the respondents. Moreover, through the line by line coding the researcher is able to begin generating categories. This allows for further development of these categories through sampling along the dimensions of those categories, which is seen more extensively in axial coding (Strauss & Corbin).

Axial coding is the process of trying to reassemble the data that was broken apart through the open coding process (Strauss & Corbin, 1998). Axial coding is the next step in the data analysis process in qualitative research after the researcher has completed open coding. In axial coding categories and subcategories begin to be more closely formed. Moreover, in this portion of the analysis there is continual examination with the researcher going back and forth through the transcripts to ensure that the voice of the participants are being coded in a manner representative of what the participants are expressing. This constant comparison by the researcher going back over the transcripts

continuously aids the researcher in getting a deeper understanding of the categories being seen and allows the researcher to gain a better interpretation of the participants' voice.

In axial coding of the transcripts, in addition to any memo writing completed during data collection, the researcher begins to do a more in-depth analysis of the codes emerging with the aim of working towards identifying relationships between the categories identified during line by line coding (Patten, 2005). The researcher during axial coding is working towards forming a more complete and precise understanding and explanation for what is being seen in the data, from the subcategories and codes that emerged in line by line coding process (Strauss & Corbin, 1998). Furthermore, axial coding focus is moving from text to concepts that represent what is emerging from the data (Strauss & Corbin). It works toward developing the categories and subcategories and discovering how the categories related to each other (Strauss & Corbin). For example, if from the transcripts during line by line coding in response to issues of family life adjustment after death of parent the initial codes of “stressful, abandoned, disconnected, isolated, parent at peace, support from others, devastated, lose, adrift, and sadness” emerged, during axial coding the researcher would go over these texts from the respondents transcripts and work towards forming a category or subcategory that conceptual explain the experiences of the participants based on the codes that were emerging and may come up with the category of “grief”. In being able to form a category to conceptually explain what is being seen in the data allows the researcher to begin working towards a better understanding of the experiences of the participates and works towards forming a theoretical understanding of what is occurring with the population being studied. Additionally, it is during this point of the analysis when no new

information appears to be emerging from the coding that a category is considered saturated (Strauss & Corbin).

Following axial coding is selective coding. During the selective coding process of analysis the researcher integrates the categories to form a theory of what is being seen in the data. It is through selective coding that refining of categories and the integration process occurs (Strauss & Corbin, 1998). The categories that were developed in the axial coding process are re-defined, re-group, and clarified further as the analysis process continues in selective coding (Strauss & Corbin). This process continues until the researcher has formed the categories that seem to be best representative of the data collected and analyzed. This leads to the development of a core category and subcategories (Corbin & Strauss, 2008). The core category is able to pull the other categories in towards developing a holistic explanation of what is being seen (Patten, 2005; Strauss & Corbin). It represents the core theme of the study and it contributes to the theoretical understanding of the research (Corbin & Strauss). Leading to the development of a theory of what is occurring based on the categories being seen from the data (Corbin & Strauss; Strauss & Corbin). For example, in a research on teen pregnancy and depression, after line by line coding and axial coding ten categories emerge, and after going back to the data repeatedly, clarifying, and redefining during the selective coding period of the analysis, the research arrived at four categories and a core category of “lack of support”, providing a theoretical explanation of the experiences of the participants in the study.

During analysis the researcher takes the categories that emerge back to the larger physician and their family research group to discuss what is emerging from the data being

seen. In this manner the study is doing triangulation because there is continual discussion, formation, and collapsing of categories with the added advantage of having a research group that can contribute a more diverse perspective. Through use of diverse perspective from the research panel, multiple viewing of the transcripts, and being able to have coding being examined and completed by more than one person is a form of triangulation and thus enabling reliability (Hope & Waterman, 2003; Roberts, Priest, & Traynor, 2006). Having panel of researchers present during the coding and analysis portion of the study adds to the reliability of the study and enables a type of inter-rater reliability (Hinds, Scandrett-Hibbons, & McAulay, 1990; Rolfe, 2006).

The researcher combines effort with the panel to ascertain the categories emerging from the data. The researcher is the person solely responsible to ensure the categories emerging are representative of the participants' experiences. By continuously going over the transcripts several times, the researcher coding, and allowing the research panel to code as well, then meeting and discussing what is being seen adds to the validity and trustworthiness of the study.

During this analysis process a more reflexive stance is taken by the researcher in order to ascertain the true experience of the participants and to foster validity and reliability to the study (Denzin & Lincoln, 2003; Flick, 2006; Horsburgh, 2002; Lincoln & Guba, 2003). Additionally, with the researcher being the primary instrument in qualitative research, reflexivity becomes even more important (Creswell, 1994). This reflexive stance allows the researcher to be very cognizant during the research process of personal biases which can influence the analysis and interpretation of the data. Particularly since qualitative research is interpretive research, it is very important in this

research method to make very present the researcher's biases, judgments, and values (Creswell). Thus the researcher journal and reflect on how personal biases may be affecting the interpretation of the participants data (Flick, 2006; Lincoln & Guba, 2003). By the researcher taking a reflexive stance, it helps to illustrate the journey taken and make very present the researcher's presentation of the information being seen.

In addition to taking a reflexive stance, memo writing is done during the analysis process. This is completed by the researcher keeping notes of all decisions, along with notes on the researchers thinking throughout the research process. Through this process of memo writing, the written record of the analysis that takes place during the analysis process is completed (Strauss & Corbin, 1998). During this process that researcher is questioning what is being seen and taking notes on that, along with making notes of the coding and categories being developed and questioning how they are similar and/or different (Strauss & Corbin). For example, if during line by line coding it is noted that some respondents use the words "tired, no time, and fatigue" to describe how they feel about their experience is regard to family life, resulting in the researcher forming a category called "lack of time". The researcher may do a form of memo writing call code notes, which is done by reflecting on the use of those words, along with memos on how the new category of "lack of time" is arrived at so as the study progress there is a record and memos on what the research was thinking and how the researcher arrived at the category "lack of time". Memo writing allows the research the ability to go back and track how coding, categories, and analytic thinking were arrived at and it also offers the opportunity to write on issues that the researcher may be thinking about in relationship to what is being seen (Strauss & Corbin).

During the analysis the researcher engender further reliability and validity by being aware of personal biases and assumptions that may have about the population being studied and how the role of researcher impacts the study (Burke, 1997; Denzin & Lincoln, 2003; Flick, 2006; Horsburgh, 2002; Lincoln & Guba, 2003; Morse et al., 2002; Roberts, Priest & Traynor, 2006). All of this is done in the analysis of the data in order to get at the authentic experience of the participants and to ensure that their voice and experiences are being authentically interpreted (Flick; Lincoln & Guba).

Social Horizons of the Researcher

The reflexive stance is very important in qualitative research because it allows the researcher to make present the biases that may influence the interpretation of the data being analyze (Creswell, 1994). Thus, this researcher makes present her background and make present her upbringing and experiences that may influence her interpretation of the data. Doing this is of great importance because being open and reflecting on my life, views, values, perceptions, and biases allows for a more open understanding of the perspective from which I am coming from and how that may influence the research process.

I am a married Afro-Caribbean woman, in her early 30s. I was born on the island of Jamaica, before moving to America with my family at the age of 13. I am the last of three children from my parents, who at the time of my birth had been married for over 10 years. I was raised in an upper middle class Jamaican family and was raised British West Indian. This type of upbringing in my family meant: being obedient and respectful to parents and elders, having manner and decorum, standing up and having a voice, learning

from your elders, and being family focused. In addition, my family has always valued time together, extended family connection, education, dedication, and hard-work.

From my birth it was expected that I would grow up, go to college, and become a professional as my grandmother, aunts, sister, and cousins had done before me. Within my family women are always well educated, determined, and driven to succeed; and the family expected nothing less from me. This contributes to my continue journey in higher education, my professional development, and the importance of reaching a place within my field that allows for further success.

In addition to being professional women, the women in my family are the primary caretakers of their children and the household, taking on traditional gender roles within the family. The men worked just as hard as the women but there are some tasks that are considered to be task of the women in the family. For example, I can remember as a child hearing my father tell my brother that men did not wash dishes if there were women in the house and hearing him tell my brother to go outside and help take care of the yard. In the Caribbean culture this try of attitude is common and it is expected that the girls not only help with the home but be educated and focused in school, which my parents always stressed to my sister and I. However, upon moving to American in my teenage years and being exposed to different type of gender dynamics I began to perceive egalitarian relationship as more adaptive than the traditional gender role relationships I saw in my family of origin. This influenced my perception of marriage and family interaction, and impacts how I interpret certain interactions within the family system.

The attitudes, practices, and values with which I grow up in influence how I interact in my personal life and how I view the world. Within my own marriage I felt it

was important to foster a more egalitarian relationship with both my husband and myself doing similar/equivalent share of the household chores. Furthermore, unlike the cultural climate in which I grew up, I believe childcare is the responsibility of both parents, and should be a shared task.

I am cognizant that my upbringing may influence my research methodology, however, I feel that making my values, perception, and biases more present will help me to be more reflexive during my analysis. It will ensure that I am making present the voice of the experiences of the respondents and conscientious in my interpretation of the meaning and context of the participants words. I will strive to ensure that my experiences and perception of life are conscientiously reflected on to ensure that it is the participants' voice being heard and interpreted correctly in the context it was said in. This awareness and making my biases present will allow for a more reflexive stance in my analysis of the data. I feel that it will also help to keep me focused on ensuring that I am accurately interpreting the voice of the participants, reducing my biases, and increasing the study reliability, validity, and transferability.

Methodological Issues: Reliability, Validity, and Generalizability

Issues related to reliability and validity are discussed in all research projects and for this qualitative research study these issues are addressed particularly since it is so often debated within the field. In qualitative research reliability is defined based on whether or not the rigor of the qualitative paradigm, such as the methods used to investigate, has been met (Flick, 2006; Tobin & Begley, 2004). Reliability and validity are demonstrated when the researcher is able to carry out the plan logically and in a

systematic manner because it adds to the study's rigor (Flick, 2006; Twycross & Shields, 2005). Also, it is important for the researcher to state upfront the judgments and biases because it enables others to see the researcher's path towards understanding the participants' experiences. All these aforementioned things that foster reliability will help the researcher to ensure that the participants experience is being accurately interpreted.

In addition to reliability is validity, which is whether or not the researcher is getting at the true and authentic experience of the participants (Flick, 2006). In qualitative research, from a constructivist perspective, it is the authenticity more than validity that is important, meaning the trustworthiness of the information being investigated (Lincoln & Guba, 2003). Reliability and validity in this study will be ensured by doing independent and multiple researchers' check, using quotations, keeping detail notes of the data movement from initial assumptions to final product (Hope & Waterman, 2003; Roberts, Priest, & Traynor, 2006).

Qualitative research also tries to ensure generalizability. However, some qualitative researchers have elucidated that generalizability is not a main goal of qualitative research because qualitative research is focused on specific findings pertaining to a specific group of people as oppose to universal finding (Burke, 1997; Horsburgh, 2002). Nonetheless, some qualitative researchers have reported that generalizability is possible when the group that the research is making inferences to is similar to the group that was studied, in a similar time and setting (Burke; Flick, 2006; Horsburgh). Therefore, some qualitative researchers use the term transferability instead of generalizability, with transferability referring to the extent to which similarities in the finding on a qualitative research may be similar to other environments and/or settings

(Tobin & Begley 2004; Twycross & Shields, 2005). By looking at transferability of a research study, the researcher can provide descriptive contextual information about the research finding which can be examined in regards to how it may transfer to other similar context or setting (Ruddin, 2006; Tobin & Begley). Generalizability, validity, and reliability all add to strengthen qualitative research rigor.

In qualitative studies rigor is fostered through use of crystallization and/or triangulation (Denzin & Lincoln, 2003). As have been discussed above, this dissertation uses triangulation to ensure reliability, validity, generalizability. This is achieved by the researcher and the research panel discussing the themes and categories being seen, going back and forth until there is an agreement regarding the categories (Hinds, Scandrett-Hibdons, & McAulay, 1990; Rolfe, 2006). This is followed by the researcher assessing the evolving theory by giving the research panel a list of the core categories and the research panel reviewing the items to see how it fits with what is being seen in the data (Hinds, Scandrett-Hibdons, & McAulay; Rolfe).

Research Questions

- ◆ What is the experience of married minority female physicians in the home and in their profession?
- ◆ With their cultural and ethnic upbringing, how do they experience their roles as mother and professional; and how does each impact the other?
- ◆ How do issues of gender impact their experience of their roles and responsibilities at home and in their career?

- ◆ How does the act of balancing between work and family contribute to the life experience of married minority female physician?

