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Dual Physician Couples: An Exploration of Family Stressors and Coping

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LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

Dual Physician Couples: An Exploration of Family Stressors and Coping

by

A. Benjamin Zinke

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

August 2012

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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.

_____, Chairperson

Curtis A Fox, Professor of Counseling and Family Sciences

_____

Ian P. Chand, Professor of Counseling and Family Sciences

_____

Susanne Montgomery, Professor of Health Promotion and Education, School of Public Health

_____

Colwick, M. Wilson, Professor of Counseling and Family Sciences

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CONTENTS

ABSTRACT

Dual Physician Couples: An Exploration of Family Stressors and Coping

by

A. Benjamin Zinke

Doctor of Philosophy, Graduate Program in Family Studies
Loma Linda University, August 2012
Dr. Curtis Fox, Chairperson

Physician families have experienced significant changes in the last half century as the rise of female physicians has resulted in an increase in the number of dual physician couples. The present research is a qualitative study of dual physician couples (N = 32). A social exchange framework is used to conceptualize the costs and rewards that dual physician couples experience with regards to work and family domains. A constructivist grounded theory was used as a theory of methodology so that findings were grounded in the data.

Results of this study showed that couples tended to struggle for what was important regarding the competing demands they faced yet, felt that their relationships were favorable when compared with their peers. Also it was found that couples tended to provide each other with empathy and that this resulted in their giving each other license to work as physicians with a less negative impact to the relationship. Theoretical analysis revealed that couples tended to experience confusing exchanges in which physician characteristics made it challenging to assess the costs and rewards of their relationship.

This study has implications for theory and research as it incorporates family theory and analysis into the literature on dual physician families. Further, it incorporates qualitative research, which was suggested as necessary in previous studies. Lastly, it has

implications for policy affecting physician work life environment and best practice intervention with these families.

CHAPTER ONE

INTRODUCTION

The face of the modern physician family has changed considerably over the last half century, most notably with the arrival of large quantities of female physicians and the resulting increase in the numbers of physicians that marry physicians. These couples are sometimes referred to as two-physician couples or physician-physician couples, but are more frequently called dual physician couples in the literature (Schrager, Kolan, & Dottl, 2007; Smith, Boulger, & Beattie, 2002). In recent years, the dual physician trend has become so popular that approximately 50% or more of female physicians marry other physicians (Fletcher & Fletcher, 1993; Myers, 1984; Sobecks et al., 1999). Despite the growing dual physician trend, the current literature remains sparse (Sotile & Sotile, 2004) and there is a preponderance of anecdotal sources. Further, much of the empirical dual physician research was published more than a decade ago (Cherpas, 1985; Fletcher & Fletcher, 1993; Tesch, Osborne, Simpson, Murray, & Spiro, 1992), and, as such, the need for further empirical examination is evident.

Objectives of the current study are as follows:

1. To fill gaps in the literature
2. To introduce family theory into the physician literature
3. To discover information that would be helpful to dual physician couples

One objective of the proposed study is to fill the gap in research, as well as answer several questions raised in previous research. For example, Sotile and Sotile (2004) call for more research on the marital dynamics of dual physician couples.

Additionally, Sobecks et al. (1999) call for qualitative research on dual physician couples, stating that

> qualitative research would illuminate the tensions and tradeoffs between choices and constraints, would uncover the extent to which normative societal pressures--stereotyping and expectations from family, colleagues, or superiors--have shaped professional compromises and would help determine physicians' overall satisfaction with professional and personal arrangements (p. 318).

More than a decade has passed and only Schrager, Kolan, and Dottl (2007) have answered this call to use any qualitative methodology in the study of physician families. However, they make no claim of having found rich qualitative data, because their study includes only three open ended questions. Further, the questions were delivered in an email survey, offering them no chance for follow-up interviewer questions that would have added depth to their findings. Also, their sample consisted of women in dual physician couples that work in academic family medicine, which is not representative of the larger dual physician population. As such, it is not surprising that they repeat the call of Sobecks et al. (1999) stating that "[f]urther research can explore models of work success balanced with life satisfaction using more in-depth qualitative interviews" (Schrager, Kolan, & Dottl, 2007, p. 254). These calls for qualitative research on dual physician couples appear to have been largely ignored by researchers until the present study.

The second objective of the proposed study is to increase the level of sophistication in dual physician literature through the use of family theory. Family theory is important because it provides various lenses that can guide research questions, lead researchers to explore previously unexamined aspects of a topic or in some cases

new topics entirely. Unfortunately, most of the prior physician family research has been a-theoretical, which not only limits the growth of current dual physician literature but also prevents the advancement of family theory. When researchers use family theory, they support, challenge, or otherwise advance our understanding of the modern family unit. When family theory is advanced through research, it in turn, can be used to better guide future research. Essentially, family theory can be used to increase the level of sophistication of a given study while simultaneously advancing or updating our understanding of the modern family unit (Smith, Hamon, Ingoldsby, & Miller, 2009). In an effort to guide research questions and add to the sophistication of literature on dual physician couples, the proposed study will draw on social exchange theory for its theoretical framework.

Social exchange theory has two main concepts, rewards and costs, the understanding of which will greatly aid the reader at this point. White and Klein (2008) explain that in a relationship, "[a] reward is anything that is perceived as beneficial to an actor's interests" (p. 70). This can include certain statuses, experiences, or opportunities that an individual finds gratifying and wishes to experience again (Smith et al., 2009). Conversely, costs might be considered the opposite of rewards, sometimes consisting of negative things one endures in order to experience rewards (White & Klein, 2008, p. 70). Simply put, social exchange theory hypothesizes that couples attempt to maximize rewards and minimize costs in their relationships with the hope of improving the overall satisfaction with their relationship. A more detailed discussion of social exchange theory and how it will be used in the proposed study will be found in the conceptual framework chapter.

The third objective of the proposed study is to seek out information that may help to improve the quality of relationships within dual physician couples. Said information will include, but not be limited to, a better understanding of the dual physician couples experience including costs and rewards of the dual physician relationship, along with solutions, advice, and theory that may lead to improvement in rewards and the minimizing of costs. As such, the findings of the proposed study may be of particular interest to physicians, family life educators, mental health professionals and policy makers as they would be among the most likely candidates to utilize and disseminate this information.

Two research questions will be examined in this study in an attempt to meet the above objectives. The main focus of the study will be (1) how dual physician couples experience the rewards and the costs associated with their multiple roles. The other focus of this study will be (2) how dual physician couples establish healthy and workable adjustments in family living and work contexts.

Rationale

As was mentioned earlier there is a lack of empirical research and a preponderance of anecdotal research available concerning dual physician couples. Aside from the fact that several researchers have called for more research (Schrager, Kolan, & Dottl, 2007; Sobecks et al. 1999; Sotile & Sotile 2004) there are several other reasons why it is important to increase our understanding of dual physician couples examine. First, balancing work and family demands will continue to be a struggle for dual physician couples and can often leave them with limited time to spend with their families

(Yandoli, 1989). An examination of the ways in which dual physician couples strive to balance competing work and family demands could result in findings that would be useful in improving marital satisfaction. Shrier, Shrier, Rich, and Greenberg (2006) suggest that there are great rewards in having physicians that have a more balanced life, such as greater creativity, more energy, and a better quality of service provided to patients. All of these attributes could improve the quality of medical care received by the patients of dual physician couples. As such, a better understanding of competing work and family demands by hospital administrators could improve physician productivity and reduce the cost of providing medical care.

Also it is important that researchers continue to contribute to the dual physician literature because it has historically been biased towards negative findings (Lewis, Barnhart, Nace, Carson, & Howard, 1993). Similar negative research patterns have been noted in the dual career literature as well (Barnett & Hyde, 2001; Bird & Schnurman-Crook, 2005; Hansen, 1997; Perrone & Worthington, 2001). This negative focus not only biases the research, but also could discourage women from seeking out careers and egalitarian gender roles (Perrone & Worthington, 2001). Certainly there are negative aspects of dual physician relationships that should be highlighted such as limited time (Yandoli, 1989) and competition between spouses (Sotile & Sotile, 2000). However, there are also positive aspects that should not be ignored, including spousal understanding (Smith, Boulger, & Beattie, 2002; Sobecks et al., 1999) increased financial security (Sobecks et al., 1999) and increased potential for equality (Sobecks et al., 1999).

In addition, further examination of dual physician couples would be of interest to those who favor gender equality in relationships given the equal levels of education and

earning potential that these couples have. Traditionally men follow what is known as the marriage gradient by marrying women that have lower education levels and earning potential (Bernard, 1982). This places men in the role of provider and women, perhaps by default, in the role of caretaker and nurturer (Friedman & Greenhaus, 2000). However, dual physician couples appear to ignore this societal pattern in favor of relationships with individuals that have roughly equal education and earning potential. Despite the fact that white-male dominated prejudices persist in the medical field, (Bickel et al., 2002) the steady rise in female physicians (Relman, 1980) may indicate that the medical field has begun to change in this regard. This could be a contributing reason why studies have shown that dual physician couples have greater *potential* for equality (Sobecks et al., 1999) than other physician families. Knowing more about how these couples are able to move towards equality and how to improve the quality of their relationships might lead to a better understanding of how to improve equality in all relationships. While this cannot be guaranteed, it certainly is worth the chance.

The proposed study will focus on both negative and positive aspects of these relationships and efforts will be made to provide solutions to negative aspects and enhance or sustain positive ones. Much of the literature appeared to utilize assumptions of social exchange theory, though the theory was never directly referenced. As such, the review of literature that follows has been largely organized around concepts of costs and rewards. An examination of the available literature will allow us to proceed.

CHAPTER TWO

REVIEW OF LITERATURE

The review of literature that follows will make use of the limited dual physician sources that are available. To further supplement our understanding of dual physician couples, we will begin by examining the literature concerning the related topics of dual career couples, physician couples, and female physicians. Examination of the dual career literature is necessary because these couples have somewhat similar experiences to dual physician couples as far as professional responsibilities and time demands (Sotile & Sotile, 2000). As such, work and family demands are discussed against the background of dual career couples. Next, we will continue our examination of the literature by focusing on physician couples. This will provides us with a greater understanding of the physician culture and the stressors that tend to be more specific to physicians. Then the reader will find a discussion of the literature regarding female physicians as concerns of dual physician couples are inexorably linked with that of female physicians. Finally, we will discuss the available literature concerning dual physician couples.

Many of the sources that are available for the proposed study might be termed un-empirical as they lack empirical analysis. Often this involves the observations of psychiatrists that have treated physicians and have taught seminars to physicians. Despite this potential shortcoming, the author recognizes that these un-empirical works are non-the-less valuable for increasing our understanding of the physician population. For example, samples of physicians that sought therapeutic services from psychiatrists might help us to understand what kinds of issues physicians tend to face. In fact, it would be difficult to discount these sources as many physicians have read this material and

found it useful in understanding and improving their work and family lives. It is also of note that we often trust our lives with the opinions of physicians, so we might give them some credibility when they write down their observations of physician and dual physician relationships. Limited use of un-empirical sources was used in the creation of the following review of literature.

Additionally, articles used in this study will be limited to United States populations, which unfortunately eliminates the use of European and Canadian articles that may have been used to further our understanding of dual career and physician couples. However, this is thought to be a necessary distinction as there are several differences in the work and family lives of professionals in the US compared with that of Europe and Canada, especially concerning physicians. Among these differences are educational requirements, salary, financial security, malpractice insurance, work requirements and the impact of socialized medicine (Yandoli, 1989).

Dual Career Couples

Dual physician couples and dual career couples are similar in that both types of couples face work and family demands (Sotile & Sotile, 2000). The issues faced by dual career couple are similar, but not identical to that of dual physician couples considering that there are some demands that are peculiar to medicine (Gabbard & Menninger, 1988). It is hoped that a closer examination of the literature pertaining to dual career couples will provide us with a deeper understanding of some of the concerns faced by dual physician couples.