Expected Results

From this research it is expected that a better understanding of married minority female physician's experience will be gained and an increase of our knowledge regarding the issues being experienced. This understanding will be in regards to their experience as it relates to their family and professional life, their ethnicity, and their gender. It is possible that the results will be similar to that seen in predominantly Caucasian female physician research studies; however, the unique experiences of their minority ethnicity possibly impact the married minority female physician differently. Her membership in a minority group may predispose her to experiences that are unique to her minority ethnicity and thus may impact how she experiences her professional and family life. It is expected that a better understanding of how her experiences all interact and affect her familial functioning and how the physician is able to manage and balance her role demands. Likewise, it is expected that issues related to gender will impact also the physicians experiences and may influence how she perceives her functioning in her multiple roles and responsibilities.

Implications

The possible findings from this study have implication for future research, practice and interventions in married minority female physician's life and the medical community, and implication for theory. These implications may be reflected in how their

familial and professional lives are influenced by gender and ethnicity, how this population is studied, and the theoretical perspectives used to understand their experiences. This study has theoretical implications in regards to being able to understand married minority female physicians from a family systems perspective and being able to have a holistic view of these professional minority women's experiences. This research and its potential findings have implications in the life of minority female physicians, how they function in their family and in their career, and how they are navigating in their multiple roles. Also, this has research implication in regards to the population being studied and gaining a clear picture of how gender and ethnicity impacts the experiences of these minority females.

As Ambwani and Dyke (2007) expressed there is need for further research regarding the work and family life experiences of minority females. This may be particularly true in the case of married minority female physicians. In family research it will be crucial to study this population and understand the issues they face in the home and in their varying environments. Further research on this population may enable family scholars to develop programs and models that more accurately address the concerns of minority female physicians and their family. This dissertation research is an initial step towards gaining insight and exploring the experiences of these minority female professionals, and it could lay the ground work for further study on this population not only qualitatively but quantitatively.

Implication for Research

The qualitative research being proposed for this dissertation will allow a glimpse into the life of minority female physicians and will add to the empirical literature in the field. With this it could help to develop concepts and bring light to essential issues that can add to a future studies, such as a large scale quantitative research studies. Concepts such as relative contribution, motherhood guilt, and work-family conflict may be seen to be key concepts in this dissertation study and may be able to bring about a more in-depth investigation of these concepts as they related to minority female physicians and their families. Also, it may help in future quantitative research to ensure that these concepts are evaluated in a larger minority female physician population to assess how it may be impacted by other factors.

This research might bring light to the need for more in-depth research on minority female physicians, particularly those who are in under-represented groups: African American, Native American, mainland Puerto Rican, and Mexican American. Research on these minority groups may help to bring light to the issue being seen in the medical field of these ethnic minority groups being under-represented in the medical field. Research by Nickens, Ready, and Petersdorf (1994) has shown that even with medical schools trying to recruit more student physicians in these ethnic groups they are still under-represented and maybe it is related to their experiences. There are implications for future study regarding how gender and ethnicity is treated and the need for sensitivity towards the possible differing experiences of married minority female physicians in comparison to their Caucasian counterparts. Also, it would be important for future study to do a quantitative study and analysis of what may be occurring nationwide with

minority female physicians and how issues of ethnicity and gender are experienced. Likewise, while this present study will be exploring these issues from a qualitative and in-depth perspective, it would be important to understand the experience of these physicians on a larger scale and from a different methodological perspective.

In the future, with more research on this population of minority professionals, change and better understanding can occur and may help to increase the minority representation within the field and in medical schools (i.e. Nickens, Ready, & Petersdorf, 1994). It is possible that because of the experiences of these minority females there is reduction in the amount of certain minority female physicians present within the medical profession (Liebschutz et al., 2006). Maybe with a better understanding of what is occurring professionally minority female physicians will bring about more sensitivity and awareness of what is occurring and lead to change. Thus, the medical profession itself and how it is treating its minority females will have larger implication for the medical community at large.

There may be research implication through the examination of the minority physician's roles that this dissertation proposal hopes to explore. It is hoped that this present dissertation research will bring more clarity to the roles of minority female physicians in the family and career. More specifically, it is hoped that this research will offer information regarding how these roles impact their function, not just due to gender but when considering their minority ethnicity. It is possible that due to culture and gender socialization, the experiences of minority female physicians may be different from Caucasian physicians that have been studied in the past. This present dissertation research hopes that through this investigation and analysis the differing aspects in the married

minority female physician life that influences her experience and the manner she interact with life may be more specifically addressed.

This present dissertation study may allow for deeper understanding of the relational dynamic within the minority female physician family. It could offer a comprehensive understanding of their family by being able to examine their marital relationship, how it is formed, the role of the spouse, and their relational interaction with their children. Research has indicated that when female contribute more to the home that the spouse sometimes compensate for this by doing more household chores and taking more active role in child care (Almeida, Maggs, & Galambos, 1993). It is possible that due to the female physician career, oftentimes requiring more hours than her non-physician spouse, the family dynamics may be a little different than in tradition structured families. This present dissertation research may illustrate that for some of the married minority physician families that traditional gender roles are not practice and instead the spouse takes a more active role with the children and within the family. Moreover, if there are non-traditional gender roles, maybe this dissertation study will be able to see how this influence the married minority female physician career and interaction within her family. Also, her role as a physician and the non-traditional gender roles that might be seen within the family may influence how spouse is perceived and treated in social setting. This may influence also their marital interaction, which would be interesting to probe for in the research study.

Implication for Practice

For family life educators, there is a need to understand the experiences of minority female physicians and how they are impacted by their experiences in their career and family life. There are implications regarding the larger issue of how their multiple roles are impacting their life experiences and how is it affecting their ability to function in their daily life. These multiple roles may be affecting the minority female physician in a manner that is not conducive to her functioning at an optimal level.

Research has shown that some female physicians feel they have to sacrifice their roles in the family in order to function in their career, which may have implications for how they function in their daily life (Philips, 2000). Further, it is possible that her functioning in her varying role may be impacting the larger functioning of her family system and in turn influencing her functioning overall. Within the family it might lead to better balance and a greater awareness of how the multiple roles that some minority female physicians function in make it difficult to be everything for everyone. It may bring awareness that anything that impacts one member of the family will impact the whole family, thus may help more physician families to be more cognizant of the factors that may be impacting its members.

With more knowledge regarding how her roles affect her familial and professional life her functioning in her system will also be understood. This might enable family scholars to develop programs, workshops, and seminars focus on these issues being experienced. Additionally, family scholars may be able to educate minority medical professionals and their families about some of the issues that are being faced by these families in the professional and familial realm. Family life educators may be able to

develop programs geared at prevention of some of these issues and programs that help these female minority professionals develop tools to navigate the differing roles in their life.

A qualitative study on married minority female physicians' familial and professional life will impact the study of professional women. It may be able to draw attention to issues that are covert in the male oriented world of medicine and bring light to the experience not only on a gender level but an ethnic level. This study may help other professional women see that they are not going through these challenges by themselves and may enlighten them to the fact that these are issues that are unique to their gender and ethnicity. These issues may be related to female physicians' career being slowed due to presence of children and their feeling that they have to choose between medicine and being a parent (Potee, Gerber, & Ickovics, 1999). These feelings may contribute to their experiences and when there is the added element of ethnicity they may be even more issues that minority female physicians need education on in order to navigate in their daily life. This has also implications for how the physicians practice within her field and in her life, and the manner in which she handle her varying roles in the family and in her profession. With research and programs directed at prevention, minority female physicians and their families may be able to make a more proactive stands on the factors that may potentially impact their life and work towards developing policies that will help to make their working and family environment more harmonious.

This dissertation research may have practice implication for the medical community in which these minority professional females daily interact. In the medical community it might give an empirical voice to some of the experiences of these

physicians and illuminate the experiences that may be going unnoticed because of a lack of awareness of the experiences of minority female physicians. It may enable family life educators to directly address issues being faced by this population of professionals and its impact on their family, and in turn allow the medical community to begin addressing the issue directly. Also, it has implications for how the medical community treats and trains its female physicians and builds their awareness of what may be occurring with that population. This could help the medical community begin to build a bridge with its minority population, so that they are not first mistakenly seen as the nurse before being perceived as the physician when they are in their professional capacity, as was shown in Liebschutz and colleagues study (2006).

Implication for Theory

The present dissertation research has theoretical implications. The theoretical perspective from which the study is being addressed is family systems theory, which will frame the information receive in a manner that is inclusive of the family and the environment in which the family interact. This theoretical framework will allow for an understanding of the married minority female physician and her family from a perspective that is aware of issues related to circularity, boundaries, feedback, equifinality, and equilibrium. In doing so the research may be able to give a holistic view of the work-family issues that are impacting the minority female and her relational interaction with her family and her work environment. This might offer a view of the minority female physician and engender a perspective of their life and how their

experience in differing parts of their life impact their functioning in other areas of their life.

This dissertation have research implications for the field of family research because it might facilitate family scholars to have a better understanding of the factors that influence minority female physicians. There are theoretical implications due to the research exploring both the work and family lives of married minority female physicians' from a systemic perspective. It may help in contributing to the literature presently available on the work-family issues being experienced by working parents and help to give a more specific understanding of that experience for married minority female physicians'.

CHAPTER FIVE
MINORITY FEMALE PHYSICIANS' FAMILY AND CAREER
EXPERIENCES: A QUALITATIVE INQUIRY

Literature

The reality of women working is not new. Over the years, women have worked both inside and outside the home. This has been true especially for minority females (Smuts, 1959; Weathers, Thompson, Robert, & Rodriguez, 1994). As documented, working women tend not to have enough personal or leisure time with family (Tiedje, 2004); and this is especially so for professional women (Hebbani, 2007). Further, professional women physicians appear to have significant stressors in their lives associated with the demands of their professional life and the conflicting familial pressures (Straechley & Longo, 2006). This is related to specific gendered experiences associated with time pressure, role conflict, work overload, and lack of support (Rout, 1996). Expectedly, the layer of minority status is likely to generate added stressor in their lives.

There has been little research on minority female physicians to date. Past research exploring their experiences has shown that minority physicians are faced with substantial challenges as a result of their race (Nunez-Smith et al., 2007). Additionally, past literature focused mainly on male and/or Caucasian physicians. Subsequently, there is a lack of empirical work on the work-family experiences of minority female physicians. Present literature on minority female physicians is sparse, and the experience of minority female physicians is even more so. Therefore, through in-depth interview of 21 participants and using grounded theory approach, this study explores of the experiences

of married minority female physicians and the impact of their multiple roles on familial and professional lives. The research seek to explore the perceptions of married minority female physicians regarding their professional and family role responsibilities, and how being a minority ethnicity and female influence the work-family facets of their life experience.

Women and Work

Work and family demands can lead to significant role conflict (Hansen, 1991; Jacobs & Gerson, 2001; Peeters et al., 2005; Perrewe & Hochwarter, 2001). Both men and women deal with conflict between their work and family responsibilities and struggle to find balance (Peeters et al., 2005; Pleck, 1999). However, women in particular have more challenges with these conflicts (Damiano-Teixeira, 2006; Grey & Lynch, 1983; Perrewe & Hochwarter, 2001; Walker, 1990).

Women from ethnic minority groups tend to face discrimination, along with cultural and psychological inequities that are different from the experiences of the majority group (Ambwani & Dyke 2007; Reid, 1998). Chavous et al. (2004) found that minority female professionals have to contend with discrimination in addition to being covertly ignored in the workplace. Consequently, this researcher speculates that these types of experiences may have implications for minority female physicians in the work place and the family, and gives rise to questions regarding whether or not married minority female physicians are having similar experiences

Professional Women and Work

To a great degree, role demands of professional females are taxing. Wolfinger and colleagues' (2009) illustrate that family structure contributes to the difficulties professional females face. They experience challenges in juggling the demands of career and family responsibilities (Whitmarsh et al., 2007).

Further examination of professional women show that those who are mothers have lower status careers, and are perceived as less competent and less committed compared to non-mothers (Correll, Benard, & Paik, 2007; Hoffnung 2004). According to Gangle and Ziefle (2009), there is a perception that motherhood makes females less productive, thus affecting their career advancements. Moreover, Maume (2004) illustrate that women adjust their work responsibilities to their family demands, while men's work is minimal or not at all influenced by the presence of children in the home (Maume). Hence, work-family issues are more pronounce for females than males and will impact their experience in the family and their career.

It is projected that 80% of employed women to date will have a child during the course of their professional life (Frankel & McCarty, 1993). Voydanoff and Kelly (1984) found that professional women that have children indicate time shortage issues associated with work demands and familial responsibilities. However, if there is family support in the form of shared duties, responsibilities, recognition, and emotional support, it helps to reduce the conflict that may exist between work and family responsibilities (Haddock, Zimmerman, Ziemba, & Lyness, 2006; Lee & Duxbury, 1998; Premeaux, Adkins, & Mossholder, 2007).

Female Physicians

Difficulty navigating between career and family life continues to arise in the literature on female physicians (Straechley & Longo, 2006). These social expectations placed on women to be the primary caregivers contribute to the role strain experienced by female physicians (Bowman & Allen, 1990; Cohen, Woodward, & Ferrier, 1988). Consequently, the emotional and physical effort that go into fostering professional development and having a family life adversely impact the career development of female physicians, more than for male physicians (Baucum-Copeland, Copeland, & Perry, 1983; & Cohen, et al., 1988). As noted by Philips (2000) female physicians often sacrifice career productivity when they become parents, while their male peers often increase productivity as their family size increase. Accordingly, Potee and colleagues (1999) found that thirty-five percent of female physicians without children and not planning on having children report feeling they had to choose between medicine and motherhood. Further, more than forty percent felt they would not be able to be both a good doctor and a good mother (Potee, Gerber, & Ickovics).

There are peculiarities to be noted about physician marriages. Often, physician marriages report being overworked and having a lack of time for the family, which affects the quality and quantity of their relational interaction with their family (Myers, 2004; Smith, Boulger, & Beattie, 2002). To manage this, some physicians choose specialties that are more conducive to a reasonable lifestyle and family time (Barnett, Gareis, & Carr, 2005).

As Shrier and Shrier (2005) illustrate professional females such as female physicians, in this generation, are less satisfied with their career choice, feel the amount

of work they have is too much, worked 40 or more hours per week, feel less in control of their work environment, and experience more stress at home and work compared to their physician mothers. Moreover, compared to female physicians of the past few decades, physicians who are at the beginning of their careers spend more time in unpaid and paid activities (Shrier et al., 2007). Moreover, female physicians experience obstacles to their career advancements and have to deal with disrespect in the workplace due to their gender (Coombs & King, 2005). These experiences have been reported to be similar for minority physicians, who also experience a barrage of issues associated with role responsibilities and discrimination based on gender and race/ethnicity (Coombs & King, 2005; Corbie-Smith, Frank, Nickens, & Elon, 1999; Liebschutz et al., 2006).

Minority Female Physicians

Married minority female physicians have concerns that come with being a member of an ethnic minority group and being female. As Liebschutz and colleagues (2006) explain, the experiences of minority female physicians are unique compared to that of Caucasian female physicians. One such uniqueness is minority physicians feeling they have to work harder and perform better than their peers in the professional setting (Liebschutz et al.). Furthermore, married female physicians from minority groups not only have to find ways to balance their roles in the family and their profession, but also have issues due to ethnicity that influence their ability to navigate their various roles (Liebschutz et al.).

Physician mothers of color report more incidents of being omitted from career advancement opportunities compared to their Caucasian peers (Shrier et al., 2007).

Research found that male and female Black physicians experience inconsistent expectations and unequal treatment in the work environment, with the Black physician being more harshly punished if mistakes are made compared to their Caucasian colleagues (Liebschutz et al., 2006). The discrimination experienced by some minority physicians have lead to feelings of inadequacy, lack of confidence in professional roles, damage sense of self, and some going as far as contemplating leaving medicine completely because of the strain on their personhood (Liebschutz et al.).

According to Nunez-Smith and colleagues (2007) minority physicians have expressed that ethnicity sometimes pervades their experiences and identity as they function in their roles at work, with the experience of feeling as if they are perceive by their race/ethnicity before being seen as a physician. All these factors impact how they experience their professional and family life. Therefore, having a better understanding of these experiences will be helpful in bringing awareness to the experiences of minority female physicians. In order to explore the work and family life experience of married minority female physicians, this study will examine the qualitative data collected from a family systems theoretical perspective.

Family Systems Theory

A family systems theoretical framework was used for this present study. This framework offers a wholistic exploration of the experiences of married minority female physicians as they function together to experience a steady state. This gives an awareness of their experiences that can not be understood in isolation (Smith et al., 2009). Through this systemic lens issues related to their roles and ethnicity were examined from a

perspective sensitive to the interconnectedness of the participants' life experiences and how it impacts their functioning within the system (Lee, 1979; Rallings & Nye, 1979; Skyttner, 2005; von Bertalanffy, 1968). It attends to the processes that exist within and between the family and the environment, and elements that make up the family (Chibucos, Leite, & Weis, 2005).

Methods

In order to explore the experiences of married minority female physicians a qualitative research study was conducted. This research is a part of a larger Loma Linda University IRB approved research study that focuses on understanding the marital life, family life, stressors, spirituality, and gender issues in physician families.

Sample and Interviews

The sample of this present study consists of 21 married minority female physician participants. The inclusion criteria include the participants being married for at least two years, female minority physician, and out of residency for at least one year. Participants were recruited through the use of recruitment flyers posted at hospitals and medical facilities around Southern California, referral from participants, and word of mouth. Once the participant met the inclusion criteria, a one on one interview was scheduled. These interviews were conducted by present researcher and seven graduate student researchers. The researchers all previously took graduate level classes on qualitative research methodology and went through training on collecting qualitative research data, interviewing participants.

Participants were interviewed in person and with participants consent the interview was audio-taped. The interview was semi-structured with probes throughout to ensure that more detail was derived from the shared experience of the participants. The interviews were 60 to 90 minutes in length and covered issues such as relationship formation, marital life, family life, stressors, spirituality, parenting, ethnicity, and gender issues in physician families.

The minority female participant was interviewed with her spouse whenever possible, and of the 21 participants 7 were interviewed with their spouse. The participants' age ranged from 29 to 54 years old, with a mean age of 40. They were in their present relationship for an average of 16 years and had a mean of being married for 12 years. The respondents had an average of two children. They spent an average of 42 hours per week in paid work and 29 hours doing childcare. Additionally, 61.9% of the respondents were Black/African American, 9.5% were Hispanic/Latino, 14.3% were Asian and Pacific Islander, and 14.3% were East Indian.

Analytic Approach

The 21 interviews came from a larger data bank of 46 physician interviews in the Physician Family study. Throughout this analysis process the researcher worked with a research team, and the researcher and the team constantly compared and discussed the coding and categories being formed. The analysis for this research followed the guidelines for developing grounded theory put forth by Strauss and Corbin (1998). The researcher began with open coding through use of line by line analysis, and began to generate initial categories. Then followed by axial coding in which more categories and

subcategories were formed. This was followed by selective coding, during which time some categories were re-defined, clarified, merged, eliminated, and re-organized.

Through the coding process, initially nine major categories and several subcategories emerged. After going back to the data the categories were re-defined, clarified, re-organized, and merged resulting in six major categories of: work demand, multiple role demand, role expectations, motherhood guilt, couple nurture, and accommodation. For example, the initial categories of family support, spouse support, and career sacrifice were re-defined, merged and re-named after going back over the data and discussing the codes being seen with the research team, resulting in the emergence of the category called accommodation. This category represented examples of family being supportive and helping to reduce the stress of work and family for the female physician. Also, it represents the adjustments that were made in the female physician's career and family life to help reduce strain of the minority female physician work demands on her family's life. For example, the statement "working weekends was really bad because that is when they (her children) are home and that is the only time I get to see them, so that is when I realized I needed to go part time" was coded under the category accommodation because it illustrated the minority female physician making career adjustments and sacrifice to spend time with family.

Another example of the coding process is the category role expectations, which emerged through clarification and merging of the two categories after continual analysis and clarification of the coding being seen. The original categories were known as family upbringing and expectation and gender roles and family demands, but with clarification and repeated analysis of the data, it became apparent that the categories were addressing

very similar aspects of the minority female physician experience, resulting in the categories being merged into one category. The category role expectations illustrates the expectations minority female physicians at times feels placed on them because of their own personal expectation of their role in the family, along with the expectations placed on them from immediate family and cultural upbringing. Similarly re-defining, clarifying, merging, and clasping of categories continued resulting in the final categories. This was followed by the primary researcher and the research team considering how the categories related to each other based on what was being seen in the data towards creating an explanation (grounded theory) of the participants' experience (see Figure 1).

Validity

Validity is based on whether or not the researcher is getting at the true and authentic experience of the participants (Flick, 2006). This is attained by the researcher independent and multiple researchers' check, using quotations, and keeping detail notes of the data movement from initial assumptions to final product (Hope & Waterman, 2003; Roberts, Priest, & Traynor, 2006). Additionally, the researcher worked with a research panel, regularly discussing categories emerging from the data with the research panel, going back and forth examining the data and the categories, and taking a reflexive stance when examining the data (Denzin & Lincoln, 2003; Flick, 2006; Hinds, Scandrett-Hibbons, & McAulay, 1990; Horsburgh, 2002; Lincoln & Guba, 2003; Rolfe, 2006). Through use of diverse perspective from the research panel, multiple viewing of the transcripts, and being able to have coding being examined by more than one person is forms of triangulation and thus enabling reliability (Hope & Waterman, 2003; Roberts,

Priest, & Traynor, 2006). All this was done to ensure rigor and trustworthiness of the information being investigated (Flick, 2006; Lincoln & Guba, 2003).

Results

As noted earlier, 21 in-depth interviews were conducted with married minority female physicians for this present study. Using grounded theory for analysis of data, a number of observations have been made. Specifically, six major categories emerged: work demands, multiple role demands, role expectations, motherhood guilt, couple nurture, and accommodation. These categories allowed for the conceptualization of the Work-Family Accommodation Model (see Figure 1).

The work-family accommodation model begins with work demands of these physicians directly impacting their multiple role demands and role expectations. Their work demands place strain on their ability to function in their multiple roles, and, in turn, impacts their expectations from self and family. Multiple role demands and role expectations have a bi-directional influence. The impact of work demands on multiple role demands and role expectations has a direct effect on motherhood guilt. Motherhood guilt contributes to the participants feeling a sense of guilt related to their perception of their role as mother and ability to adequately function in that role. This affects couple nurture which has a bi-directional relationship with multiple role demands. These interactions appear to result in stress and strain on the participants and their family. However, accommodation, when present within the family system of the participants, exerts a buffering influence on work demands and the other categories that are directly and in-directly affected.

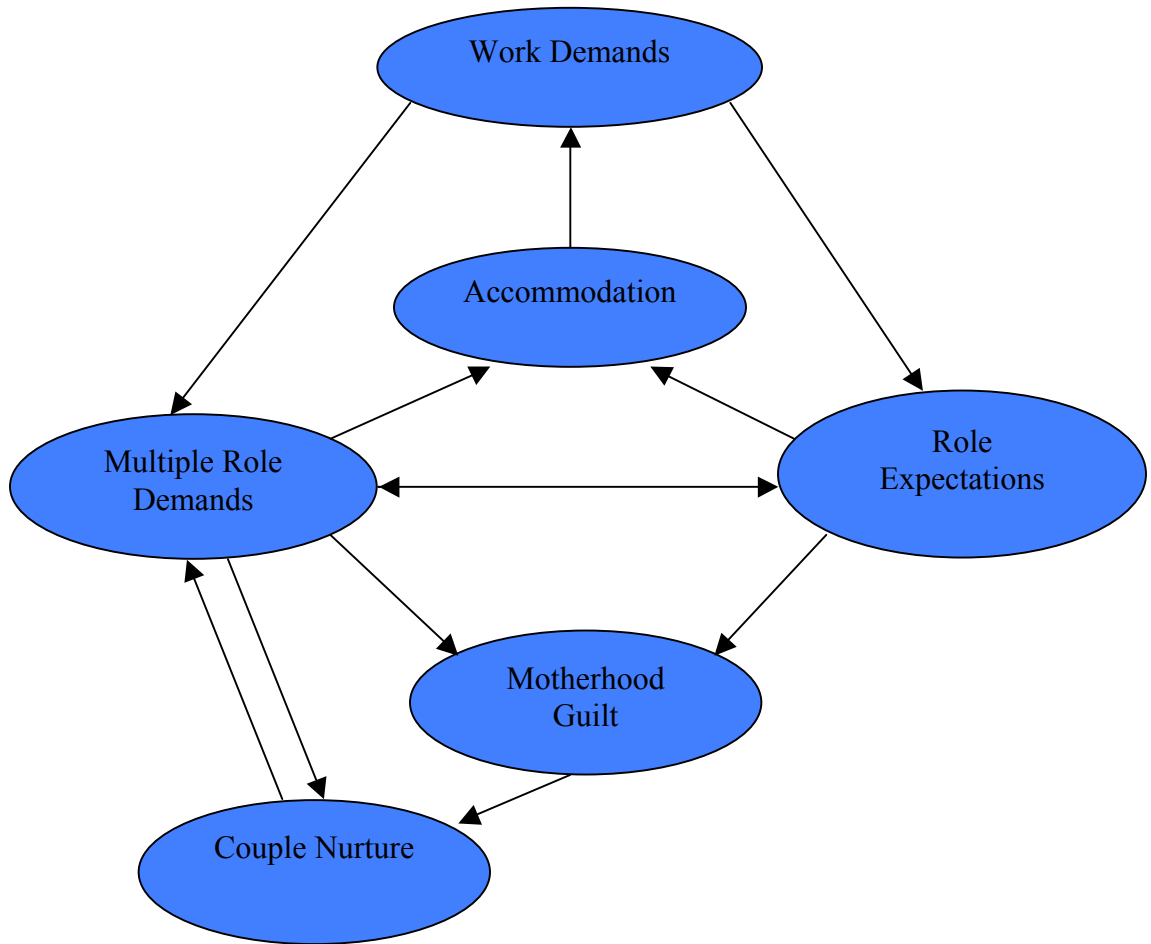


Figure 1. Work-Family Accommodation Model

Work Demands

For this present study, work demands refers to the pressures and challenges associated with one's work, which includes work expectations, time constraints, perceptions of others, and discrimination. These demands are thought to be magnified on account of participants' gender and ethnicity. Work demands has the ability to affect the quality of family life and can compromise the ability to balance work and family.