The term dual career couple describes a relationship between two people in which both have careers that provide income, social camaraderie, and professional as well as personal identity (Bird & Schnurman-Crook, 2005; Cherpas, 1985). The dual career couple is an attempt to have it all: a family, a satisfying career, and a comfortable income (Hill et al., 2006). These couples derive a sense of identity from both work and family roles and their ability to achieve balance in both domains (Bird & Schnurman-Crook, 2005), but they are not always able to achieve that balance (Betchen, 2006). The discussion that follows will first explore gender issues followed by the potential costs and rewards that are experienced by dual career couples.

Gender

Many of the potential costs and rewards found in the literature appear to be related in some way to gender roles within dual career couples. Traditional gender roles put men in the position of breadwinner and women in the position of caretaker and nurturer (Friedman & Greenhaus, 2000). Conversely, non-traditional or egalitarian gender roles encourage couples to share breadwinner, caretaker, and nurturer responsibilities equally (Hochschild & Machung, 2003). The discussion bellow examines three other concepts that are related to gender: marriage gradient, unpaid family work, and role conflict.

Marriage Gradient

Betchen (2006) describes the dual career couple as a relationship where power struggles can easily take place, because in dual career couples men are not necessarily

needed by their wives and families. This may have to do with the prevalence of traditional values and more specifically with the marriage gradient as it likely impacts the experience of relationship for most couples. The marriage gradient has to do with the fact that in traditional gender roles men tend to marry down and women tend to marry up (Bernard, 1982). That is, men typically marry women that are younger, shorter, less educated and lower paid and women tend to marry men that are older, taller, more educated and higher paid. The explanation provided by Bernard (1982) is that men want to marry women that look up to them as much as women want to marry men that they admire. While dual career relationships might appear be the answer to this concern, there is also potential for the marriage gradient to cause issues in these relationships.

For example, Betchen (2006) suggests that men in his practice sometimes use sexual dissatisfaction as a way to regain power, especially when the women earn more money. Further, the marriage gradient can cause concern for high status women, because the pool of available men with higher status is small (Strong, Devault, & Cohen, 2005). Hochschild and Machung (2003) point out that this dynamic often results in power imbalance, because it would be easier for men to replace their wives than for women to replace their husbands.

Unpaid Family Work

Hochschild and Machung (2003) suggest that this power struggle often results in women doing approximately two-thirds of unpaid family work, because they do not want to be divorced. Unpaid family work is an important aspect of adult life, as it refers to household work such as cooking, cleaning, and childcare (Jacobs & Gerson, 2001).

Hochschild and Machung referred to unpaid family work as the "second shift," adding that after women get home from work they still have the unpaid family work of running a household.

Role Conflict

Psychological distress is common in dual career couples that are experiencing conflict between work and family roles (Barnett & Hyde, 2001). Role conflict has to do with the competing or contradictory demands experienced either within a role or between two or more roles. Examples of the most common roles referred to in the research are worker, spouse, and parent (Strong, Devault, & Cohen, 2005). Friedman and Greenhaus (2000) found that dual career women often have more work-to-family conflict, meaning that work often interferes with a woman's ability to fulfill family obligations. Conversely men in dual career couples have more family-to-work conflict meaning that men often find that their family obligations interfere with their ability to meet work obligations. Also, there are certain times in the life of a couple when they are more likely to experience work-family conflict, especially when there are small children and potential caretakers work outside the home (Jacobs & Gerson, 2001; Voydanoff, 1987).

Costs

Based on the fact that women tend to have more difficultly balancing family and career demands (Litzky, Purohit, & Weer, 2008) one might assume that men and women tend to have differing experiences of the dual career experience. For example, Bird and Schnurman-Crook (2005) found that women in dual career couples took the lead in

unpaid family work and that husbands were seen as helpers, but not primarily responsible for the completion of unpaid family work. In keeping with this Betchen (2006) depicts women in dual career couples as being in a double bind, because they are torn between family and work obligations. Unfortunately, there is an increasing trend of dual career couples that put in an excess of 100 hours per week in combined work hours (Jacobs & Gerson, 2001) potentially adding to role conflict in dual career couples. This excess of work hours and/or inflexible work hours can often lead to a lack of time and energy for family life as well as increased role conflict (Hill et al., 2006).

Also, Pixley (2008) points out that couples tend to favor the career that can bring the most financial reward to the family. While this is understandable, it may also have unforeseen consequences as individuals may have to change locations and employment to favor the career of their partners. Often a change in location that advances the career of one partner can result in less favorable working conditions or possible unemployment for the other partner (Pixley & Moen, 2003). Not surprisingly, Pixley found that most career decisions favored the careers of men. Among several other variables, Perrone and Worthington (2001) discussed the significance of role conflict and coping as important considerations for marital quality among dual career couples.

One major cost that dual career couples might face is limited time with their children (Jacobs & Gerson, 2001; Milkie, Mattingly, Nomaguchi, Bianchi, & Robinson, 2004). Childcare is a central issue in the realm of work and family, as there is often conflict between work ideals and childcare ideals (Bianchi & Milkie, 2010). That is to say that childcare interferes with the ability to work and work interferes with the ability to adequately and consistently meet the needs of children. The research shows that

parents expressed concern about not spending as much time with their children as they would like. This time deficit with children has to do with both the quality (Daly, 2001) and quantity (Milkie et al.) of time. Milkie et al. found that approximately 50% of parents in the US felt they were not spending enough time with their children. Daly suggests that family life ideals have not kept pace with changes in the work place, allowing parents to lament that their children are not receiving enough quality family time. However, in a decade review, Bianchi and Milkie (2010) found that the majority of research on working mothers demonstrated little or no negative impacts on outcomes for children.

Coping

Much of the research on dual career couples has noted that the preponderance of research is excessively negative (Barnett & Hyde, 2001; Bird & Schnurman-Crook, 2005; Hansen, 1997; Perrone & Worthington, 2001). This excessively negative focus could not only bias the research, but also discourage women from seeking out egalitarian gender roles (Perrone & Worthington). Barnett & Hyde (2001) call for future research to focus on more of the positive aspects of dual career couples.

Bird and Schnurman-Crook (2005) points out that while studies on dual career couples tend to focus on stress patterns, there are significant positive adaptation patterns that could also be found. Many of the potential costs found in the literature appear to be related in some way to the gender roles of dual career couples (Betchen, 2006; Friedman & Greenhaus, 2000; Pixley, 2008). For example, O'Hare (1997) suggests that egalitarian

dual career couples will be more successful in achieving balance between work and family demands.

As was mentioned earlier, role conflict is a large concern for dual career couples, but fortunately, there are potential solutions. Several articles suggest that scaling back work hours can have positive effects for reducing role conflict in dual career couples (Becker & Moen, 1999; Hill et al., 2006; Reynolds, 2005). Hill et al. (2006) recommend that dual career couples work no more than 60 hours between the couple per week. Couples that did this were able to improve the fit between work and family, family satisfaction and, job flexibility as well as decrease the tendency for role conflict. The advantage of this approach is that unpaid family work can be attended to while allowing both individuals to have a rewarding career and involvement with their families (Hill et al., 2006).

Reynolds (2005) point out that higher income couples tend to deal with work-to-family conflict by reducing work hours, because their income makes it easier for them to do so. Blair-Loy (2001) suggests that the solution that seems to be favored by younger generations is to subcontract household tasks to paid workers such as nannies. Also, dual career couples could attempt to decrease work-family conflict by such things as favoring the career of one partner at one point and then switching to favor the career of the other at another time (Becker & Moen, 1999). Though we have already discussed the issues that this could cause if one career is favored indefinitely (Pixley, 2008) this plan to temporarily favor one career could be the answer for increasing work and family balance for many a dual career couple.

Bird and Schnurman-Crook (2005) used qualitative methodology to discover a number of other coping strategies that dual career couples employed in their study so as to balance work and family demands. These strategies fell into two categories, problem focused strategies that are designed to resolve the problem directly, and emotion focused strategies that helped dual career couples cope with the stress of unresolved problems. Among the problem focused strategies were: dividing a problem into more manageable components, advice seeking, and changing expectations. Emotion focused strategies included such things as: accept limitations, exercise, relaxation techniques, talking as a couple, completing tasks to help ease the burden of the other partner, venting to partner, and collaboration in parental decisions. Bird and Schnurman-Crook point out that gender and cultural considerations influenced which coping strategies individuals tended to employed.

Rewards

After so much consideration for the potential costs of dual career relationships and possible coping strategies it might be logical to conclude that it is a bad idea for couples to engage in these relationships. However, there are also significant rewards that can be experienced by dual career couples. The most obvious advantage is increased income, which may be linked with increased satisfaction with the dual career lifestyle (Perrone & Worthington, 2001). There is also the possibility of positive crossover, which Barnett and Rivers (1996) describe as the sharing of information and other resources that may be helpful in the careers of both partners. Bird and Schnurman-Crook (2005) also mentioned in their qualitative study that couples appeared to have a relational focus,

meaning that they focused more on couple and family interests and less on self promotion. Other rewards to the couple include similarity of experiences that may lead the couple to better understand each other and improved physical, psychological, and relational heath (Barnett & Hyde, 2001; MacDermid, Roy & Zvonkovic, 2005).

Men in particular described the advantages of dual career relationships as having less pressure to provide, enjoying relationships with wives that had higher self esteem, and the ability to have increased family involvement (Barnett & Hyde, 2001; Betchen, 2006; Bird & Schnurman-Crook, 2005). Women reported a sense of personal identity from having a career as well as opportunities to experience success, social support, value in the eyes of her children, and identity validation when their partners approves of their professional accomplishments (Barnett & Hyde, 2001).

As we can surmise from the above information, the dual career couple has many potential costs, but it also has much potential for rewards. As we will see in later discussions the same can be said of dual physician couples. However, we will first discuss literature pertaining to physician families so that we can highlight aspects of the physician culture that have not yet been discussed.

Physician Couples

Doherty and Burge (1989) found that physician couples are less likely to divorce when compared to the general population. They suggest that these results are to be expected considering the fact that those with high status careers are less likely to divorce. Further they found that female physicians were more likely to divorce than male physicians, but the discrepancy was explained by the higher prevalence of divorce among

employed women. Doherty & Burge found that female physicians were less likely than other employed women to get a divorce. However, they caution the reader against interpreting their findings as based entirely off of sociodemographic factors. Eisenberg (1989) critiques this article and points out that marital stability does not imply marital satisfaction. That is, Doherty & Burge are unable to state that physician couples are happier, merely that they are less likely to divorce.

Gabbard and Menniger (1989) suggest that physician relationships are characterized by perpetual postponement of family time and emotional intimacy in favor of work. Also, they argue that this postponement is a strategy to purposefully avoid intimacy. Gabbard and Menniger state that middle aged medical couples fall into a pattern in which there is:

> " (1) a gradual erosion of marital intimacy; (2) a reduction or absence of emotional expressiveness; (3) the absence of consistent and meaningful communication and an avoidance of touchy or troubling issues; (4) a diminution, or even cessation, of sexual relations; (5) a gradual divergence of interest to the point where the marital partners have little in common; and (6) mutual withdrawal that results in a subtle estrangement of the couple" (p. 2380).

The picture that Gabbard and Menniger (1989) provide makes the marital relationship of medical couples sound more like roommates and less like a relationship. Further, they suggest that rather than *withholding* intimacy, that physicians are often *incapable* of intimacy. Lastly, Gabbard and Menniger propose that medical couples may need to accept the fact that they will never be able to completely balance their work and family demands, but that there are rewards in striving none-the-less.

By contrast Lewis, Barnhart, Nace, Carson, and Howard (1993) question the assumption that our society has created about physicians and physician relationships.