The influence of work demands on the quality of family life is illustrated by Natalie, who has two children. She expressed, "The hours have really affected our

marriage...it (work) is very demanding...very emotionally demanding outside of the physical demands at times.” This is seen also in Amber’s response, and she is a part-time pediatrician who noted, “it’s stressful because of the demands of the job and the amount time...there are times when you are so tired, so frustrated, you don’t want to see anybody.” Expressing similar sentiments, Rena, spoke about the influence of work demands: “I think just the time because no matter how much you do want medicine to not be such a major part of life, it does eventually happen.”

Along with the normal stressors of career and the demands of time, the data showed that there were implicit and explicit expectations associated with being a physician. Alexandra, a surgeon, spoke about how these expectations added to work demands: “It’s stressful and what is expected of physicians is greater than what is expected in other professions.” Heather, a mother of two, like did some of the other participants responding to the question of the demands of work on family life, commented:

...as a woman, I am not sure the field of medicine with all the hard shifts and rough hours and how hard it is on the family, whether that is the wisest choice... There is a lot of expectations... I think I am like so stressed out at work, once I come home, I don’t want to think about it.

In addition to dealing with expectation inherent in their career, work demands is made more complicated by patients and colleagues perceptions of female physicians from minority groups. This exposes these minority female physicians to covert prejudices, discrimination, and feeling pressured to prove their worth. Debra, a second generation physician, noted:

Once in a while a white person will come to me and say, ‘how did you become a doctor?’ I say well my father’s a doctor...and I’m going to let them know all of us didn’t come from the ghetto... That’s the impression I guess they feel, I am a special Negro.

Andrea, a surgeon with three children, reported on her experience of discrimination and expressed sentiments similar to other respondents:

They look at you as a token... Patients look at me initially as, ‘are you sure you know what you are doing?’ ... I have proved myself because it is how you prove yourself that they treat you... Even some of the surgeons and anesthesiologists who have to give report to me because I am a female, they get an attitude... Some of them haven’t figured out that they need to treat me with respect. They have thought that they need to speak to me in a slave mentality. I have to stand up to them. I’m not rude, but I let them know that if they want me to treat them with respect that they must respect me. They look at my color and the fact that I am a woman and they feel that they don’t owe me any respect. I must prove myself every day... You always have to fight.

These experiences showed the pervasive nature of race/ethnicity in the work environment of minority female physicians. It demonstrated how ethnicity affected work demands by adding the element of having to prove self because of the color of their skin.

These participants had to deal with workplace discrimination due to their gender and minority ethnicity. Angie, a full-time physician with three children, reported significant instances of gender discrimination in her medical career that occurred when she and husband were expecting their first child and a male professor in medical school asked her, “Why did you all let this happen? Why were you not careful?” More of this form of gender discrimination was seen with Mary, who had a male physician say to her that “women belong pregnant and barefoot.” Monica, radiologist with two children, reported a comparable experience during pregnancy and stated that male colleagues were unhappy with her pregnancy:

One of them (a male colleague) is a good friend and he says, great, you're going to ruin the call schedule. But I worked extra hard to get my work in before I left...To this day I worked twice as hard before hand to make up for when I was gone and it worked out fine.

The experiences of these physicians illustrate how work demands directly impact their lives. The participants talked a lot about the pressures that they experienced as a minority female physician, feeling stressed for time, and having to deal with discrimination. These factors appear to influence work demands and impact their ability to balance professional and family lives. Nicole represented many of the participants in the sample when she said, "medicine is set up for men...highly discriminatory against women".

Multiple Role Demands

Multiple role demands is a crucial element in the model and refers to the married minority female physicians feeling caught in a struggle between their roles as mother, wife, and physician, and often it leads to feelings of overwhelm. Many of the participants talked about having the multiple role demands. This was illustrated well by Sophia, a first generation full-time physician:

Trying to balance is one of the things that is challenging and I'm still working towards...My desire is to have a little better balance. And by balance I mean being able to be a good wife, mother, doctor, all that...Especially since I'm spending so many hours outside of the home. It is almost impossible to do all that.

Heather has a supportive spouse still but continues to experience strain from her multiple role demands:

Just because you are working does not exempt you from all the other obligations of being a mom, cooking nutritious meals for your children, cleaning, and making sure there is clean clothes for them...my husband helps out but I am ultimately the one that's responsible.

Trying to functioning in all their roles at times becomes taxing and is a continual issue being faced by the participants in this study. As Natalie reported, "I tease some of my colleague with saying that I need a wife. Because we have to do what you do and then go home and do what a wife does." Part-time physician Kareen, who has two children, commented:

...there is the stress with trying to juggle everybody's schedule which again is self imposed to some extent because my kids don't have to be scheduled like they are... The more kids you have and the more they are doing, the constant movement that you have. I have to juggle all that, and then the worse part of it is juggling me. I take the lowest precedence.

Married female physicians reported feeling a lack of time due to the many demands of their multiple roles. For many of the participants, multiple role demands continue to engender feelings of not being able to balance all their role responsibilities which impacts their functioning and leads to them feeling caught in a bind between career and family.

Role Expectations

The category role expectations refers to the expectations and beliefs that the family and the physician have of self as mother and wife. It represents the participants' feeling pressures in their family roles because of expectations placed on themselves due to gender, family, and cultural upbringing. Some respondents experience certain

expectations from their family to be the primary caretaker because of their gender, while some place that expectation on themselves because they feel it is expected of them to perform in that role within the family unit. The experience of Alexandra was similar to many of the other women in this present study, when she noted, “I do most of the childcare...I’m the one that has to be there. I am the one that has to have the cell phone all the time.” Additional, the feeling that it is the woman’s role to take care of the children and the family is was demonstrated when some of the participants explained it was more acceptable to put the family first. Illustrating this, first generation physicians, Nicole commented, “I think it is more acceptable for women doctors to place family over male doctors.”

For some of the participants the role as the primary caretaker is due to their socialization and background, which impacts their perception of women’s role in the family. Sophia, who is a full-time physician, expressed that her upbringing contributes to how she perceive her role in her family as mother and wife and fosters the feeling that it is her responsibility to take care of the home:

...Being able to be supportive of him in the sense that providing in the home, making sure there’s food and the home is clean. And making sure his clothes are laundered and shirts are ironed and all these things are part of what I see as the duties as a wife...They (wives) took care of things, that is engrained in my background so I still feel like I should do these things...

Many of the participants reported likewise experience, and this was noted by Alexandra, a psychiatrist with one child, “due to how families are structured, I think it (her work) plays a bigger burden in a way.”

Many of the married minority female physicians in this study placed expectations on themselves to be the primary caretaker of their family and experienced feelings of it being expected by their family to be the main caretaker. They expressed feeling it was more acceptable for the female to put family before work and to be the primary caretaker, as a result of family upbringing and expectations placed on the role of mother and wife.

Motherhood Guilt

Motherhood guilt refers to the married minority female physician feeling unable to be there for their children and feeling guilty that they do not have more time to spend with them. Motherhood guilt is experienced often because of the heavy demands of work that influences role expectations and multiple role demands, which and leading to the participants' feelings unable to be the mother they want to be and feeling guilty as they are unable. This is reported by many participants of the study. Heather, a second generation physician, illustrated this well:

I have a lot of conflict, am I a good mom, how is me working affecting my children. I don't know if men or male physicians go through that kind of conflict, like me worrying how it affects my children...I feel like maybe my kids need me more.

Heather went on to express feeling "guilt as a mom for not being there." Similarly, emergency medicine physician, Pam, expressed, "I would like to have more energy so that on my time off I can spend time with her." Abigail, a second generation physician with one child, explained:

I'm the one that spoils the child. I think it's because I'm the one that's not home a lot. And so I think of her a lot. When I'm on call I'll go to the children's gift shop

and he (husband) says why are you doing that? Because I miss her...I think although I was raised in a family where mom always worked, I still felt guilty...And the fact that you don't see your child, it's hard.

For many of the participants there is a conflict between their roles and a sense of wanting to spend more with their children. Alexandra articulated similar feelings when she spoke about her son being sick and having to go to work feelings conflicted. She explained that at time it is like asking herself, what are you going to be today? "...Are you a good doctor/bad mommy or good mommy/bad doctor?" These experiences foster feelings of wanting to be home with their children due to not being able to spend more time with children.

For the mothers in this study, making time for their children was very important. However due to work demands, multiple role demands, and role expectations, they experienced motherhood guilt. The participants expressed feeling a lack of time with their children, feeling guilty that they were not more present with them, and worrying about whether or not they were doing enough as mothers are expected often to be. They conveyed feelings a sense of being caught between their roles as mother and physician that influenced how they experienced their roles and impacted their perception of self as mother. Motherhood guilt appears to be present when women in the study worked full-time or part-time, whether they are first or second generation medical professionals, and/or whether or not they had a supportive spouse.

Couple Nurture

Couple nurture refers to how participants in the study make time for couple dyad even when they live under the pressure of work demands and multiple role demands, which includes the care of children. Some couples make time specifically for the couple relationship. They accomplish this by scheduling couple time and doing activities together, in order to nurture the couple dyad. Demonstrating this, Angie explained that she did marital arts with her husband as their quality time together. She stated, “kung Fu was something that was just me and you (husband). We spar and beat each other up and get away with it.” Heather finds her quality time with husband after she put her children to sleep and goes to watch a funny show and laugh with her husband:

After we put the kids to bed, (Husband) and I would sit and just watch a comedy show and just like laugh that sort of you forget about all your worries, whatever your worries are. And we will do that, that sort of thing that we have this little thing where we love to laugh.

Mother of three, Rena, explained she had to make adjustments in order to spend time with her husband because she has school age children. She stated that she and spouse make time for couple relationship by scheduling date nights:

We go out on Saturday night... Getting a babysitter on Saturday was just something that we had to do so that we could have our time alone... We really do give most of our energy to the kids and we will carve out time for ourselves and we are very dedicated to that time... He is very good at knowing when we need to get a way. Because even that carved time is still a short moment. So at least every month and a half or so, he'll say, you know what, let's go to San Francisco for the weekend.

For a few respondents', couple nurture happens in the context of the family. For example, Brenda and Scott reported having limited time together and the time they have together includes the only child:

Quality time for all of us means going to temple... And sometimes when we have a weekend and our daughter is happy and not really fussing too much we try to go to a place to eat out...with her (daughter), she likes to be in the car.

At times there is significant failure associated with trying to manage couple nurture, this is due often because of a lack of time. Amber illustrated this concept of poor couple nurture well: "I would love for us to spend more time together...don't get a lot of personal communication and about the time we would do that we are both falling asleep because we are both so tired." Pam, a full-time physician with a daughter, described her current relationship with spouse:

We don't see a whole lot of each other...We do try to spend time together and communicate often. I'm not sure we are always successful but we are still trying...We actually have almost opposite schedules. We barely see each other now.

Abigail's expressed similar experience of non-intentional neglect of the spousal relationship when she commented, "It's (intimacy) rare for us, our child sleeps with us, and she's almost four years old."

Some of the couples were aware of how multiple role demands impact their couple relationship and actively took steps to make time for the couple dyad. These couples accomplish this by scheduling time away, taking up activities that allowed for them to be together without their children, and/or they make time for each other at the

end of the day after their children went to sleep. However, due to work demands and other role responsibilities, some minority female physician participants experience non-intentional couple neglect in their relationship. This appears to be a result of other role responsibilities and due to the couple time being experienced in their family time together.