This study states that prior studies have pathologized physicians by assuming that physicians are attracted to medicine for such reasons as: substance abuse, intimacy avoidance, and of course higher status. Further Lewis et al. challenges the assumption that physician spouses are co-dependents who leach their identities from the physician. Lewis et al. question the sampling of prior studies, specifically whether sampling done at marital enrichment seminars is representative of the physician population.

It may be difficult to characterize physicians with such a broad stroke, yet there are some concerns that physicians do tend to have in common. For example, physicians often face stressors such as malpractice suits, long work hours, patient expectations for physician perfection, and physician expectations of themselves (Gabbard & Menninger, 1988). It could be argued that these stressors must but have an impact on physicians and their relationships.

In an examination of the family experience of physician wives, Sotile and Sotile (2004) found that increased work hours of the physician partner, tended to correlate with decreased marital satisfaction as well as satisfaction with work and family balance. However, it was also discovered that reduction in physician work hours by as little as 7.5 hours per week significantly improved marital satisfaction. Sotile and Sotile stated that physician wives were relatively satisfied with their husband's work schedule and even reported an average of over an hour of time per day in which the couple was able to spend together. Overall, Sotile and Sotile suggest that physician relationships are somewhat similar in martial satisfaction to that of non-physician relationships. Further, they state that the quality of a physician relationship has less to do with work and work hours and more to do with how physician couples treat each other. Participants stated

that marital satisfaction of physician wives is impacted greatly by their husband's work-stress. Sotile and Sotile state that work and family stress of physicians was often the result of frustration over decisions that favored family instead of work.

Sotile and Sotile (2004) suggest that the non-physician wives of physicians that choose to have a career (dual career couples) may have improved marital satisfaction, given the opportunity for personal fulfillment and social contact provided by employment. They warn that early parenting years may be a time of increased stress for physician relationships, with wives of physician sometimes referring to themselves as "married, single parents" (p. 56). When asked for advice to give other physician wives, participants in this study stated that in early parenting years, it was helpful for physician wives to build their own supports and accept that physicians would often not be able to attend family functions. Further, participants stated that husbands could be helpful by honoring their wives roles as parents and homemakers.

Female Physicians

In 1980, Relman proclaimed, *Here come the women*, signifying the entrance of great quantities of women into the medical field, not as nurses or assistants, but as physicians. Since that time female physicians have continued to grow in number. For example, in 1960 approximately 6 % of medical students were female, but by 2001 females represented 45.8% of medical students (Bickel, Clark, & Lawson, 2001). In the 1980 approximately 12 percent of physicians in the workforce were women, but by 2006 that number had more than doubled to 30 percent (American Medical Association, 2008).

If this pattern continues there is reason to believe that female physicians will constitute approximately 50% of all physicians at some point in the future.

Unfortunately this increasing equality in numbers has not resulted in equality of pay as female physicians earned 41% less than male physicians (Medscape, 2011). While this statistic may seem staggering, a closer inspection of the source reveals that this does not account for the fact that female physicians tend to work less hours and choose specialties that make less money. This is probably due to the fact that women are more likely than men to choose a specialty based on family needs instead of career ambition (Bickel, 2000; Bowman, Frank, & Allen, 2002). Despite this increased family focus Sotile and Sotile (2000) discovered in their therapy practice that non-physician husbands of female physicians tended to resent their wives for not taking on more traditional roles. Factors that may contribute to this resentment may include things such as expectations for traditional gender roles and unpaid family work that were mentioned earlier.

Another concern was raised by, Frank, Rothenberg, Brown, and Maibach (1997) when they found that Hispanics and African Americans were underrepresented as female physicians and Asians were overrepresented when compared to the general population. The cause of this underrepresentation of Hispanic and African American females is yet unknown, but Bickel et al. (2002) suggests that a great deal of it may be caused by the white-male dominated prejudices that are often found in the medical field. Further, a comparison of practicing physicians and academic physicians shows that women are underrepresented in the field of academic medicine (Draznin, 2004). Both the lack of diversity relative to the population in medicine and the lack of female physicians in

medical academia may create a shortage of mentors to encourage female students and especially for minority female students (Bickel et al., 2002). It is possible that this shortage of mentorship could discourage female physicians from seeking employment in academic medicine, which might in turn make it more difficult for women to achieve greater equality in the medical field.

One of the problems that likely contributes to the lack of female physicians in academia is that medical careers often require women to be the busiest during their prime child bearing years (Bickel et al., 2002; Carnes, 1996). Bowman, Frank, and Allen (2002) suggest that the importance of childbearing and childrearing are often overlooked by the medical field. Instead physicians are expected to continue with the same quantity and quality of work as before they had children. Draznin (2004) suggests a solution for solving this problem in academia using what she calls a "mommy tenure track." She proposes that female physicians in academia be given leave to work part time with no repercussion towards their careers. Then, when their children are old enough to be put in school the female physician will resume fulltime work. It is possible that the same sort of arrangement could be made for practicing physicians as well, since many sources discuss childbearing and childrearing as a significant issue for female physicians (Bickel et al., 2002; Carnes, 1996; Shrier, Shrier, Rich, & Greenberg, 2006; Verlander, 2004).

Back in 1990's, Bailyn (1993) was urging the US medical field to follow the example of European medicine which is more supportive of physicians having balance between work and family. Unfortunately, there have yet to be any significant moves in the direction of making medicine a more family oriented field. Shrier, Shrier, Rich, and Greenberg (2006) suggest that there may be great rewards in having physicians that have

a more balanced life, such as greater creativity, more energy and a better quality of services provided to patients.

One problem that continuously interferes with moving towards the aforementioned family oriented practice of medicine is the characteristic that Louie, Coverdale, and Roberts (2007) use to describe these medical professionals:

> Physicians are prone to overworking. Diverse factors contribute to this result, including the medical school selection process and a professional ethic that embraces hard work, excessive service demands, and fiduciary obligations to patients which promote the interests of patients over physician self-interest. (p. 129)

Perhaps Louie et al. (2007) should have added that physicians also put the interest of their patients over the interests of their families. It's important to note that the above quote is referring to the older tradition of medicine before the arrival of such large quantities of females into the profession. However, this tradition is still with us today and it is the culture in which female physician work. One might say that Louie, Coverdale, and Roberts accuses medical schools of using a selection process that specifically looks for candidates that will put the interest of their patients over their own interests and that of their families. While this may be a noble gesture, one must also consider the cost to the physician family and the potential cost in the quality of medical care that physicians are able to provide to their patients.

Dual Physician Couples

Only thirteen years after Relman (1980) proclaimed *Here come the women*, Fletcher and Fletcher (1993) announced *Here come the couples* to describe the changing

relationship trends in which physicians regularly marry other physicians. A natural function of having larger numbers of female physicians was that it facilitated the possibility of having greater numbers of dual physician couples. As the female physician population increases, the population of dual physician couples will continue to increase in number for the foreseeable future (Myers, 1984; Sobecks et al., 1999). In fact, this trend has become so popular in recent years that approximately 50% or more of female physicians marry other physicians (Fletcher & Fletcher, 1993; Myers, 1984; Sobecks et al., 1999). The following discussion will concern costs and rewards that dual physician couples tend to experience.

Costs

As with any relationship, there are issues with which dual physician couples tend to struggle. In fact, there is even some research that discusses therapeutic interventions specifically designed for dual physician couples (Sotile & Sotile, 2000). This suggests that these couples not only have problems specific to medicine, but also problems peculiar to being in dual physician relationships. The two major findings of the current empirical literature regarding costs that dual physician couples tend to face are limited time and competition between partners.

Limited time

Yandoli (1989) suggests that while partners of medical students have a taste of how busy a physician can be while the physician is in training, they typically assume that at some point their physician partner will have more time for the relationship. They also

assume that their physician partner has the intention to spend more time together. As was mentioned earlier, we must consider that some physicians may postpone emotional intimacy until some abstract future in an attempt to avoid it entirely (Gabbard & Menniger,1989). Thus, it becomes complicated to explain this limited time, because it could have to do with legitimate work concerns as easily as if could have to do with avoidance of intimacy.

Graddy (1994) contends that the very qualities that make an excellent physician are also qualities that make up inattentive spouses. These would be the same qualities that were mentioned by Louie, Coverdale, and Roberts (2007), such as a willingness to work hard and put the needs of patients before the needs of the physician's self, relationship and family. There is a possibility for dual physician couples to severely damage their relationships due simply to physical and emotional neglect of the relationship (Gabbard & Menniger, 1989). In his practice as a psychiatrist Myers (1984) found that infidelity was a recurring issue for dual physician couples, which may be associated with lack of time and neglect of the relationship.

This lack of time could impact not only the romantic relationships of dual physician couples, but also their relationships with their children. In a study done by Smith, Boulger, and Beattie (2002), more than 90% of dual physician couples reported that they had children. The most common method for handling childcare in their population involved hiring a nanny. This is of course an option that is more feasible for dual physician couples as they tend to have higher income. As with all families, time constraints are more pressing for dual physician families while they have small children,

but this issue tends to decrease as the children mature and require less attention (Smith, Boulger, & Beattie).

Competition

Sotile and Sotile (2000) suggest that dual physician couples are prone to competition with each other to see who can work harder or make more money, because they are often both driven to succeed. This competition can often degenerate into a relationship that is lacking in physical and emotional intimacy. This would appear to be in line with the findings of Louie, Coverdale, and Roberts (2007) when they argue that medical schools tend to select individuals that will sacrifice their own needs in favor of the needs of their patients.

As with all relationships maturity can be an important factor in determining relationship quality of every physician couple (Sotile & Sotile, 2000). The extent to which dual physician couples endure these costs will likely be dictated by their level of maturity and their willingness to negotiate their work and family lives. The argument could also be made that maturity will also dictate the extent to which dual physician couples will experience rewards.

Rewards

There are a number of rewards that are available to dual physician relationships. While some of these rewards may be found in dual career relationships or other types of physician relationships the literature would suggest that dual physician couple tend to

experience them in greater qualities. The three major rewards that are described in the current literature are spousal understanding, financial security, and equality.

Spousal understanding

Sobecks et al. (1999) points out that the shared professional interest of dual physician couples can lead to greater enjoyment of time spent together and greater overall life satisfaction. Physicians all speak the same basic language regarding their work, with a few quirks brought on by specialties. This would allow dual physician couples to communicate much easier and to enhance their understandings of work stressors and successes. Some studies have cited this kind of understanding as one of the greatest strengths of the dual physician relationship (Smith, Boulger, & Beattie, 2002; Sobecks et al., 1999).

Financial security

An obvious reward is that dual physician couples tend to have higher combined income than most physician couples. Sobecks et al. (1999) found that this higher income allowed family physicians in dual physician couples to work less than other family physicians. Further Sobecks et al. implied that dual physician couples might be inclined to choose less stressful, and competitive careers that are lower paying, because of the assured financial security that dual physician couples enjoy. It should be noted that the sample used by Sobecks et al. might be considered younger than the typical dual physician couple. This could explain why this finding appears to contradict the picture of dual physician couples that compete with each other and have very limited time.

Equality

One very significant finding is that dual physician couples tend to have both partners more involvement in child rearing when compared to other physician families (Sobecks et al., 1999). Traditional gender roles were not entirely absent from dual physician couples that were sampled, yet these gender roles were found in a reduced capacity. Female physicians in dual physician families were more likely than men to take on unpaid family work as is found in the vast majority of families. However, male physicians were shown to take on more unpaid family work when compared to other male physicians (Sobecks et al.). As was referred to earlier, this may have something to do with the higher income of dual physician couples and their sequent abilities to work less hours while still receiving a healthy income.

A Note on Specialties

Yandoli (1989) asks what types of personalities are drawn towards specific specialties and what impact can this have on their relationships? Yandoli acknowledges that there could be a great deal of differences in relationships due to differences in specialties. Schrager, Kolan, and Dottl (2007) may have found a trend in the specialties of physicians that are more likely marry other physicians. For example in their study of dual physician females in academia, Schrager, Kolan, and Dottl found that 45% of female dual physicians worked in obstetrics and 47.5 % of the female physicians had husbands that worked in primary care. This finding is supported by Smith, Boulger, and Beattie (2002) who found that dual physician couples were more likely to have primary care specialties such as family practice, internal medicine, or pediatrics.

These findings indicate that there may indeed be trends related to the specialties of dual physician couples. Assuming there is a pattern, we know little about potential causes of it. For example, it seems logical that some medical students would make the choice of a particular specialty with their spouse's career in mind, or as we have discussed before, that female physicians tend to choose their specialties based on the needs of their families (Bickel, 2000; Bowman, Frank, & Allen, 2002).

Conclusion

Dual Physician couples experience rewards and costs in their relationships that are somewhat peculiar to the dual physician phenomenon. While they tend to struggle with limited time and competitive spirits, they also can experience such rewards as understanding, financial security, and equality. The extent to which dual physician couples experiences these rewards and costs may be influenced by things such as age, maturity, and specialties of the physicians involved.

While dual physician couples have potential for more egalitarian roles, the evidence would suggest that dual physician couples have are not entirely devoid of traditional gender roles. It is interesting that the marriage gradient in which men marry down and women marry up appears to be largely ignored by dual physician couples at least in regards to mate selection. However, the marriage gradient says nothing about who does more unpaid family work and whether one physician's career is favored over another.

Future Studies

Given the growing dual physician population and the impact this population undoubtedly has on the medical field, it is evident that further studies are required. First and foremost it is necessary for studies to provide accurate descriptions of the number of dual physician couples in the United States and the demographic data concerning these couples. While we are able to achieve some small measure of understanding of this population through the piecing together the findings of various studies, as of yet no study has attempted to provide a proper description of this population. Details that might be of interest include variables such as numbers and percentages of dual physician couples, age, age at time of marriage, specialty, location of practice, work hours and number of children. Also, thus far no studies appear to discuss the homosexual dual physician population, which may be of interest given recent societal changes in the definition of marriage. Also, studies of dual medical student couples would be necessary to determine how and why these couples tend to marry in such large quantities. Further, it would be of interest to know how dual physician couples choose their specialties with regards to their plan to have families.

Further studies need to be done linking dual physician couples with work and family concepts. The majority of research appears to be done by physicians that have firsthand experience of the physician lifestyle, but little knowledge of work and family, which could provide greater clarity to their work. Such research might be more useful to hospital administrator in making policies that would increase work and family balance of physicians. Greater work and family balance of physicians is linked with greater creativity, more energy and a better quality of service provided to patients as was

mentioned by Shrier, Shrier, Rich, and Greenberg (2006). One last concern is that the research is largely out of date. In the United States there have been only three empirical studies of dual physician couples in the new millennium. Considering the dramatic changes that families have experienced in recent years, it is evident that more research is required. Now that we have established the need for more research we will proceed with a discussion of the conceptual framework used in the proposed study.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

Social exchange theory seeks to provide us with a conceptual framework for understanding why individuals enter into relationships, stay in or leave relationships, and feel satisfied or unsatisfied with relationships (Chibucos & Leite, 2005). Social exchange theory was originally an economic theory that was later applied to family theory. Despite this change from economic theory to social theory it maintains a utilitarianism that is reminiscent of Adam Smith.

As was mentioned previously, the terms *costs* and *rewards* are important concepts in social exchange theory. From a social exchange perspective "[a] reward is anything that is perceived as beneficial to an actor's interests" (White & Klein, 2008, p. 70). This can include certain relationships, statuses, experiences, or opportunities that an individual finds gratifying and wishes to experience again (Smith et al., 2009). An example provided by Smith et al. is a college couple that is trying to decide if they should get married. Rewards in their relationship include, attraction, love, sex, kindness, and intelligence. Conversely, costs might be considered the opposite of rewards, sometimes consisting of negative things one endures in order to experience rewards (White & Klein, p. 70). Using the same example provided by Smith et al. of the college couples, examples of costs include, poor job prospects, feelings of inadequacy, possibly having to move, and having to discuss feelings.

Social exchange theory has four basic assumptions, each assumption builds on the former, outlined by Smith et al. (2009) and White and Klein (2008). The first basic assumption is that individuals are motivated by self-interest, which means that

individuals seek rewards and avoid costs. Thus individuals seek relationships that they perceive to be personally beneficial. The second assumption is that individuals often rely on past experience to make decisions even when confronted with a situation in which we do not know the outcome. Individuals cannot fully know the results of decisions they have never made, but they can guess based on logic and other past experiences. The third assumption is that humans are rational beings able to calculate the potential costs and rewards in a situation and make choices accordingly. If we understand the values, interests, and perspectives of an individual we may be able to explain their actions. Conversely, if we do not understand their values, interests, and perspectives it may be very difficult to explain their actions. The fourth assumption is that social relationships involve reciprocity. Individuals tend to stay in relationships that satisfy their needs, wants, and expectations, and in which they satisfy the needs, wants, and expectations of the other(s); both of which are important for the health and longevity of a given relationship.

Application to Dual Physician Couples

Given what has been described considering the literature, a systems diagnosis can be attempted at this time. In the past physician marriages typically involved male physicians marrying women who were less educated. In most cases, these male physicians expected unpaid family work to be attended to by their non-physician wives. Now with the advent of dual physician couples both are engaged in high power careers and thus their roles begin to shift. Female physicians often do not have the time, energy, and resources, to do the unpaid family work and keep up a demanding medical career.

Through the process of dating a marriage dual physician negotiate roles, consciously or otherwise to adhere to traditional gender roles or to embrace egalitarian gender roles. Partners will negotiate to maximize rewards and minimize costs and these choices will likely be influenced by age, maturity, and specialties of the physicians involved. A number of options can be negotiated to manage unpaid family work, including such things as hiring help, one or both partners reducing hours, and lowering standards of unpaid family work, etc. Each dual physician couples will make this negotiation at least once and probably more that once to adapt to work and family changes.

Critiques of Social Exchange Theory

Probably the most common criticism of social exchange theory has to do with the idea that humans tend to behave rationally (White & Klein, 2008). Critics of this theory believe that humans often behave emotionally rather than rationally and often are encouraged to behave in ways that are in favor of others, but counterproductive for themselves. For example, let us say that a relationship between Dr. and Dr. X (a dual physician couple) is presently peaceful until she chooses to bring up a controversial issue that starts an argument. She might be thought of as acting irrationally which would disprove the assumption that humans behave rationally (and certainly there is potential for him to see it that way). Supporters of social exchange theory have a different view, believing that individuals that behave in a way that appears to be counterproductive are acting rationally while using different motives or priorities. Using the same example, we may discover that she started the conflictual conversation in order to resolve this ongoing issue, thus allowing them to experience greater intimacy in their relationship. Also in this

example we see that there is potential for the couple to have differing values as she may value intimacy higher than peace and he may value peace higher than intimacy.

While some may question whether the general population is able to make decisions rationally, there may be less question as to whether physicians are able to make rational decisions. In fact, it could be argued that, of all the populations, physicians are among the most likely to act rationally; they are often accused of having a high IQ (intelligence quotient) and a low EQ (emotions quotient). If we assume that physician couples are rational actors then this begs the question of which factors are most prominent in the minds of physicians when they make decisions to marry and to stay married.

Another critique of social exchange theory is that it uses tautological reasons, meaning that it uses terms that are defined by each other and thus is difficult to scientifically disprove (Turner, 2002). This leads to circular thinking in which we define behavior as a function of reward and reward as a function of behavior (Smith et al., 2009). We can use the aforementioned example of Dr. and Dr. X to explain this issue, in that her behavior (starting a conflict) may be a function of the reward (intimacy). We cannot prove that the behavior of the woman was not a function of reward, because we define reward as a function of the behavior. This tautology would appear to be one of the main weaknesses of this theory (White & Klein, 2008). An argument could be made that the qualitative methodology that will be employed in the proposed study may be able to address this concern through closer examination of couples in the study.

Some may find social exchange theory to be cold, calculating, and based on thought rather than emotion. However, it is important to acknowledge that some of the

less measurable things like social approval, equality, attraction and love are weighed in relationships (Blau, 1964; Foa & Foa 1980; Nye, 1979). When considering the idea that individuals get into relationships for things such as love and equality, social exchange theory seems have an ability to capture more completely the human experience of being in a relationship.

Feminist Critique

A feminist critique is that social exchange theory has a masculine bias in that it focuses on a sense of self as "separate" rather than "connected." As such it is easier to explain the behavior of individuals with social exchange theory than it is to explain group behavior (Smith et al., 2009). Social exchange theorists reply that individuals support the families or groups when they perceive it to be in their best interest. When individuals are forced to make a decision between doing what they perceive to be in their best interests or what society demands, their choice tends to hinge on the importance they assign to the opinion of society. That is to say that if someone places great importance on their reputation they would be more likely to yield to societal pressures, whereas someone that places very little importance on their reputation might not. In either case, such individuals would still be doing what they perceive to be in their best interests. An alternative social exchange perspective might be that truly altruistic behaviors may be considered rewarding, because these behaviors allow one to define one's self as "good." Also, one may enjoy the joyful feeling of knowing that one did "a good deed" or "the right thing." Certainly, it can be argued that these are rewards to the individual.

As a side note, Hochschild and Machung (2003), known feminists, appears to make use of social exchange assumptions when they discuss how power dynamics impact who does the unpaid family work (p. 165, 166, 212, 260, 263). Specifically they describe some women as weighing the pros and cons of insisting that their husbands share unpaid family work considering the increased tension this may cause in the relationship and the subsequent increased likelihood of divorce. They hypothesize that these women often do the unpaid family work themselves, because they are afraid that if they get a divorce they will have increased difficulties with finances, difficulty finding another husband, and they will have to do all the unpaid family work anyway. They describe these women as deciding that it is in their best interests to simply stay quiet and do the unpaid family work with minimal help from their husbands. This is in no way to critique the work of Hochschild and Machung, but merely to point out the irony that such a cornerstone of feminist literature would include social exchange concepts.

One component of the feminist critique that is certainly valid is the fact that social exchange theory provides a framework that is better suited for understanding the individual decisions rather than group decisions, thus as the size of the group grows it becomes more complicated with this conceptual framework to understand the overall workings of the group (White & Klein, 2008). As such social exchange theory can provide us with a volume of information that may become cumbersome and awkward by comparison with other family theories with large samples. Fortunately, in the proposed study, we are interested in the marital dyad of dual physician couples, a group of two. Also, the use of qualitative methodology would appear to fit well with social exchange theory as the sample size will remain relatively small and the added information might

aid the researcher in achieving a main goals of grounded theory qualitative research, which is a deeper understanding of experiences of participants and theory creation.

CHAPTER FOUR

METHOD

The purpose of the proposed study is to examine the experience of dual physician couples as they negotiate multiple work and family roles. Two research questions will be examined in the proposed study in an attempt to fill the gap in research. The main focus of the study will be (1) how dual physician couples experience the rewards and the costs associated with their multiple roles. The other concern of this study will be (2) how dual physician couples establish healthy and workable adjustments in family living and work contexts.

As the reader will no doubt notice, the above research questions were influenced by social exchange theory. Charmaz (2006) suggests that theoretical frameworks (such as social exchange) are useful for getting research started and perhaps for evaluating research results, but may get in the way of analysis. Additionally, the reader will notice that social exchange theory has been instrumental in the formation of the interview questions (See Appendix B) as they are based on the first two social exchange assumptions mentioned in the previous chapter. The first assumption is that individuals in relationships seek rewards and avoid costs, thus questions will be asked to explore these rewards and costs. Another assumption is that humans seek out relationships that have reciprocity, so questions discuss what each individual contributes to the family and how satisfied each is with their relationship. Further, it should be noted that social exchange theory does not lend itself to any particular method of analysis or rigor. As such, social exchange theory will be used as a jumping off point for the research and will

be returned to in the answering of research questions, but will not be at the foreground of the following discussion of methodology.