Accommodation

Accommodation refers to the family and/or the married minority female physician making adjustments to allow for family time. It functions as a buffer between work demands and the aforementioned categories. For these participants accommodation is seen in four forms and appears to help reduce the strain between work and family domains. In one way accommodation is experienced through the use of extended family support. Mary demonstrated this when she spoke about her parents helping to take care of her two daughters, “they (Mary’s parents) take care of the girls for a couple hours after school. They’ll come pick them up.” This presence of extended family support help to cushion the effect of work demands on the minority female physician family life. The family support offer the participants room to experience and function in their roles.

Another way the participants’ negotiated accommodation was through support from spouse. This was exemplified by some husbands taking on the role of primary caretaker and shifting to working half-time from home. Brenda, a full-time physician, expressed sentiments similar to many of the participants whose husbands worked part-time. She reported, “He has always been supportive...He has a more definite schedule so he has been taking on the brunt of the work when it comes to taking care of the kid. Like

picking her up...He does a lot of it.” By the husband being willing to put his career second in order to adjust to the work and family demands of being in a physician marriage it reduce the strain on family life.

A third form of accommodation is seen in a situation in which some participants made career sacrifices and adjustments in order to have quality time with their family and to ensure family functioning. This was done often by making the decision to reduce work hours because this was believed to be in the best interest for the well-being of the family, thus allowing for more quality time. Amber explained:

I think it has worked...because it's the sacrifices that I've been willing to make. As a part-time physician I get the best of both worlds. I get to do what I love as far as medicine and I can do what I love as a mother.

Henry, the husband of Mary, reported, “I think sacrificing part of our careers was for the benefit of our kids because we wanted to spend time with them.” Moreover, career adjustments were noted to be associated with some of the participants choosing specialties that allowed for family life. Debra specializes in Rehabilitation medicine and demonstrated this well when she commented that she went into that specialty in order to be able to have time for family. She stated, “I wanted to raise a family and have decent hours and I hate being on call and I came down to PMNR.”

The final form of accommodation is characterized as being able to communicate, working as a team, and being willing to compromise, which helped to reduce the impact of work demands. Amber echoed this form of accommodation for many of the participants in her expression:

I think we work well together as a team. There was never a problem with this is my role, this is your role. We just step in and fill in when we thought there was a need...He helps with the kids, he helps with the housework. Like I said there have never been any defined rules, so if something is not done he steps in and does it. He supports me.

Amber went on to say that they “established that good communication from early and we have grown to appreciate things about each other.” Taylor’s husband reported, “you have to be giving, you have to be sacrificing, you have to be able to sacrifice to marry a physician.”

For many of the respondents accommodation was shown by their extended family support, making kids the priority, setting boundary with work, making it a priority to spend time together as a family, making career adjustments, and learning to mix work and play together. Through this the participants are able to reduce the work demands present in physicians’ life.

Discussion

The purpose of this study was to examine the experiences of married minority female physicians in their professional and family lives. This was accomplished by using a qualitative grounded theory analytic approach. From this qualitative analysis some interesting finding emerged, most significantly, six categories: work demands, multiple role demands, role expectations, motherhood guilt, couple nurture, and accommodations. Together these categories allowed for some insights into the experiences of married minority female physicians, and, in their voices a conceptual understanding of their experiences was attained.

For the data, the category, work demands, emerged and shed some light on the work factors that seem to be an important part of the lives of married minority female physicians. These factors include time conflicts, expectations of colleagues and patients, discrimination on account of their gender and ethnicity, and feeling enormous pressure to prove their worth in their profession. Moreover, the work demands of the participants held significance in their lives, contributed to feelings of guilt, and influenced their familial and professional roles. All this affects the experience of work demands felt by the participants. This finding in this present study was expected to some degree, since ethnic minorities and females no less in the past have reported being perceived as less competent, having limited time for family due to work, and having to deal discrimination because of their gender and race. Additionally, it was expected that as reported in previous research by Liebschutz and colleagues (2006), the married minority female physicians in this present study felt they had to function at a higher level and work harder than their majority counterparts, which was reported by the participants of this study.

Among the participants interviewed for this present study, the category of multiple role demands emerged. This finding was expected since the study focused on the career and family lives of married minority female physicians. The study showed that many of the participants experienced multiple role demands, and for the participants in the study this was illustrated by the struggle to balance between the roles as physician, wife, and mother. This quest to find balance among the multiple roles was pervasive among the participants and led often to feelings of being overwhelmed.

This feeling of being overwhelmed, as mentioned above, appeared to derive from having a limited amount of time to function in their different roles. As reported in earlier

work by Bowman and Allen (1990), managing the demands of their multiple roles was one of the unique challenges for female physicians. Therefore, it was expected that the participants in this present study would experience strain in their multiple role demands, but it was interesting to note the degree to which this was experienced. Additionally, multiple role demands was voiced as being experienced by both part-time and full-time physicians. This could be related to the participants often feeling that they are the primary caretakers, along with feeling they have to prove their abilities in the work environment. However, it should be noted that when the married minority female physician had support from spouse or family, it helped to alleviate some of the strain experienced in trying to function in their multiple roles.

In addition to multiple role demands, there were self and family imposed expectations about what it means to be a wife and mother for the minority female physicians in this study. From analysis of the interview transcripts, role expectations appeared to be a function of the participants' cultural influences, family upbringing, and perception of gender role expectation. For many of the participants, there was the influence of socialization, culture, and/or internal perception that they had to be the primary caregiver in their family. With this, there appeared to be the perception for some of the participants that it was more acceptable to place the family role before work role and demands. This was true especially with regard to childcare, which is similar to previous research that showed that with the presence of children in the family, female physicians' work hours were reduced significantly (Grant et al., 1990).

As literature shows, there is social expectation placed on women to be the primary caregivers of the family, and are thus responsible for the household and childcare

(Bowman & Allen, 1990; Cohen, Woodward, & Ferrier, 1988). These expectations were experienced by the participants of this present study. Consequently, when they were not able to function in their prescribed roles or to the degree they wanted, it led to feelings of guilt in their role as mother and poor couple interaction. However, some participants were able to share the responsibilities of childcare and household responsibilities with their spouse because the some spouses understood the demands of their wives' career and were willing to share in these activities. This adjustment that was seen in some of the marriages studies may represent the commitment of the spouse to contribute to the home economy by sharing in tasks not traditionally assumed by the spouse.

As mentioned in the previous paragraph, some of the participants in the study experienced guilt in their parental role, which was referred to as motherhood guilt. While there have been allusions in previous research to a lack of time for engaging in parental nurture of their children, the category of motherhood guilt seemed to loom large in this analysis. This guilt seems to have been the direct result of over involvement in work that seemed often to be very demanding on them. This feeling of guilt was present for both part-time and full-time married minority female physician mothers.

Couple nurture was another interesting category that surfaced in this present study. This category was illustrated in the experience of some participants taking active measure to make time for the couple relationship. While some of the participants reported a lack of time in the couple dyad, some of them sought to be very deliberate in their efforts to nurture the marriage bond. As research shows physician marriages experience issues related to being overworked and having a lack of time for the family, which affects the quality and quantity of their relational interaction with their family (Myers, 2004;

Smith, Boulger, & Beattie, 2002). It was interesting to see the level of dedication that prevailed in the experience of some to invest time and effort in the nurture of each other in the marriage. Also, there was an awareness of the effects that the career of minority female physicians had on the marriage and the adjustments some were able to make to nurture their relationship as a couple. These findings support the notion that selecting and having a spouse who is supportive and committed to nurturing the partnership is helpful in integrating career and family life and leads to increased family satisfaction (Shrier et al., 2006; Warde, Moonesinghe, Allen, & Gelberg, 1999).

Accommodation, one of the emerging categories in this present study, appears to tie the various categories together. It emerges as a buffer between work demands and the family lives of the participants. Accommodation was seen in family support, compromises, and adjustments that were made in the family to reduce strain between work and family. With this, the participants were able to reduce the pressures of their work demands in a manner that improved functioning in their families, along with reducing the feelings of guilt as a mothers and being able to spend time in the couple relationship. For some participants, accommodation included choosing a specialty that was more conducive to having a family life. This approach was observed by others as a strategy for managing the multiple role demands of work and family Barnett, Gareis, and Carr (2005). Furthermore, while the effect of having spouse support and extended family support was expected, the degree to which they were reported and how much it helped the participants balance work and family was unexpected.

Strengths and Limitations

A number of strengths and limitations may be noted with regard to this present study. With regard to limitations, the present study used a very localized sample of physicians from southern California. While this design does not demand randomization to establish veracity, the experiences of the physicians in a particular geographical context may have excluded the experiences of physicians in other contexts and thus cautions transferability. Additionally, it should be noted that this study not using multiple methods of triangulation (i.e. focus group) may be a limitation. Furthermore, since this study is cross-sectional and looks at one snapshot in time, it offers some limitations and it could benefit from future research doing a longitudinal exploration of this population.

On the other hand, a number of strengths may be noted about this present study. For certain, this study used a qualitative research design. As such, it was able to offer a rich description of the women in the study. Their experiences were noted in their own voices and thus the theories that emerged were very close to the data used in the analyses.

Also, while qualitative studies do not concern themselves with sample size as a premium, the study was able to derive a sample of 21 minority female physicians. The sample size was able to achieve theoretical saturation and this was determined from the analyses that were done. As such, the sample allowed for the generating of theory from the experiences of these women physicians.

Another strength of this study was its ability to contribute to new knowledge in the area of minority females that are physicians and how they are able to manage work and domestic roles in their couple relationships. Many of the studies reviewed used quantitative methods, and some qualitative. Also to be noted is the fact that there are a

number of anecdotal studies that have been done in this area of inquiry. This present study was able to add to the existing empirical literature and was able to advance understanding of this phenomenon using empirical means. Altogether, research conducted on these families has been sparse in the empirical literature, and so this present study has served the field in good stead.

Implication for Research, Theory, and Practice

Past literature on the work and family life experiences of married minority female physicians' have been sparse and poorly represents the experiences of minority female physicians from the ethnic groups of African American, Native American, mainland Puerto Rican, and Mexican American. Additionally, past research often focused on the experiences of male and/or Caucasian physicians, with little attention given to the experiences of minorities. Therefore, this study worked towards filling some of the gap missing in the literature on work and family lives of married minority female physicians.

Research

The present study used in depth interviews of minority female physicians, and in a few cases, the experiences of their spouses. While valued data was derived from the participants, a more deliberate pursuit of a sample of multiple informants from the study may have yielded richer descriptions of the phenomena under investigation. Future research may benefit from treating the family as the unit of analysis instead of individual (the physician), as was done in present study. Furthermore, future study should consider conducting focus group interviews on this population. This would offer a more complex

and rich analysis of the information gathered. It would allow cross check of data with other female physicians to determine a goodness of fit of their experience with the data.

Also, while the study design was consistent with the data sought, less is known about the developmental nature of the physician experiences. As such, future research that is longitudinal in design may allow the securing for important data on the family experience in question. Future studies using such a design are encouraged highly. Better still, mixed methods design may allow for more useful data, even those respond to critics on both sides of the methods debate.

Theory

The major theoretical perspective that was used for this study was family systems theory. In light of this framework, the theoretical model derived from this framework was consistent with family systems theory. For example, the category accommodation was representative of the concepts of family systems theory. Accommodation functions as feedback between work demands and the other categories, in addition to the interconnectedness with the other concepts in the theoretical model that was developed in this present study. The family systems theoretical perspective appeared to have been an appropriate framework for studying this phenomenon.

This present study allowed for the development of theory from the data that was used and the building of a theoretical model on the platform of family systems theory. Additional theorizing would be helpful to unpack the construct of work demands that illustrates married minority female physicians' experiences of feeling they have to prove themselves in order to be respected. As illustrated in this study the effect of work

demands on the family life of the participants was reduced when accommodation was fostered in their family environment. Therefore, future study would benefit from more in-depth analysis of the accommodation occurring in the families of minority female physicians. Additional empirical examination of the professional and family lives of minority female physicians' will help to engender sensitivity and awareness of what is being experienced and lead to change in practice, along with better understanding of the needs of this population.

Practice

It must be concluded that physicians operate out of a unique context, the characteristics of which include: strong identification with career, heavy work demands, and high work stress, among other things. These realities affect their ability to participate in the family sphere. In the literature these realities have led to role overload, role conflict, slowing of career (Phillips, 2000; Rout, 1996; Tiedje, 2004). Moreover, it contributes to feeling overworked specifically and not having enough time for the family, which affects the quality of the family interpersonal interaction (Myers, 2004; Smith, Boulger, & Beattie, 2002). Consequently, many minority female physicians are entering the profession with a lack of models and experiences from which to draw. This demands education and programs in varying forms to educate and help these minority women navigate the sometimes treacherous journey towards optimal person and professional well-being. Therefore, this study has important implication for family life educators and therapist who work with this population, towards assisting in their adjustment in their career and family. This present study highlights the need for cultural diversity training

and workshops to affect work environments, thus making them more inclusive and respectful of the experience of minority female physicians.

Negotiation and conflict management skills for married minority female physicians, along with family life education, and therapeutic interventions supported by work benefits would be beneficial also. It would have implication for the development of work policies that would affect change in the realities of married minority female physicians. This may include policy efforts that serve to correct the under-representation of certain minority groups, through pipeline programs, mentoring, and other such programs. These programs become very important for minority students while in medical school because it would help many of them negotiate the uncharted waters of their profession. For, as research shows having a strong support system in the form of minority colleagues and mentors present in the work environment helps to reduce the effect of discrimination (Liebschutz et al., 2006).

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APPENDIX A

INFORMED CONSENT FORM

Medical Doctors and Their Families: A Qualitative Inquiry

Loma Linda University Department of Counseling and Family Science

Consent Form

Thank you for choosing to participate in this study on physicians and their marriages and families. We would like to talk with you and your spouse about your relationship and familial experiences so that we may better understand physician families. The project is overseen by Doctoral level Faculty at Loma Linda University within the Department of Counseling and Family Science.

Purpose

The purpose of the interview is to gain insight and knowledge into the marriages and families of physicians.

Voluntary

Your participation in the interview is completely voluntary. You have the right to not participate in the interview and withdraw from the interview at any time.

Confidentiality

All information you share is confidential, which means all identifying information about you or your spouse will be removed from the interview transcripts. Only members of the research team will have access to the audio tapes and transcripts from which all identifying information will have been removed.

Referral

Due to the nature of the interview questions, you may experience emotional discomfort or new awareness of interpersonal issues. If you should chose, you may pursue counseling services at:

Loma Linda University
Marriage and Family Therapy Clinic
164 W. Hospitality Lane, Ste 15
San Bernardino, CA 92408
(909) 558-4934

Psychological Services Clinic
Loma Linda University
11130 Anderson Street
Loma Linda, CA 92354
(909) 558-8576

By signing below, I give my informed consent to participate in this research project:

Name of Participant

Date

Signature of Participant

Date

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRES (PHYSICIAN AND SPOUSE)

Medical Doctors and Their Families: Physician Questionnaire

Please answer the following questions:

1. Gender: Male Female
2. Age.....
3. Country of Birth:.....
3A. If other than the USA, how long have you been in the US? years
4. Race/ethnicity you most closely identify with:
 Caucasian Black/African American Hispanic/Latino American
 Asian American Other.....
5. Religious organization/denomination that you most closely identify with?.....
6. Where did you attend medical school?.....
7. Year of graduation from medical school.....
8. Where did you do your internship/residency?.....
9. Medical specialty
10. Current place of work: Private Practice
 Community Hospital University Hospital Other.....
11. Marital Status: First Marriage Second Marriage Other.....
11a. Spouse Occupation
.....
12. Years in current marriage
13. Years in current relationship.....
14. Number of children
15. Number of children living at home
16. Children's gender and age in the home:

<i>Birth Order</i>	<i>Gender (male/female)</i>	<i>Age</i>
First child		
Second child		
Third child		
17. How many hours per week do you typically spend on:
 Paid work..... Housework..... Childcare.....
 Leisure..... Being with spouse..... Being with child(ren).....
 Being with both spouse and child(ren).....
18. Do you have a housekeeper? Yes No If yes, for how many hours per week?.....
19. Please respond to the following items using the following scale:
 1 - Extremely dissatisfied
 2 - Very dissatisfied

16. Do you have a housekeeper? Yes No
If yes, for how many hours per week

17. Please respond to the following items using the following scale:

- 1 - Extremely dissatisfied
- 2 - Very dissatisfied
- 3 - Somewhat dissatisfied
- 4 - Mixed
- 5 - Somewhat satisfied
- 6 - Very satisfied
- 7 - Extremely satisfied

Please write the appropriate response in the blank to the left of the item number.

- _____ 1. How satisfied are you with your marriage?
- _____ 2. How satisfied are you with your husband/wife as a spouse?
- _____ 3. How satisfied are you with your relationship with your husband/wife?

APPENDIX C

QUALITATIVE INTERVIEW QUESTIONNAIRE

Interview Questions for

Medical Doctors and their Families: Qualitative Study

A. Physician as Individual (background, family of origin, identity, career)

1. How did it come about in your life that you chose to become a physician?
 - a. Probe: How did your childhood and family experiences affect your desire to become a physician?
 - b. Probe: How did you choose your particular specialty?
2. What is it like being a physician for you? (shape who you are/what you should be)
 - a. Probe: How rewarding or satisfying is your professional life?
 - b. Probe: What are some aspects of being a physician that are challenging to you?
 - c. Probe: What makes your work meaningful to you?
 - d. Probe: How does being a physician help shape your identity/sense of self?
3. What core values or ethics guide you personally as a physician?
 - a. Probe: What motivates you and guides you in your profession?
 - b. Probe: How do you relate to the core-values/ethics of your profession?

B. Relationship Formation (how the couple met, what attracted them, etc.)

1. Please tell me about the story of your relationship.
 - a. Probe: How did you two meet?

- b. Probe: What attracted you to each other?
 - c. Probe: What stage of your medical training or career were you in when your relationship began? What was it like to begin a relationship during that time? (ASK ONLY IF APPLICABLE)
2. How has your relationship evolved or changed during each stage of your medical training and career?
- a. Probes: During medical school, residency training, early practice, established practice, retirement? (ASK ONLY IF APPLICABLE)

C. Marital Relationship (satisfaction, challenges, conflict, intimacy, time, etc.)

ALL questions must be asked of MD AND professional spouse. Include ALL probes.

1. Tell me about your expectations for marriage.
2. How would you describe your current relationship?
 - a. Probe: What aspects of your relationship do you find most satisfying?
 - b. Probe: *Get a sense of how the following are experienced*
 - i. intimacy (physical, emotional, sexual)
 - ii. communication
 - iii. time together
 - iv. closeness
 - v. sense of partnership
 - c. Probe: What aspects of your relationship do you perceive to be most challenging or how might you wish it to be different?
3. What aspects of being in a physician marriage most impact your marital life?
4. How does being married to your spouse affect your work life?

- a. Probe: How does your spouse support your career goals?
 - b. Probe: How does your spouse support you with the demands of your profession?
 - c. Probe: *(to the physician then to spouse)* What are some areas in which physicians have expressed a need for more spousal support?
5. Can you talk about how you both manage work and family?
- a. Probe: How are housework (and childcare) responsibilities divided?
Why is it that way?
 - b. Probe: How do you manage the responsibilities or the conflict associated with paid work and family work?
6. **ASK BOTH PARTNERS:** how do you manage the professional demands of your job and that of your spouse?
- a. Probe: How do you manage when there is a conflict between your job and your spouse's job?
 - b. Probe: What are your thoughts about how your spouse feels about how their needs are being met? Probe further for professional and personal needs
 - c. Probe: Would you say that one person's professional responsibilities precedence over the others'? Why is that?
 - d. *Probe: How do you perceive support from your partner?
7. How do the two of you handle disagreements or conflicts between yourselves?
8. What do you do as a couple to nurture your relationship with each other?

9. What advice about marriage and staying connected to each other would you give to couples that have work schedules like you do?

D1.--Immigrant Couples (Immigrant Physicians only)

1. It is common for both spouses to work outside of the home. How does this fit with your cultural upbringing (being from the Caribbean)?
2. Has this issue of both spouses working outside the home been a source of conflict in your marriage?
 - a. If so how?
3. From time to time, conflicts between career and family arise for dual career couples.
 - a. Do you feel that your cultural heritage has helped or harmed the way you negotiate these conflicts? How so?

D2.--Minority Female Physicians

1. At times, professional who are members of a minority group face challenges because of their race or culture. As a minority female physician, have your experience any of these challenges and how did it impact your functioning at work?
2. As a minority female physician, could you tell me of some of the challenges you face in your profession in relation to your race and/or ethnicity?
3. (As a minority female physician), could you describe for me some of the challenges you face in your family life in relation to your race and ethnicity?

4. As a result of the demands of your profession and the demands of family life, if you had a choice to do your education over, would you chose the same profession, why or why not?

E.--Spirituality (in professional and personal lives)

1. Please describe your view of God.
 - a. Probe: If you don't believe in God, how do you make sense of life?
 - b. Probe: Do you have a particular worldview? What makes life meaningful to you?
2. What is your experience of God being aware or not aware of you and your thoughts and feelings?
 - a. Probe: What lets you know he is aware or not aware of you?
 - b. Probe: How do you experience His awareness of you?
3. Can you describe a difficult experience and what thoughts or emotions you were or were not able to share with God?
 - a. Probe: Describe what it's like trying to articulate your feelings/thoughts to God?
 - b. Probe: What might be holding you back from sharing certain things with God? (i.e. guilt, shame?)
4. How would you describe your impact on God?
 - a. Probe: Describe your how your choices, thoughts, behavior affect God?
5. How do you know whether or not you are willing to be influenced by God?
 - a. Probe: How do you feel when you are aware of God wanting you to do something you may not want to do?

6. What is your experience of being able or not able to influence God?
 - a. Probe: What is it like feeling like you can or cannot alter God's actions?
7. What is your experience of being able or not able to influence God?
 - a. Probe: What is it like feeling like you can or cannot alter God's actions?
8. Sometimes what one believes about God may not match one's experience of God. Can you describe what that's like for you?
 - a. Probe: What is it like for you when you don't experience what you believe to be true about God?
 - b. Probe: For example, when something bad happens, I might not feel God cares. Or it may be hard to feel God loves me even when I believe God loves everyone. What's it like not experiencing what you believe?

Sections F, G, and H contain questions for the physicians only:

F.--Stress (*questions for the physician only*)

1. What are your thoughts about the demands of your professional life?
 - a. Probes: What are the demands? How stressful are the demands?
2. What other demands or expectations do you experience apart from your job?
 - a. Probes: What are those demands? How stressful are those demands?
3. How do you cope with stress?
 - a. Probes: What works best? What does not work as well?
4. What kinds of support are available to you in managing the stressors in your life?

- a. What is most helpful about their support? Least helpful?
- 5. How does stress affect your relationships?
 - a. Probes: With your spouse? With your children? With colleagues?
With patients? With friends or extended family?

F1. Stress (for spouse of MD). If spouse is not a professional then will ask about their daily stressors.

- 1. What are your thoughts regarding the demands of your spouse's profession?
- 2. What are the demands of your own profession?
- 3. As a couple, how have you been able to cope with the varying demands of each partner's profession?

Probe: What works best?

Probe: What does not work as well?

G.--Physicians and Gender

- 1. (*Male and Female physician*) Tell me about any differences you have observed between female vs. male physicians
 - a. Probe: What if any are the differences you have experienced?
 - b. Probe: In the workplace?
 - c. Probe: In marital life?
 - d. Probe: In experiences of parenting?
 - e. Probe: In regards to ethnicity (personally and to other professionals at work)

2. (*Female and Male physician*) How have you felt supported and empowered (as a woman) in your professional life?
 - a. Probe: In the workplace?
 - b. Probe: In marital life?
 - c. Probe: In experiences of parenting?

*****For those couples with children, only:* -----

-----**H.--Parenting**

1. How did you make the decision (or how are you making the decision whether or not) to become parents? (**If have no children move to section H**)
2. How does having children impact your professional life?
 - a. Probe: When in your professional training or career did you begin your family?
 - b. Probes: Do you feel this was the ideal timing? What would the ideal timing be, if there is any?
3. What does quality time as a family look like?
4. How are you able to arrange for quality time as a family?
5. How do you balance work and family demands with your personal needs?
 - a. Probe: What values and priorities guide you in balancing these demands and needs?
 - b. Probe: What expectations do you place on yourself?
 - c. Probe: What expectations does your ethnicity place on you?
 - d. Probe: What does it mean to be a good parent? How do you achieve that?

- e. Probe: What does it mean to be a good spouse? How do you achieve that?
 - f. Probe: How positively do you feel about your ability to meet these expectations from yourself and from others?
6. What is your relationship like with your children?
- a. Probes: Is it enjoyable? How do you spend time together? What do you do? How do you communicate with each other?
7. How is parenting handled with your children?
- a. Probe: How do you discipline?
 - b. Probe: Who does most of the discipline of the children?
8. What aspects of being a physician parent affect your parenting or your relationship with your children?
- a. Probe: What are some of the benefits to your family of your being (your spouse's being) a physician?
9. How do you think your child(ren) view(s) your professional life as a physician?
10. If you had a choice to do your life over again, would you choose the same profession, **why or why not?**
- a. Probe: For family life

******For those couples in dual-physician marriages, only******

I.--Dual Physician Marriages

1. Perhaps there are costs as well as benefits associated with being a two physician household. In your estimation what would you say are some of those costs?