Grounded Theory

Constructivist grounded theory qualitative methodology will be used to capture the experiences of dual physician couples as outlined by Charmaz (2006) though some input will also be taken from Corbin and Strauss' (2008) more positivist perspectives on grounded theory. In this approach efforts will be made to ensure that the findings of the study are "grounded" in the data, meaning that analysis will involve repeatedly consulting the data to ensure that finding represent the experiences of the participants.

Constructivist grounded theorists do not believe in an objective reality. Guba and Lincoln (2008) put this well when the state that "objectivity is a chimera: a mythological creature that never existed, save in the imaginations of those who believe that knowing can be separated from the knower" (p. 275). Instead constructivist grounded theorists believe in realities that are co-constructed by researcher and participant (Charmaz, 2006) taking a middle ground paradigm between positivist and postmodern approaches (Charmaz, 2000). As realities in the proposed study are considered to be co-constructed it is important now that the reader should know a little bit about the background and his assumptions of the researcher.

The researcher is an upper-middle class Caucasian male who has a bachelor's in social work, a master's in relationship and family therapy and is currently pursuing a PhD in family studies. He is also the son and grandson of physicians and is also related to individuals in with degrees such as PhD (Theology), DDS, LMFT, LCSW, and MBA.

As one might assume, the researcher comes from a family culture that values education and hard work for both men and women. The researcher's heritage espouses values of hard work and education, while his training and experience as a therapist encourages him to value equality and shared responsibilities within couples. The researcher's interest in the topics has to do with his exposure to the physician culture and a desire to better understanding and positively impact the quality of dual physician relationships.

Parent Study

The proposed study is part of a larger research project consisting of faculty and students from the school of Counseling and Family Sciences at Loma Linda University with the purpose of examining the experiences of physician families. The research group consisted of nine students and two faculty members that were largely middle class. Concerning ethnicity, one faculty member was Afro-Caribbean and the other was South American. Also three students and were Afro-Caribbean, one was African American, and five were Euro-American. Seven of the nine researchers had training and experience as therapists. The utilization of therapy skills in order to facilitate effective interview practices was discussed with emphasis put on the fact that these therapists were not to enter into therapeutic relationships with participants.

Topics explored within this group included studies of female physicians, minority physician, physicians as parents, spirituality in physicians, physician married to professionals, and of course dual physician couples. All nine doctoral students collaborated in the development of the interview guide (See Appendix A) and in initial coding. All students were enrolled in doctoral programs in the field of family science and

completed several research courses in both qualitative and quantitative methodology. In addition, members of the group were provided with further training order to sharpen the qualitative coding skills of each researcher.

Sampling

Participants were chosen starting with a convenience sample initially comprised of acquaintances of the interviewers. Participants were also recruited from Southern California hospitals using letters to introduce physicians to interviewees (See Appendix C). Subsequent participants were recruited through snowball sampling. Three inclusion criteria focus on finding participants that have and continue to have the experiences that the study wishes to measure. Thus inclusion criteria comprised of (1) physicians being at least one year out of residency, (2) married for at least two years, and (3) currently practicing medicine. It was thought that having experience being married and practicing medicine simultaneously might provide participants with the kinds of experiences needed in order to better answer interview questions.

Interviews

Qualitative interviews were conducted with physician couples either at their homes or place of business. Participants were asked to sign consent forms (see Appendix D) and fill out demographic data about themselves (see Appendix E) before the interviews began. Semi structured interviews guides were used, but researchers were encouraged to stray from the interview guide to ask clarifying questions.

Couples were interviewed together whenever possible. However, if only one physician was available this physician was considered a key informant and the interview commenced. Confidentiality was maintained through the use of pseudonym to disguise participant identities. Interviews will be taped-recorded and then transcribed, with the omission of any names or other identifying information. All interviews were semi-structured and lasted approximately 60- 90 minutes. Interview questions were created with the intent that they would allow physicians to comfortably discussing the aspects of their relationship.

Results of Previous Studies

As was mentioned previously, the proposed study is part of a parent study, thus the results of previous works in this project are of note. In a study of female physicians Starner (2010) found that female physicians tend towards traditional roles especially after they have children. Further, men represented in the study tended to avoid taking on an equal share of unpaid family work, despite the fact that their wives had heavy physician roles. Female physicians in the study reported great difficult when it came to balancing work and family demands mainly due to the stressors associated with patient care and intense work hours. Starner also found that female physicians could use coping skills such as reaching out to others, especially family for support, or "reaching in" to meditation or prayer for relaxation and rejuvenation.

In a similar study Clarke (2011) found that minority female physicians tended to experience heavy work demands associated with being a physician were exasperated by racism and sexism. Many individuals in her study reported that they had to prove

themselves to colleagues and patients before they were accepted as competent physicians. Further, participants reported struggling with both gender and ethnic expectations, the guilt of which compelled them to take on the majority of unpaid family work, despite the fact that they had a demanding careers. In an effort to accommodate competing demands, Clarke found that minority female physicians reduced work hours and in many cases chose specialties that were more conducive to being a wife and mother.

Fider (2011) found that physicians married to professionals were able to mediate work and family conflict by adopting non-traditional roles or seeking the help of family members or hired help. For many couples in the Fider study, these approaches made it possible for participants to focus on career goals without worrying as much about household chores and childcare. Additionally, Fider found that physician careers in her sample were favored over the non-physician professionals regardless of gender. Fider suggests that this may be due to the prestige physicians and possibly the added potential for income they tend to enjoy.

In a study on spirituality among physician couples Esmiol (2011) found that there was a link between spirituality and couples. Specifically, she found that those who tended towards traditional male-dominated relationships also tended to think of their relationship with God as based on duty, seemed to have less desire for emotional intimacy in their romantic relationships and exhibited unilateral communication styles. Conversely, those who reported a more egalitarian relationship style reported thinking of God and their romantic relationship in terms of closer emotional intimacy, described bidirectional communication styles and appear to have greater equality in their relationships. Esmiol suggested that it was surprising that these power differences

existed even among high power physician couples and suggested that therapists who serve this population should consider the link between spirituality and gender equality.

Current Study

What follows is a discussion of how data will be analyzed in a constructivist grounded theory approach for the proposed study. Charmaz (2006) points out that "the analysis results from the researcher's involvement at every point in the research process" (P. 148). It is important to mention that many of these processes occur simultaneously and that they are broken apart in the discussion that follows simply for the sake of description.

Sampling

Five dual physician couple interviews were completed by the group. Further sampling will be required for the present study so saturation will be obtained. Dual Physician couples will be asked the same questions that other physician couples have been asked (See Appendix A) as well as questions that the researcher has developed specific to dual physician couples (see Appendix B).

Theoretical sampling will be used in further sampling to more effectively seek out data that will be useful in developing concepts. According to Corbin and Strauss (2008) when using theoretical sampling the researcher is like a detective following leads wherever they may go. For example, in the proposed study, analysis will be done on initial interviews that may lead to the emergence of new concepts. Subsequently, interview questions may be altered in order to better capture information surrounding

these concepts. Previous participants may be contacted in order to confirm concepts and further sampling will also be used to confirm findings. Sampling will continue in this manner until saturation is complete, which is to say that no new concepts are emerging from new continued sampling (Corbin & Strauss, 2008). Granted the specific population in the proposed study will be difficult to find as dual physician couples that actually have free time together may not wish to spend it being interviewed. However, every attempt will be made to ensure saturation.

Dyadic Interviewing

Looking at the couple dyad as a unit of analysis, the argument could be made that hearing from both individuals would allow us to have a more complete picture of the relationship. If we assume that it is ideal to speak to both individuals in order to better understand a couple, then we must consider how best to obtain this information. Eisikovits and Koren (2010) suggest that this can be achieved through a number of approaches including joint interviews with the couple and separate interviews with each member of the couple. As is often the case with research methods, there are advantages and disadvantages of each approach. For example, joint interviews provide the opportunity to capture couple interaction, such as filling in details of their narrative or even disagreement on details, which can be used as data (Allan, 1980). However, joint interviews might also lead couples to edit their responses in order to avoid conflict or could result in one person dominating the discussion throughout the interview (Arksey, 1996). By contrast, conducting separate interviews with each member of the couple would not contain couple interaction, but would arguably contain the most genuine

responses from the participants, thereby increasing trustworthiness (Eisikovits and Koren, 2010). For the purpose of increasing trustworthiness in the proposed study, efforts will be made to conduct separate interviews with both individuals in each couple.

Coding

The following discussion of coding is taken from Charmaz (2006) and explores how line by line coding, focused coding, and theoretical coding will be used in the analysis to produce theory that is grounded within the data. It is important to note that this is not a linear process in that the researcher will often go back to previous methods of coding either to consult or to discover fresh codes. Throughout the coding process, social exchange assumptions will be reduced to a consciousness that "there must be some things that attracted dual physician couples to each other and that still to keep them together." It is hoped that this will reduce the likelihood that preconceived categories related to social exchange theory, such as *costs* and *rewards*, will be used.

Line by Line Coding

The first step in coding used in the proposed study will be line by line coding which is one form of initial coding suggested by Charmaz (2006). Line by line coding has to do with recording terms that capture the meaning that emerges from a segment of an interview. Codes are intended to be provisional and firmly grounded in the data. Codes should consist of the action and meaning of the participants. Line by line coding has to do with providing a code to describe each line in a given transcript using action

words often ending in “ing.”. This will make it easier for the researcher to avoid using preconceived ideas and leaves the researcher open to explore nuance.

Focused Coding

Focused coding will be the next major step in analysis, wherein the researcher will use codes taken from line by line coding and focus on those that appeared most frequently or that appeared to be the most significant. This means the researcher will have to make decisions about which codes seem to capture the experiences of the participants in a way that is both complete and accurate. Again, Charmaz (2006) suggests that the researcher must stay close to the data, so as not to prove preconceived ideas.

Theoretical Coding

Theoretical coding will consist of finding possible connections between categories that have emerged from the data in focused coding. In essence the researcher will use theoretical coding to clarify how categories relate to each other and what kind of analytic story these categories tell. Charmaz (2006) offers the example that a pattern may emerge through coding of the data in which the researcher can predict under what conditions certain phenomena occur and when they tend not to occur. Obviously, the quality of the theoretical codes that emerge will be the direct result of the quality of previous coding and of the data itself. While it is possible for these findings to appear objective, it is important for the reader to understand that at this point in the analysis the

voice of the researcher will have joined with that of the participants to co-construct a reality that is grounded in the data.

Memo writing

Memo writing will be used as informal and spontaneous notes concerning concepts and connections between concepts provided by line by line coding and focused coding. It will also be used to record thoughts and intuition of the researcher directly after conducting each interview. Charmaz (2006) points out that memo writing can be particularly useful in grounded theory because it encourages the researcher to begin analysis early in the process thus allowing the researcher to explore new themes in ongoing interviews. Also, memos provide an opportunity to for the researcher to raise awareness to any preconceived ideas that may influence coding. Corbin and Strauss (2008) also point out that many of these ideas would be lost if they were not recorded reducing the ability of the researcher to find meaningful results. Thus memos continue to be useful throughout the entire research process from interviews to rough draft of a paper.

Methodological Rigor

The concept of methodological rigor applied to qualitative research is complicated to say the least. Whereas quantitative researchers often use standards of rigor such as reliability, validity, and generalizability, qualitative researchers must use standards of rigor that best fit the specific characteristics of the study (Corbin & Strauss, 2008: Flick, 2006). For the purposes of the proposed study methodological rigor will be described in terms of credibility, reflexivity, and transferability.