2. Perhaps we talk a lot about the negative aspects of physician life. As a dual physician family, what do you think are some of the benefits associated with your both being physicians?
 - a. Probe: Benefits to work
 - b. Probe: Benefits to family
 - c. Probe: Benefits to self
 - d. Probe: Benefits to relationship
3. Can you tell us a little more about how you are able to balance work as well as family demands as a dual physician couple?
4. Based on the way you're able to manage your family work and your paid work, how would you say this affects your sense of satisfaction in your marriage?
5. What are some of the contributions you perceive yourself making to your family work and to your marriage even as a highly trained professional?
 - a. Probe: Family work is household chores such as laundry, dishes, childcare, etc.
6. What advice would you offer to others in dual physician marriages?

APPENDIX D
INSTRUCTIONS ON CONDUCTING QUALITATIVE
INTERVIEWS

*Instructions on Conducting Qualitative Interviews – presented by Dr. Susan Montgomery
on September 16, 2009 at Doctor’s Project Meeting.*

- It is important to build rapport with the interviewee. Use the first few minutes of the interview to get to know the participant.
- Keep the interview objectives in mind as you conduct the interview, that way you are aware if the important issues are covered even if all the questions are not asked.
- Questions should not be read. Try to commit the flow of questions to memory that way the interview is more conversational.
 - Questions should be open ended, clear, short, simple, conversational, and should not be double barrel
- Questions should follow a ‘question journey’ with the least intrusive questions being asked first, followed by questions that are more intrusive, then ending with questions that give power back to the interviewee. You may choose to ask about successes and things that have worked.
- The interview environment:
 - Avoid tables (can be seen as barriers)
 - Mimic non-verbal without making fun of
 - Use appropriate eye contact
 - Private environment

- Give the interviewee the option of where to meet (their home may not be the best option)
- Transcription of interviews should occur shortly after interviews.
- Have two recording devices – just in case...
- Make observational notes following the interview.
- If consent is not given to record, make the interviewee aware that you may have to pause to take notes during the interview process.
- Meetings with the research team should be held after interviews are completed to ensure that everyone is on the same page and to evaluate level of saturation. This may show that some questions need to be changed.
- When interviewing couples:
 - Not the dominant speaker
 - Normalize
 - If difficult questions are avoided, try to ask again at some point during the interview (rephrase it). If the question is avoided again, don't continue to ask it.
- Focus groups can be used to validate the experiences of individuals.

Suggestions for current study:

- Interview key informant first then interview couple
- Use group validation process
- If saturation is achieved for one area, focus on other areas where saturation has not been achieved.

APPENDIX E
CODING CATEGORIES WITH QUOTES

Work Demands:

- ◆ The hours have really affected our marriage...it (work) is very demanding...very emotionally demanding outside of the physical demands at times.
- ◆ It's stressful because of the demands of the job and the amount time...there are times when you are so tired, so frustrated, you don't want to see anybody.
- ◆ I think just the time because no matter how much you do want medicine to not be such a major part of life, it does eventually happen. There is always work that I bring home... the time factor is the biggest issue.
- ◆ I enjoy my work. It's challenging but it's a good fit for me. And I am so glad that I found psychiatry. But as a woman, I am not sure the field of medicine with all the hard shifts and rough hours and how hard it is on the family, whether that is the wisest choice...There is a lot of expectations...I think I am like so stressed out at work, once I come home, I don't want to think about it.
- ◆ It's stressful and what is expected of physicians is greater than what is expected in other professions.
- ◆ The pressure, the intense pressure, uh, when a case comes through and I miss something, or I'm scared I'm going to miss something or I don't know the answer, but I know there is something wrong, talking to other physicians is highly stressful because they can be very belligerent... It is just a lot of stress, the level of decision making, the level of production. I have to produce. I have to read fast and come up with the appropriate answer, that kind of thing... When I am really wound up about

work, I can't do anything else. I do worry... All the usual stress from being mom and wife, but my work just adds a whole other level, because every day when we take the cases, the next day we open all the cases from the previous day to see if I missed anything.

- ◆ Once in a while a White person will come to me and say, 'how did you become a doctor?' I say well my father's a doctor...and I'm going to let them know all of us didn't come from the ghetto...That's the impression I guess they feel, I a special Negro.
- ◆ ...Often I think there are some colleagues that think you got through by some affirmative action or maybe you took some easier Board Exam or we had an easier Residency, that we had some sort of leg up and we are not as smart they are or we had it easier than them. Because of your color and because of affirmative action, you were able to get here... because you are Black and you can't be smart enough to be a physician. So, yeah, there is always that sort of thing and again being Black just like being female you have to prove yourself.
- ◆ They look at you as a token. I didn't know how Black I was until I came to America...Patients look at me initially as, 'are you sure you know what you are doing?'... I have proved myself because it is how you prove yourself that they treat you... Even some of the surgeons and anesthesiologists who have to give report to me because I am a female, they get an attitude... Some of them haven't figured out that they need to treat me with respect. They have thought that they need to speak to me in a slave mentality. I have to stand up to them. I'm not rude, but I let them know that if they want me to treat them with respect that they must respect me. They look at my

color and the fact that I am a woman and they feel that they don't owe me any respect. I must prove myself every day... As a woman, you have to let them know that you know your job and you know what you are doing. So that is the kind of thing I have to deal with on a daily basis... So that lets you know what you have to go through as a female, an African-American and a Caribbean. Three strikes and you're out. You always have to fight.

- ◆ Medicine is set up for men. I think highly discriminatory against women.
- ◆ The male (male physicians) has received more respect than the women, I think just based on the fact that for ages males always meant the physician so they tend to look up to them. At my previous job, the person that ran the clinic looked down on me as a female and as a female pediatrician. Thinking that what I did was less.
- ◆ Why did you all let this happen? Why were you not careful?
- ◆ He (a male physician) said 'women belonged pregnant and barefoot.
- ◆ One of them is a good friend and he says, great, you're going to ruin the call schedule. But I worked extra hard to get my work in before I left... To this day I worked twice as hard before hand to make up for when I was gone and it worked out fine.

Multiple Role Demands:

- ◆ Trying to balance is one of the things that is challenging and I'm still working towards... My desire is to have a little better balance. And by balance I mean being able to be a good wife, mother, doctor, all that... Especially since I'm spending so many hours outside of the home. It is almost impossible to do all that.

- ◆ Women have to do dinner, dishes, homework, snack, bath time and wash a load of clothes. Yesterday I was just exhausted. I was literally doing 5 things at a time so that at the end of the hour I had all these things done, instead of doing one thing and then going on to another. My husband just doesn't understand it. I'll be up at 1 in the morning making lunches for the next day because he really doesn't know what goes into a lunch.
- ◆ Just because you are working does not exempt you from all the other obligations of being a mom, cooking nutritious meals for your children, cleaning, and making sure there is clean clothes for them...my husband helps out but I am ultimately the one that's responsible.
- ◆ There is more of a balancing act because it is not the two of us anymore because the kids are involved. So you are trying to balance the kids, spouse and then your own.
- ◆ After we had a child there's a lot more stress. There are times when a mother can crack. Like myself. It's hard.
- ◆ ...Always fighting to keep the balance.
- ◆ It is certainly difficult to balance all that life demands.
- ◆ I'm trying to find that balance.
- ◆ I'm the one that struggles a lot because I will take on so much.
- ◆ I tease some of my colleague with saying that I need a wife. Because we have to do what you do and then go home and do what a wife does.
- ◆ ...there is the stress with trying to juggle everybody's schedule which again is self imposed to some extent because my kids don't have to be scheduled like they are...The more kids you have and the more they are doing, the constant movement

that you have. I have to juggle all that, and then the worse part of it is juggling me. I take the lowest precedence.

- ◆ It has changed because now there are children. And there are more responsibilities. When we were first married we were both full time ER doctors... (with the addition of children) One of us has to be home and be awake for the kids, so we couldn't both work nights... Then we realized that we couldn't run the house hold the way we wanted to with the children and have both of our busy schedules, so I went part time which allowed me less work hours and I was able to be home more...
- ◆ I try to keep my work separate from my home life... I think I've become better at sort of disassociating myself from work. So I sort of kind of leave work at work. You know, all the stress that happens there, and all the, you know, problem patients and all the overwhelming things I try to leave it there and then come home and just deal with you know my husband and our family life and things like that.
- ◆ I feel like I wish I had more of a choice. And sometimes I feel like I don't have a choice.

Role Expectations:

- ◆ I do most of the childcare... I'm the one that has to be there. I am the one that has to have the cell phone all the time.
- ◆ Women are usually in a serving mode and we serve our families continually.
- ◆ I think it is more acceptable for women doctors to place family over male doctors.
- ◆ I think I put my ability to be a mother as first before physician. A wife and a mother first

- ◆ I wish that he would listen to my suggestions and when I really feel something should be a certain way.
- ◆ I think he is (concern) but he doesn't understand totally
- ◆ Due to how families are structured, I think it (her work) plays a bigger burden in a way.
- ◆ ...Being able to be supportive of him in the sense that providing in the home, making sure there's food and the home is clean. And making sure his clothes are laundered and shirts are ironed and all these things are part of what I see as the duties as a wife...They (wives) took care of things, that is engrained in my background so I still feel like I should do these things... I try to change some of that in terms of my vision...especially since I'm spending so many hours outside the home. It is almost impossible to do all of that.
- ◆ What's stressful for me is um, and some of that is brought on by my own self, my own expectations, that I would like for my house to look a certain way, and my house never looks that certain way and that creates a certain amount of stress. And you know, there are just not enough hours in the day, and I don't have enough energy when I get home at the end of my day to do the things that I want to do.
- ◆ I so think that men have it much easier in general only because they don't have the outside responsibilities.

Motherhood Guilt:

- ◆ When the kids were babies, I didn't really have that much guilt, dilemma or burden, should I be at work both of the kids were babies and they didn't know I am not there, of course I am working. But as the kids are older, I feel a lot more burden. And I

don't think its because anyone is putting it on me... There are times when the kids would ask me can you go on a field trip with me, and there are lots of times when I can't... May be I put the stress on myself. I wonder if I should be more involved in my kid's school, things like that. Should I do more?... I feel like maybe my kids need me more.

- ◆ Guilt as a mom for not being there.
- ◆ I was always feeling guilty because I was running from home schooling to work and I felt I wasn't doing, doing either well, or as well as I could.
- ◆ I would like to have more energy so that my time off I can spend time with her.
- ◆ I'm the one that spoils the child. I think its because I'm the one that's not home a lot. And so I think of her a lot. When I'm on call I'll go to the children's gift shop and he (husband) says why are you doing that? Because I miss her... I think although I was raised in a family where mom always worked, I still felt guilty... And the fact that you don't see your child, it's hard.
- ◆ The woman definitely have a lot of guilt if she leaves her child in daycare for all those hours of the week... There is a certain amount of guilt associate with that (child being in daycare)... And so there is almost a yearning to be able to spend more time with the child... You wonder sometimes if you are doing the right thing by allowing that child to spend so much of the formative years in child care, day care.
- ◆ I feel like my time with my kids is so limited that my kids take priority in my spare time, because almost the entire day we spend apart. So sometimes if I have to put priority its kids first... I don't feel like I am good parent many times. There are many

times when I feel like I have failed...I feel like I don't do enough for them, so I carry this burden. It's a heavy burden.

- ◆ I'm going to take him to school and they can call me and I'm a bad mommy... you feel bad when you can't make it to work because you need to stay with you kids.
- ◆ ...Are you a good doctor/bad mommy or good mommy/bad doctor?
- ◆ My son would call me daddy, which caused me to cry because daddy was who did everything for him...When I left my son was sleeping and when I came home my son was sleeping. Sometimes that only opportunity that I had to see my son was when I would give him breakfast and he would say, 'thank you daddy'.
- ◆ He (husband) is very supportive. He admires what I do. Even so much so that when I talk about working a little less, he is in disagreement. He doesn't appreciate how intense it (work) can be.
- ◆ I was just telling someone the other day, when you're looking at a career you don't think about ok the long term as far as kids. At least I didn't... I was just telling somebody if I had known what motherhood entailed and family life entailed. As far as the joys of it and the, for lack of a better term, the demands of it, I'm not so sure I would have chosen this career path. Because it pulls away from really what I would like to do which is raise my kids. My husband is doing a very good job of it, but I'd sure like to do it myself.
- ◆ Sometimes I used to feel guilty that I didn't practice with them as much and when they got to their lesson they were as prepared as they should have been. Or I'd feel guilty that I wasn't there enough. In fact I was discussing with some friends that we are so busy doing all these things, that we really don't take the time to sit down with

the children and talk to them about what is really important in life... Those are the things that I think about and worry about as a parent. I wonder if I am really giving them the things they need. I spend as much time with them as I can... the most important thing to me and in my life is being a mother and caring for my family.