Credibility

As was mentioned previously, constructivist grounded theory takes a middle ground paradigm between positivist and postmodern approaches (Charmaz, 2000). Positivist concepts such as validity and reliability often do not do not fit with non-positivist research. Credibility is one possible substitute concept in research that has a non-positivist paradigm (Flick, 2006) and is often referenced by Charmaz (2006). Credibility has to do with how well the researcher captures the experience of participants within the results of the study (Charmaz, 2006). In order that the reader can believe that the proposed study is credible, efforts will be made to demonstrate that the data are adequate and that findings are grounded in the data. The researcher will accomplish this by exploring how methods of data gathering and data analysis have been used to co-construct study results. In essence, the researcher has been discussing credibility when describing sampling and data analysis. Furthermore, the reader will be informed that the construction of the data provided in the results is just one plausible interpretation of the data, as outline by Corbin and Strauss (2008). To further add to the credibility of the study the findings will be presented in such a way that the reader is able to follow the logic of the study and decide for themselves if the findings are believable. One last method of ensuring credibility of the proposed study will be to use reflexivity.

Reflexivity

Reflexivity has to do with the researcher's critical reflection on the fact that the researcher is the instrument of analysis. "It is a conscious experiencing of the self as both inquirer and respondent, and teacher and learner, as the one coming to know the self

within the process of research itself" (Guba & Lincoln, 2008, p. 278). The researcher will follow the recommendation of Charmaz (2006) by examining decisions and assumptions made about the research and making these known to the reader. In this way the reader will be able to understand to what extend the results were influenced by the researcher. In the process of creating reflexivity the reader can decide for themselves whether to trust the findings. A further benefit of reflexivity is that the researcher also has an opportunity to examine input into the study and make adjustments to improve the quality of the study. Reflexivity will be used throughout the research process, but most notably through the use of memo writing.

Transferability

One form of generalizability often used in the qualitative world is called transferability (Lincoln & Guba, 1985). Transferability is a collaborative process involving both the researcher and the reader, in which they must decide to what extent the findings of a study can be applied to individuals outside the study (Polit & Beck, 2010). Given this collaboration between researcher and reader, it is important to remind the reader that the proposed study will demonstrate one plausible reality that will emerge from the data and that will be co-constructed by both the participants and the researcher. The reader must bear in mind that the researcher is hesitant to conclude that his findings are transferable even to dual physician couples in general. It is incumbent upon the reader to determine how transferable research findings are to a given population.

Results

One of the most wonderful things about qualitative research is that one can never fully know what kind of results one might get. It's not like quantitative research in which the research either proves the hypotheses or fails to prove it wrong. Qualitative analysis can go in any direction leaving it free to follow the lead of the data. However, some conjecture can be made as to the possible results of this study.

For example, in answering the research questions, findings may be similar to the qualitative study of dual career couples Bird and Schnurman-Crook, (2005) an examination of costs and rewards within these couples. However, the current study will go beyond that of Bird and Schnurman-Crook in that greater exploration of concepts will occur as well as theories about connections between concepts. The literature also points to possible generational differences (Blair-Loy, 2001) that may be important to note as new patterns may be found among younger couples that have yet to be noted in the literature. Several works have speculated that physician specialties may have influencing factors in relationships (Dyrbye, Shanafelt, Blach, Satele, & Freischlag, 2010; Schrager, Kolan & Dottl, 2007; Smith, Boulger, & Beattie, 2002; Yandoli,1989) but it would be difficult to speculate as to these results at this point. Most exciting of all is the possibility that this constructivist grounded theory qualitative study has the potential to create theories of the dual physician experience that may have a positive impact on the both the literature and individual relationships.

Limitations

As with all studies, the proposed study will have its limitations. One such

limitation has to do with the combination of constructionist grounded theory and social exchange theory. Grounded theory does not typically make use of preconceived categories such as *costs* and *rewards*; rather grounded theory typically uses categories that emerge from the data. However, at this point it is important to mention that Charmaz (2006) never meant for grounded theory to be used as a set of rigid rules, rather it is intended to be modified to fit the needs of each individual study. In the current study it is argued that the structure provided by social exchange theory will mainly be used in the formation of research and interview questions. As such it will be as likely to bias the results of the study.

Furthermore, steps can be taken that will address this potential limitation. For example, during the coding process, social exchange assumptions will be reduced to a consciousness that "there must be some things that attracted dual physician couples to each other and that still to keep them together." This will be useful in that it does not imply any specific categories and leaves the researcher open to codes, categories, and theories that emerge from the data. The advantage of approaching data analysis from this consciousness is that it does not hinder the emergence of completely unrelated categories that from the data, but at the same time provides some focus on issues that surround the quality of their relationship. In essence the researcher would like to give some attention to this topic as it can be answered by theory that emerges from the data, while ensuring that further themes are discussed. This discussion will no doubt be the subject of many a memo as the researcher reflexively explores anything that impacts findings. Further, the reader will be aware of the researcher's failure in this regard if the results of the proposed study *only* reflect and *completely* support social exchange theory.

Some may consider the sample size of this study to be a limitation as positivist researchers are used to having much larger samples on which they can make generalizations. However, qualitative researchers needn't be apologetic about having small sample sizes, because their data often include hundreds of pages of raw data comprised of interview transcriptions and memos (Sandelowski, 2001). Also, grounded theory employs theoretical sampling in which the researcher continues sampling until saturation is reach. Therefore, sampling beyond saturation would be utterly useless as no new data would be found. Furthermore, grounded theory is not concerned with generalizability, but focuses on quality exploration and theory creation regarding its sample.

Some might even argue that the use of qualitative methodology is a limitation of this study. However, the researcher believes that the attention to detail provided by qualitative analysis can produce much more meaningful results than could quantitative analysis. Furthermore, the current study provides an opportunity to answer the call for qualitative research on dual physician couples. Lastly, the use of qualitative method fits well with the research questions and can be used to create theory that connects concepts and categories that would not originate from quantitative analysis.

Implications

There are a number of implications for the proposed study, in areas such as theory, research, and practice. As the first dual physician study to employ family theory this study will expand the horizon of both family theory and dual physician literature. As we have previously discussed, physician family literature has largely ignored family

theory, which doubtless has robbed this literature of potential richness and sophistication. Also, family theory may benefit from the proposed study as its usage in this study may provide new insights into social exchange concepts and assumptions. Lastly, the use of grounded theory will ensure that a new theory will be discovered that explains and clarifies ways in which dual physician couples can achieve a healthier balance between work and family demands.

Additionally, research will benefit as gaps in the literature mentioned by previous authors will be addressed in the proposed study. Qualitative methodology will be used to ensure that light will be shed on previously unanswered questions, specifically regarding the balance of work and family demands. Family theory will be added to the physician family literature as well as work and family concepts, both of which have been missing in the physician literature. Also, it is expected that the use of qualitative methodology will aid in the discovery of questions that are outside the scope of the present study. These gaps in knowledge will be highlighted so that future studies may be conducted for the sake of increasing our understanding of the dual physician experience.

With the dual physician population growing at the rate of female physicians the potential information found within this study could be put into practice to impact tens of thousands of physician households. Family life educators and their clients may experience benefits from a deeper understanding of the dual physician and how they can balance work and family demands. Mental health professionals may be able to operationalize the results of this study so as to have a stronger impact on their clients. Policy makers such as hospital administrators might make more family friendly decisions

as a result of the finding in the proposed study that could result in increased physician productivity.

Conclusion

The increase in the number of female physicians from the 1960's to the present has dramatically impacted the medical field. Women have thrived despite patriarchal values inherent to medical practice and have proven that they make competent physicians. Dual physical families with their increased egalitarianism have kept pace with the rise of female physicians, again changing the face of medicine. As with many topics, a closer look at dual physician families leaves us with more questions than answers. Accordingly this vast and unexplored topic provides us with many opportunities for future research into this increasingly common type of physician relationship.

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CHAPTER FIVE

DUAL PHYSICIAN COUPLES: AN EXPLORATION OF FAMILY STRESSORS AND COPING

Abstract

Physician families have experienced significant changes in the last half century as the rise of female physicians has resulted in an increase in the number of dual physician couples. The present research is a qualitative study of dual physician couples (N = 32). A social exchange framework is used to conceptualize the costs and rewards that dual physician couples experience with regards to work and family domains. A constructivist grounded theory was used as a theory of methodology so that findings were grounded in the data.

Results of this study showed that couples tended to struggle for what was important regarding the competing demands they faced yet, felt that their relationships were favorable when compared with their peers. Also it was found that couples tended to provide each other with empathy and that this resulted in their giving each other license to work as physicians with a less negative impact to the relationship. Theoretical analysis revealed that couples tended to experience confusing exchanges in which physician characteristics made it challenging to assess the costs and rewards of their relationship.

This study has implications for theory and research as it incorporates family theory and analysis into the literature on dual physician families. Further, it incorporates qualitative research, which was suggested as necessary in previous studies. Lastly, it has implications for policy affecting physician work life environment and best practice intervention with these families.

Introduction

The face of the modern physician family has changed considerably over the last half century, most notably with the arrival of large quantities of female physicians (Relman, 1980) and the resulting increase in the numbers of physicians that marry physicians (Fletcher and Fletcher, 1993). These couples are sometimes referred to as two physician couples or physician-physician couples, but are more frequently called dual physician couples in the literature (Schrager, Kolan, and Dottl, 2007; Smith, Boulger, & Beattie, 2002). As the female physician population increases, the population of dual physician couples will continue to increase in number for the foreseeable future. In recent years, the dual physician trend has become so popular that approximately upward of 50% of female physicians marry other physicians (Fletcher & Fletcher, 1993; Myers, 1984; Sobecks et al., 1999).

Despite the growing dual physician trend, the current empirical literature regarding dual physician couples in the United States remains sparse (Sotile & Sotile, 2004) though there is a preponderance of anecdotal sources. It should be noted that there are some European articles that were not utilized as European physicians are thought to have different experiences than their United States contemporaries in areas such as educational requirements, salary, financial security, malpractice insurance, work requirements and the impact of socialized medicine (Yandoli, 1989). Further, much of the empirical dual physician research was published more than a decade ago (Cherpas, 1985; Fletcher & Fletcher, 1993; Tesch, Osborne, Simpson, Murray, & Spiro, 1992) and, as such, the need for further empirical examination is evident.

The present study answers the call of previous research for a qualitative analysis of dual physician couples (Schrager, Kolan, and Dottl, 2007; Sobecks et al., 1999). More specifically, Sobecks et al. called for qualitative research on dual physician couples that "would illuminate the tensions and tradeoffs between choices and constraints" experienced by dual physician couples (p. 318). As such, social exchange theory will be used to explore costs and rewards that are experienced by dual physician couples.

Social Exchange Theory

Social exchange theory was used as the major theoretical framework for this study. This framework was used as a lens through which the researcher as well as the reader can understand why individuals enter into relationships, stay in or leave relationships, and feel satisfied or unsatisfied with relationships (Chibucos & Leite, 2005). This theory has two main concepts, rewards and costs, the understanding of which will greatly aid the reader at this point. White and Klein (2008) explain that in a relationship "[a] reward is anything that is perceived as beneficial to an actor's interests" (p. 70). This can include certain statuses, experiences, opportunities, or emotional connections that an individual finds gratifying and wishes to experience again (Smith, Hamon, Ingoldsby, & Miller, 2009). Conversely, costs might be considered the opposite of rewards, sometimes consisting of negative things one endures in order to experience rewards (White & Klein, 2008, p. 70), or negative aspects of the potential partner such as concerns about the health, finances, or emotional connection with the potential partner. For example, a physician might weigh the costs and rewards of being in a dual physician relationship versus being in a relationship with a non-physician. The expected rewards of

being in a dual physician couple might be increased finances and professional camaraderie, while the costs might be decreased time for family interaction. Simply put, social exchange theory hypothesizes that couples attempt to maximize rewards and minimize costs in their relationships with the hope of improving the overall satisfaction within their relationship.