- ◆ After I had my child everything changed. There's another body at home that really needs you and you really are compelled to be their caregiver.
- ◆ ...there are some you know I mean sometimes is because of inequities in the way that um...historicity you know women have been perceived, but I think increasingly is because woman just don't put in the same amount of effort. So and it's not a bad thing but if you are a mom and a wife you have other responsibilities and so, and I think when you recognize that and accept that and deal ...because otherwise you are torn and feel guilty, so you can decide that your are going to have children and consequently you know put your carrier on a different level.

Couple Nurture:

- ◆ ...we have two children and it is difficult to be by ourselves. So we just understand that it's life so we make an effort to as often as we can...It's just a matter of child care and planning.
- ◆ I would love for us to spend more time together...don't get a lot of personal communication and about the time we would do that we are both falling asleep because we are both so tired.
- ◆ I went to Greece by myself. He (husband) is not into travelling so he stays home and I travel.

- ◆ We don't see a whole lot of each other... We do try to spend time together and communicate often. I'm not sure we are always successful but we are still trying... We actually have almost have opposite schedules. We barely see each other now.
- ◆ I think she would like more time with us. When I worked nights I think we had more time together, but my husband does not like the idea of me working nights. Because it limits his time with me, although it improves my time with her. I'm a little torn right now because I like working nights because it gives me more time with her. Get home at 5:30 in the morning, go to sleep, get up by one o'clock and the rest of the day is with her before you go back to work.
- ◆ Quality time for all of us means going to temple... And sometimes when we have a weekend and our daughter is happy and not really fussing too much we try to go to a place to eat out...with her (daughter), she likes to be in the car
- ◆ We are both very supportive of each other working and the beauty of having Sabbath where we try to spend time together as a family also helps nurture communication and we have time together to pray together.
- ◆ Being able to spend quality time with my husband. Being able to have time to listen to him...Being able to be intimate with him and having the energy and time to be intimate. Being able to go out on dates, dinners and do things together like we did when we married.
- ◆ I'll be honest with you, when I was struggling in the beginning with the whole marriage, parenting, doctor balance, the area that got left behind was the relationship with the spouse initially. Because my thinking was he's a grown man and can take

care of himself...Then eventually I started seeing the importance of being there for the spouse...The spousal relationship is very important. I realize that and so I started making certain, not changing per say, but adjustments to allow that relationship to still have its time...We've gotten a babysitter now who can come in on weekends if needed so that we can still go out to dinner her and there. Those changes I think are important.

- ◆ I think that when you have small children it's so stressful. Because we had five years together without children that really saved us because we could remember the time when it was just us and what that was like... we needed those memories to rely on when we were up all night with the kids and they become the center of attention.
- ◆ Quality time is in this room. We just finished time in this room and we're either doing homework. Just the other day we were doing homework, and he was helping one and I was helping the other. And playtime is when we are at the beach or skiing.
- ◆ We do spend a lot of time together. I think that her free time and my free time we schedule so we are all doing something together. I think it's rare that we go away, I mean I may take some time to play golf with my friends. And this year she went for five days with some friends to Mexico, she had the opportunity to do that. But for the majority of time we try to spend it together. My oldest daughter had a project to do the mission, a mission project. So we just said hey, she had Santa Cruz. We said, let's take a few days together, let's hang out and go over there.
- ◆ I worked really hard to spend time together and do things together, but my work is so stressful and it carries me into a different place that he doesn't understand... I think when we do have time and our family is visiting, we (her and husband) have gone

away. We have only left the kids for one night since they have been born. Ever. This is bad but we kind of feel like we had a lot of time together alone when we were dating and before the kids came... A lot of other couples leave and go to Cabo San Lucas for a while. They may leave their kids with their parents or whatever, but I miss my kids. I can't leave them.

- ◆ It's (intimacy) rare for us, our child sleeps with us, and she's almost four years old. I get home, get the baby ready, then lay there and I fall asleep... We don't have date nights. We do, it's probably every month, once every two months. The first three and a half years with my child I don't think we have gone on too many dates... we do go out but we try to do things as a family...
- ◆ My husband and I became certified scuba divers when we were in North Carolina so we do that sometimes. We don't get a chance to do that often. Travel, too. I love to travel too. So whenever we get an opportunity we travel.
- ◆ After we put the kids to bed, Joseph and I would sit and just watch a comedy show and just like laugh that sort of you forget about all your worries, whatever your worries are. And we will do that, that sort of thing that we have this little thing where we love to laugh.
- ◆ Early on we would go out once a week. We had an isolated time, "date night." No matter what was going on, all of our friends knew, we were out. It is Wednesday. That has had to change because of school, and homework and we didn't want to be away during the week because we felt that we needed to be there to help the kids, especially when the homework got very intense... So now we just make adjustments for it. We go out on Saturday night. We get a sitter... Getting a babysitter on Saturday

was just something that we had to do so that we could have our time alone. We as a couple will get selfish with our time. We will tell the kids get out, not now, because we are talking. We really do get most of our energy to the kids and we will carve out time for ourselves and we are very dedicated to that time... He is very good at knowing when we need to get a way. Because even that carved time is still a short moment. So at least every month and a half or so, he'll say, you know what, let's go to San Francisco for the weekend.

- ◆ Being able to plan and schedule things makes it easier to make sure that we have time everyday if possible but at least every few days for good quality time.
- ◆ I love having Frank there as every night after my day I know Frank will be there, we'll always have dinner together.
- ◆ ...We decided that we need to find something that doesn't include children or work because that is where we spend most of our time. We work together, we do our children together. So Kung Fu was something that was just me and you. We spar and beat each other up and get away with it. You can get out your frustrations... That worked out some of our frustrations. We used to do other martial arts also. Listening to jazz is something we like to do.
- ◆ We haven't done much because this last month of school with my son has been rough.
- ◆ He (husband) is really good at trying to find time and finding ways for us to spend time together, alone together. So, we have some time, and my mom has just been a wonderful resource in being there and taking care of the kids whenever we needed to get away, so we probably, actually get away by ourselves a couple of times per year.

Accommodation:

- ◆ They (Mary's parents) were retiring and I was able to talk my mom into coming out for a couple of months ...and they came and it was so stress relieving, I think that our stress level was almost eliminated, it just went from one hundred ad fifty percent to like twenty percent... And they take care of the girls for a couple hours after school. They'll come pick them up.
- ◆ Since my daughter was born we've had maybe six month. But my parents, his parents, they take turns coming over. It's a huge help.
- ◆ I wouldn't want her to stop being a physician just because we have a kid. And I think the family support we have is huge.
- ◆ We got help from his mom quite a bit...She took care of both daughters and she still does. I mean she does a lot for my kids... she still has to pick them up from school everyday except Fridays, she takes them off to piano lessons, things like that. She takes care of all of that. And the kids come home and she will feed them, snacks or meals because they are hungry. She does all of that.
- ◆ My mom lives close by. She is probably 30 or 40 minutes away and she will come and stay because my nanny doesn't drive... My mom would come and stay and drive the kids to doctor's appointments, dance class, piano lessons and things like that. If they needed to be picked up from school, she could do those sorts of things...You have got to have support and it really does take a village. And when you have that kind of support, we two careers, you have got to have a village to get things done.

- ◆ He has always been supportive...He has a more definite schedule so he has been taking on the brunt of the work when it comes to taking care of the kid. Like picking her up. Taking small course with her. He does a lot of it.
- ◆ I'm the one home with the kids from the time they were born... My objective for her (wife) is that she's out working so she should not have any concerns as far as having to worry about kids dressing, care, provisions, feeding, and homework. She shouldn't have to worry about that.
- ◆ I go to work and come home. And he takes up the slack for everything else. That's very helpful because I can concentrate on work.
- ◆ He really had to pick up, basically being the "wife" in the relationship. He just picked up the slack.
- ◆ I think it has been a struggle for him in some ways. He has felt that he has been dragged around the country. It has been my job that made us move. They would call and offer me a job and we had to go. He has been jerked around the country.
- ◆ My job tends to take precedence over his.
- ◆ I think it has worked...because its the sacrifices that I've been willing to make. As a part time physician I get the best of both worlds. I get to do what I love as far as medicine and I can do what I love as a mother. I had to do that because I am supposed to be my child's primary caretaker. It's taken me all this time to get to a point where I say I love being a mother and I want to be home with my kids... I went from wanting to run away from mother hood even though I knew it was the right thing to do, to actually loving it.
- ◆ I have had to make job decisions that have been limiting.

- ◆ I think sacrificing part of our careers was for the benefit of our kids because we wanted to spend time with them.
- ◆ I wanted to raise a family and have decent hours and I hate being on call and I came down to PMNR.
- ◆ I think people express their need or their priorities are family and children, largely by choosing their specialty. Because we know going in which specialties have more time and which have a culture of valuing family over profession.
- ◆ The reason I specifically chose emergency medicine is because it would give me blocks of time to be at work and then blocks of time when I was not at home focusing on other things.
- ◆ When I saw myself crying and very depressed. I thought there is a change I can make here, I don't have to stay in this practice and I can make it better. My time with my child has been golden... Everybody have choices.
- ◆ I waited until my residency was done before I had children and I worked part-time after that.
- ◆ I realized that working the nights which is part of being an ER doctor and working weekends was really bad because that is when they are home and that is the only time I get to see them. So that is when I realized that I needed to go part time.
- ◆ The first two years was a real lesson for me in terms of carving out time for relationships and family and holding that sacred.
- ◆ Right and I think one of the things we've done is to prioritize what it is we want. I think sacrificing part of our careers was for the benefit of our kids because we wanted

- to spend time with them...Prioritizing the kids for the most part, the main thing is finding ways so we can be with them and provide them the best.
- ◆ ...when you are working someplace they always ask more and more of you all the time. It was very easy because I didn't have a lot of options with the kids, so I said I have the kids, I can't work that early, I can't stay that late or I can't take an extra shift because of the kids. Once you establish that boundary at work and the county they will keep trying to ask you but they know where you stand and after a while they don't ask anymore.
 - ◆ I think we work well together as a team. There was never a problem with this is my role, this is your role. We just step in and fill in when we thought there was a need...He helps with the kids, he helps with the housework. Like I said there have never been any defined rules, so if something is not done he steps in and does it. He supports me.
 - ◆ Established that good communication from early and we have grown to appreciate things about each other.
 - ◆ I've worked on things that are important to her to make her happy.
 - ◆ There were definitely times when I felt so unappreciated and overworked and Andy (husband) was always there to support me in that and keep me going.
 - ◆ We work as a team. Dylan (husband) will do laundry and iron so I don't have to worry about that, I will cook.
 - ◆ Somehow we fill in the gaps; we don't tend to gripe about it. If there is something we don't like the way the other does it, the next person does it. We share the responsibilities.

- ◆ He's so flexible and understanding and sort of willing to go with the flow...that single-handedly has been the thing that has kept our marriage going...he's been totally unselfish and he's let me pursue my dreams.
- ◆ We try to eat together, we try to worship together, we try to play games together. And then we have this thing where he will take them to give them their baths.
- ◆ You have to be giving, you have to be sacrificing, you have to be able to sacrifice to marry a physician
- ◆ I don't think they understand that their mom is a physician. Mom is just mom.
- ◆ I understand its (medical field) complexities and its demands on people's time and so because she is part of that I know she will always share her time between the hospital and here (home)... I know that her heart would want to be here but she has accepted the responsibility of the hospital... you have to be very giving, you have to be sacrificing, you have to be able to sacrifice to marry a physician.
- ◆ Family comes first and work comes second. There can be a balance and there have to be sacrifices on both ends. But as long as you know what position in the hierarchy each thing is the choices are easier.
- ◆ Being a wife and a mother is very meaningful.
- ◆ I think the hours is the one thing that, we don't have traditional hours, the nine to five thing. I think in our relationship we do know that and so we do know that we have long hours and so that's just part of it.
- ◆ Yeah Henry really understands what the workload is for me, and vice versa, and so we often try to help each other with what the best schedule is going to be, how we're going to work through things. We consult one another a lot.

APPENDIX F

DEMOGRAPHIC OF RESPONDENTS

Table 1

Demographic Description of Respondents

	Mean	Mode	Minimum	Maximum
Age	39.7	34	29	54
Years in Relationship	15.9	15	6	33
Years Married	12.2	8	2	28
Number of Children	1.8	2	0	4

N = 21 minority female physicians

Ethnicity	Percentage
Black/African American	61.9
Asian/Pacific Islander	14.3
East Indian	14.3
Hispanic/Latino	9.5