It should be noted also that social exchange theory proports that individuals tend to feel more satisfied with their relationships if they feel others have more rewards than others or are able to avoid certain costs experienced by others (White and Klein, 2008). Some may find social exchange theory to be cold, calculating, and based on thought rather than emotion. Nevertheless, it should be noted that social exchange theory does have the ability to examine some of the emotional aspects of being in a relationship that are more difficult to quantify, such as social approval, equality, attraction and love (Blau, 1964; Foa & Foa 1980; Nye, 1979).

Review of Literature

It is often the custom for researchers to provide statistics concerning their topics of interest, yet an extensive search through multiple databases (Academic Search Premier, Ebsco, SocINDEX, PsycARTICLES, PubMed) and websites (American Medical Association and the US Census Bureau) did not produce statistics concerning the number of dual physician couples in the United states. Nor did such a search provide information regarding the divorce rate of dual physician couples, yet again underscoring the need for more research on this topic. The most recent statistics regarding the divorce rate of physician couples was produced by Rollman, Mead, Wang, and Klag, (1997).

They found that there was a 29% incidence of divorce among their sample. As the divorce rate among dual physician couples has yet to be measured, it is impossible at this point to state how they compare with the larger population of physician couples.

It has been suggested that the dual physician literature is biased towards negative findings (Lewis, Barnhart, Nace, Carson, & Howard, 1993) and that similar negative research patterns have been noted in the dual career literature as well (Barnett & Hyde, 2001; Perrone & Worthington, 2001). This negative focus not only biases the research, but also could discourage women from seeking out careers and egalitarian gender roles (Perrone & Worthington, 2001). It should be noted that dual physician couples are one type of dual career couple that is none the less distinctive from other types of dual career couples in its ethical obligations to altruistically put needs of the patients before their own (Swick, 2000).

Certainly there are potential costs associated with being in dual physician relationships that should be highlighted such as limited time (Yandoli, 1989) and competition between spouses (Sotile & Sotile, 2000). There are also potential rewards that should not be ignored, including spousal empathy (Smith, Boulger, & Beattie, 2002; Sobecks et al., 1999) increased financial security (Sobecks et al., 1999) and increased potential for equality (Sobecks et al., 1999). It should also be noted that some of the above costs and rewards might be experienced differently based on choice of specialty (Dyrbye, Shanafelt, Blach, Satele, & Freischlag, 2010; Schrager, Kolan & Dottl, 2007).

In addition, further examination of dual physician couples would be of interest to those who favor gender equality in relationships given the equal levels of education and earning potential that these couples have. Traditionally, men follow what is known as the

marriage gradient by marrying women that have lower education levels and earning potential (Bernard, 1982). This places men in the role of provider (Friedman & Greenhaus, 2000) and women, perhaps by default, to perform unpaid family work such as cooking, cleaning, and childcare (Jacobs & Gerson, 2001). It is of note that dual physician couples appear to ignore this societal pattern in favor of relationships with individuals that have roughly equal education and earning potential. This could be a possible reason why studies have shown that dual physician couples have greater potential for equality than other physician families (Sobecks et al., 1999).

Shrier, Shrier, Rich, and Greenberg (2006) suggest that there are great rewards in having physicians that have a more balanced life, such as greater creativity, more energy and a better quality of service provided to patients. All of these attributes could improve the quality of medical care received by the patients of dual physician couples. As such, the findings of this study may be of interest to dual physician couples as well as hospital administrators.

Method

The purpose of this present study was to examine the experience of dual physician couples as they negotiate multiple work and family roles. Two research questions were examined in this study in an attempt to fill the gap in research; (1) how do dual physician couples experience the rewards and the costs associated with their multiple roles and (2) how do dual physician couples establish healthy and workable adjustments in family living and work contexts. Qualitative methodology was used to explore these research

questions, so as to provide more in-depth answers that represent the lived experiences of the participants.

Grounded Theory

This present study used a constructivist grounded theory approach as the methodology of choice. Constructivist grounded theory is a theory of methodology that is used in qualitative research to ensure that the findings of the study are "grounded" in the data (Charmaz, 2006). To this end, efforts are made to ensure that the researcher stays close to the data, so that findings of this study represent the experiences of participants. For the purposes of this study, an objective reality was not assumed, rather, it was assumed that realities that are co-constructed by researcher and participant (Charmaz, 2006). Concordantly, one must know something of the researcher to understand how his views may have influenced the present findings.

The researcher is an upper-middle class Caucasian male who has a master of science degree in marriage and family therapy and is currently pursuing a doctor of philosophy degree in family studies. He is also the son and grandson of physicians and comes from a family background that values hard work and education. His training and experience as a therapist supports the value of equality and shared responsibilities within couples. The researcher's interest in the topic has to do with his exposure to the physician culture and a desire to better understanding and positively impact the quality of dual physician relationships.

Background and Procedure

The current study was part of a larger research project of sixty-six physician interviews with both individuals and couples. The group consisting of two faculty and nine students from the school of Counseling and Family Sciences at Loma Linda University with the purpose of examining the experiences of physician families. Topics explored within this group included studies of female physicians, minority physician, physicians as parents, spirituality in physicians, physician married to professionals, and of course dual physician couples. All nine doctoral students collaborated in the development of the interview guide and in initial coding. All students were enrolled in graduate programs in the field of family science and completed several research courses in both qualitative and quantitative methodology. In addition, members of the group were provided with further training order to sharpen the qualitative coding skills of each researcher.

Sampling

Participants for the study were recruited from Southern California hospitals using letters to introduce physicians to interviewees and a convenience sample followed by snowball sampling. Inclusion criteria were that participants be (1) at least one year out of residency, (2) married for at least two years, and (3) currently practicing medicine. It was thought that having experience being married and practicing medicine simultaneously might provide participants with the kinds of experiences needed in order to better answer interview questions. Qualitative interviews were conducted with physicians either at their homes or places of business. Semi structured interviews were used, allowing

researchers to stray from the interview guide in order to clarifying questions or pursue new paths of inquiry. All interviews were approximately 60- 90 minutes and covered such topics as family background, marital relationship, spirituality, stress, female physicians, and parenting for those that had children. For those participants that were dual physician couples, specific questions were asked regarding costs and rewards of being in dual physician relationships as well as how they tend to seek balance between work and family demands (See Appendix B).

For the present study, the sample consisted of twenty-four dual physician interviews, with either individuals or couples. To clarify, eight interviews were completed with couples (n=16) and sixteen were conducted with individuals (n=16) for a total of thirty-two participants (N = 32). Among the individual interviews, ten were performed dyadically (n = 10), such that five male physicians (n = 5) were interviewed separately followed by separate interviews with their five female counterparts (n = 5). There were also six interviews (n = 6) in which participants were interviewed individually, but their spouses were unable or unwilling to participate in the study. For the purpose of this paper these six individual interviews will be termed non-dyadic interviews.

Participants

Concerning sample demographics, fifty-six percent were females (n = 18) and forty-four percent were males (n = 14). Participants came from diverse backgrounds with nine percent reporting that they were African American (n = 3), twenty-two percent Asian (n = 7), forty-four percent Caucasian (n = 14), twenty-two percent Hispanic (n =

7), and three percent Middle Eastern (n = 1). The age range of participants was between 28 to 75 years of age with a mean age of 45. The sample consisted of seventy-five percent Protestant Christian individuals (n=24) with the remainder being a mix of various other faiths. Ninety-four percent of the participants stated that they had children with fifty-nine percent having two or more children.

Analysis

Throughout the process of analysis, the researcher consulted with students and faculty from the parent study as well as study participants in order to improve accuracy of the findings. Theoretical sampling was used in order to seek out data that was useful in developing concepts as outlined by Corbin and Strauss (2008) and Charmaz (2006). Sampling continued in this manner until saturation was complete, meaning that no new concepts emerged from new sampling (Corbin & Strauss).

Before beginning analysis the researcher double checked all transcripts to make sure that they accurately represented the recordings. Methods of coding included readings all 1100 pages of the transcripts at least four times and using line by line coding, focused coding, and theoretical coding, as outlined by Charmaz, in order to produce theory (in this case called "confusing exchanges") that is grounded within the data. In line by line coding forty-eight terms were recorded that capture the meaning that emerged from a segment of an interview. Analysis continued with focused coding wherein the researcher used codes taken from line by line coding and focused on those that appeared most frequently or that appeared to be the most significant to create four categories. Lastly, theoretical coding was used to discover connections between categories that have

emerged from the data in focused coding. In essence the researcher used theoretical coding to clarify how categories relate to each other and what kind of analytic story these categories tell.

These efforts mentioned above were made to ensure that coding was kept close to the data throughout analysis as suggested by Charmaz, so that the results accurately reflected the voices of the participants. Memo writing will be used as informal and spontaneous notes concerning concepts and connections between concepts provided by line by line coding and focused coding.

Dyadic interviewing was used to solve the problem mentioned by Eisikovits and Koren (2010) that even though joint interviews with couples are valuable, as they tend to produce couple interaction, (Allan, 1980) they might also lead couples to edit their responses in front of their spouse (Arksey, 1996). By conducting separate interviews with each member of the couple the researcher was able to obtain potentially more genuine responses from the participants, thereby increasing trustworthiness of their responses (Eisikovits & Koren, 2010).

In order to analyze these dyadic data, interviews with couples were read in the same sitting and their answers were compared with special attention paid to discrepancies. Analysis revealed that the responses of participants were very similar within couples, suggesting that respondents shared the same story, though female participants usually provided more detail. It is also of note that the only distinguishable differences that were found between those that were interviewed dyadically and those that were interviewed as a couple was that couples tended to provide less complete answers concerning sexuality. However, it should be mentioned that the same pattern

was found between couple interviews and non-dyadic interviews suggesting that participants were simply less comfortable discussing sexuality in interviews if their spouse was present.

Credibility

Credibility is one possible substitute for concept such as validity and reliability in research that has a non-positivist paradigm such as constructivist grounded theory (Flick, 2006) and is often referenced by Charmaz (2006). In the present study efforts have been made to demonstrate that the data are adequate and that findings were grounded in the data, so that the credibility of the study can be established. For example, theoretical sampling was used to obtain an ethnically diverse sample and continued until no new findings emerged, meaning that saturation was complete (Corbin & Strauss, 2008). Also transcripts were made from interview recordings and were double checked by the researcher for accuracy. Dyadic interviewing was used to ensure that participants were able to accurately describe their lived experience without fear that their spouse would be upset (Eisikovits & Koren, 2010). Next, multiple readings of the transcripts using line by line coding, focused coding, and theoretical coding were used to ensure that the results were firmly grounded in the data, so as to reflect the lived experience of participants (Charmaz, 2006). Further, the researcher made liberal use of reflexivity, in which the researcher critically reflected on the fact that the researcher was the instrument of analysis and that results were firmly backed up by the data and not just the researcher's perspective as outlined by Charmaz.

One form of generalizability often used in the qualitative research world is called transferability (Lincoln & Guba, 1985). Transferability is a collaborative process involving both the researcher and the reader, in which they must decide to what extent the findings of a study can be applied to individuals outside the study (Polit & Beck, 2010). Given the fact that the findings are co-constructed by the researcher and participants as well as the fact that this is a qualitative study with a relatively small sample size, the researcher would encourage the reader to use caution when deciding the extent to which findings are transferable to other groups, as suggested by Polit and Beck. Confidentiality is maintained in the results that follow through the use of pseudonyms as well as leaving out potentially identifiable information such as physician specialties so that participants can maintain anonymity.

Results

Using constructivist grounded theory four major themes emerged from the data: struggle for what's important, empathy, giving license to work, and how do we compare. Also a grounded theory, called confusing exchanged, emerged from the data. These results will be discussed herein.

Struggle for What's Important

The struggle for what's important has to do with the dual physician couple's effort to juggle the competing demands of children, spouse, and work so that they can reach the most optimal balance that is possible for them.

> Alice: You can't be wonder woman. That's what we learned in the 70's, 'cause in the 70's women thought we could have it all. But in now-a-days in the 21st century, you can't have it all because something's going to have to give. It may be your kids…It may be your marriage. It may be your profession but you have to decide how much of each you want… That's the way I see it as you cannot be a 100% career, academic person and expect to have all your kids turn out wonderful, if you even have them… Or even stay married to the same guy.
> Interviewer: So you can't have it all…or maybe you can have it all, but not all of it (laughing).
> Alice: …not all of it. You can only have 75% of each of those things…

Alice exemplifies the struggle for what's important that is echoed by most participants in this study.

As the following couple demonstrates, part of the struggle is in deciding how to allocate the limited resources of time and energy.

> Ashley: …my thought would be we're both in um, a profession that is very taxing and demanding and requires not just time, like going to work and putting in the time but the emotional investment in it. And so, I think a cost would be the we're both in that and so coming home sometimes it is exhausting or just it's harder to lean on each other on days we both work because we are both very exhausted from it and so that's real demanding.
> Steven: Yeah but in a similar vein, it's a service profession so we're hearing peoples' um, stories and concerns all day and you know and I just have to save a bit of energy in myself for hearing more stories when I get home… I can't just give it all to the patients 'cause that's not fair for the family… I think we both… put an effort to not let work just overrun our lives because there can be a tendency to do that, you know. People always want more at the hospital, patients want more of us…

The struggle to allocate these limited resources of time and energy toward work, children and spousal relationship were echoed by a majority of the participants. One further element that must be discussed before we can explore this topic any further is the generational shift in priorities.

Generational Shift

As Adam points out, a generational shift has occurred in which physician couples have tended to move the costs away from their children.

> Adam: As a generational thing people are much more attuned to time off, what is going to be my time off rather than how much money am I going to make… Now both men and women are saying I want my free time, I want to spend time with my family and my spouse and if you want to pay me less that's fine but I want protected time off.

Several participants made similar observations that modern physicians seem to give higher priority to their family time than did previous generations. Given this focus on children, the next few pages will be devoted to exploring costs to the relationship and costs to their careers experienced by participants as well as how they minimized those costs.

Costs to the Relationship

Despite the fact that Adam mentions time with his spouse as a priority in the above quote, in the below quote, he and his wife mention that "(m)uch of what we do revolves around our kids. It's kind of fun doing that, going to their games, watching what they do." Crystal responded by saying "(w)hen we do have time we say wow isn't this wonderful too bad we don't have more of this kind of time. It doesn't happen that often." It should be noted that respondents often spoke of spending time with their family they usually clarified that it was time spent with their spouse and their children together. For example, Kimberly, who was interviewed (dyadically) two weeks after Rob, pointed out that "…one of the things (Rob) said to me after this interview with you he said 'I realize

we don't spend time together.'" Only through the process of answering questions for this study did Rob appear to realize how little alone time they had alone together. Kimberly later reported that they have done a better job of spending time alone together since the interview with her husband.

Physical Intimacy

Given that couples often stated they had little time together, it is not surprising that physical intimacy was often compromised. For example, Doug said "So, intimacy? Sometimes I think that suffers because we're so tired." Devin explained that in recent memory "there has never really been a time where we both have, it was optimal for both of us." It follows that, limited time and energy, as well as the sometimes odd hours, tends to impact the physical relationship of dual physician couples. While many dual career couples with children might state similar concerns it is perhaps the emotionally and physically tiring work that physicians tend to do that appears to make these issues worse for dual physician couples.

It should be mentioned that there were a few participants that found a way around this cost. For example, in a dyadic interview, David talked about it this way:

> David: I see that there is something about a woman who is being taken care of by her husband as in "let's go out on the weekend" or "let's go out", there is a happiness and satisfaction that you can kind of tell and you can see how they communicate. That was very important to me. Time wise I have to respect the fact that she is exhausted… I wish that you can always have your wife there and ready to go anytime but you know life gets in the way. That is not reality.

In a subsequent dyadic interview, his wife Audrey was more direct in discussing her physical relationship with her husband, stating that:

> Audrey: I am very satisfied with that. He is very good at knowing when we need to get away… So at least every month and a half or so, he'll say, you know what, let's go to (name of city) for the weekend… We leave the kids and we will go. And so that is very common for us to just get away. So that is his way of telling me that he is not getting the intimacy that he wants… he will say, we're going to (name of different city) for the weekend, call your mother.

Only a few participants stated that they made this kind of time for physical and emotional intimacy, sometimes using conferences as an excuse to get away from their work and children. As Audrey mentions, grandmother's also appeared to be particularly useful in watching the children while the parents were away, as most babysitters might not be as available or reliable for an entire weekend.

Looking at the dyadic analysis, it is of note in this couple that David simply stated the ideal of going away for the weekend and discussed the fact that she was often too tired for intimacy, but did not directly answer the question regarding physical intimacy. By contrast, Audrey answered that they were in fact able to make time for physical intimacy and added how they were able to arrange this on weekend trips. In this way females in dyadic interviews seemed to confirm and then add detail regarding the couple relationship. Speaking of the data as a whole, this was one of the only situations in which there was a divergence in the data such that some went against the dominant pattern. As has been stated earlier, the costs of being in a dual physician couple are not only to the relationship, but also to work.

Costs to Career

Dual physician couples in this study tended to favor spending time with their kids over career advancement. Don points out that:

> 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 finding ways so we can be with them and provide them the best…

Many participants expressed this desire to provide their children with the best. Kimberly stated that "as much as I love being a physician I knew that I loved being a mother more. (I've) got all of menopause to become a Doctor." At the time of saying this Kimberly was working part time and stated that she intended to keep it that way until her son could drive. Given the nature of these costs it seems only natural that dual physician couples would find some way to minimize them.

Minimizing Costs

Some methods of minimizing costs have been mentioned in previous research or even in the preceding pages of this study, yet warrant a brief discussion at this point as it is an integral part of the struggle for what's important. For example, we have just discussed that participants reported reducing work hours was a technique used by participants in order to spend more time with their family. Many participants also mentioned that they hired help in order to reduce the amount of unpaid family work, which allowed them to have more time and energy for their family as well. Also, it should also be noted that a few couples did appear to make room in their busy schedules for quality time with their spouse. Probably the most interesting method of minimizing costs used by participants was to establish non-traditional roles to complete household tasks.

Non-Traditional Gender Roles

Even with paid help participants reported that there were often day to day things that needed to be done by the couple. Participants reported these tasks were completed using non-traditional gender roles. For example, Heidi reported that it was:

> Heidi: Just divide and conquer… pretty much we have no, gender rules here you know it's just whoever is here and can do whatever it is they do they do it. Umm actually he is a better cook than I am; he is probably more fastidious of keeping the house clean than I am.

In a dyadic interview, Rob referred to his new born son, stating that: "I took care of him for the first six months while she was working…" In a dyadic interview his wife, Kimberly confirmed what he said adding that:

> …we had a reversal so he was home most of the time and umm I would pump and he would give the milk… and it was cute cause he would make dinner and he would have the house clean quote, unquote"

Later she added that Rob had this time available only because he didn't get placed at the fellowship he wanted, but also stated that "to this day he is very fond of that time."

As the previous dyadic analysis shows, females participants tended to have the same story as their husbands, but they sometimes provided a little extra detail. It is also of note that non-traditional gender roles seemed to arise out of practicality rather than gender ideology. Participants often stated they started out with very traditional roles, but changed those roles, because it was simply impractical to wait for a person of a specific gender to complete a specific task.

In essence, participants stated that they had equality, because whoever was home did whatever needed to be done. Yet a closer examination of the data showed that

females were more likely to work part time, which may have been the result of cultural expectations for females. As we saw from a previous quote, Kimberly did go part time to be more available for the children. As a result of this, female participants spent more time at home and performed more of the unpaid family work. Thus it is difficult to call this equality, but perhaps it could be called a step towards equality, because they tended to share certain roles when at home. It is also of note that the combination of having hired help and working part time seemed to provide female participants with time for yoga classes or other forms of exercise and relaxation to reduce stress. As was mentioned earlier, the struggle for what's not only includes costs and ways to minimize them, but also rewards.

Rewards

Participants reported a number of rewards of being a dual physician couple. Again some of these finding have been discussed in previous research, but warrant a brief mention at this juncture. The most obvious one is that they both were able to have rewarding careers that provided them with prestige, income and exciting challenges. Also, many participants reported that the income of two physicians was part of what allowed them to have more balanced lives, because they were able to spend time with their family without having to make huge sacrifices to their financial security. Of course, quality family time appeared to be a huge advantage experienced by participants. It should also be noted that participants tended to express a great deal of mutual respect for the accomplishments of their spouse.

Given the above information, we can see that the struggle for what is important means that dual physician couples strive to optimize their lives by spending as much time as they can on the most rewarding aspects of their lives. It means living the dream of having it all, yet simultaneously giving up the dream of having all of it. It means being able to have a rewarding career and spouse that you respect. It also means having the ability to spend time with your children and to provide them with advantages in life.

Understanding

When asked about the rewards of being part of dual physician couples, the participants of this study unanimously stated that the most important reward was their capacity to understand each other. This is not surprising given the fact that the concept of dual physician couples understanding each other is well established in the literature. While taking a closer look at the idea of understanding, two distinct yet connected concepts emerged from the data, empathy and license to work.

Empathy

Given that physicians often have had similar educational experiences, such as medical school and residency, it follows that they might be better able to empathize with the experiences of other physicians. Jen demonstrates this when she says,

> Jen: I like that he's a physician because he could understand what I am talking about if I have to vent when I come home, which I do and I don't have to explain what I mean cause he knows what I mean.

Like Jen, many participants reported that an important aspect of empathizing was being understood without having to explain. They stated that post call they tended to have very little energy left to provide a lengthy explanation of what happened during their day. As Doug says "we don't have to spend time explaining about the basics. We can communicate in professional jargon."

Of course, there is more to empathizing than venting frustrations. Andrew demonstrated this well when he said,

> Andrew: (w)hat I do see is very important in marital happiness is… the ability of the couples to live in each other's world. It's going to be particularly true in physician marriages because physicians live lives that are very busy, very stressful and very interesting. It seems (a) terrible shame if any physician, neither a husband nor wife has this much fun in what they're doing and this much challenge and the spouse doesn't even understand, have a clue what's going on. It's sort of like two completely different worlds.

When asked to what extent he thinks it is possible for a non-physician to live in the same world as a physician, Andrew replied with

> Andrew: (i)t's possible but very difficult. Medical school is… a life changing experience. You're not the same four years later, that you were when you started medical school… if you go through medical school, you have a lot of shared experiences, very stressful experiences but very mind-expanding and growth promoting in terms of emotional stability, emotional understanding. You deal with death. You deal with dying… All of those things change you and if your spouse changes at the same time and at the same rate, it makes life a lot less lonely.

Thus, we can see that empathy means that dual physician couples have the ability to more fully understand and live in their spouse's world. It means growing together and more fully sharing the joys and sorrows of a medical career. It means being understood by your spouse with little to no explanation necessary and is arguably one of the greatest

rewards experienced by dual physician couples. Though some may argue that the best reward is when empathy is operationalized so that dual physician couples to give each other license to work.

Giving License to Work

Giving license to work means having a spouse that empathizes with physician obligations, such that damage to the relationship is minimized when physicians have to perform work functions interfering with quality time for the family or couple. Haley demonstrates this when she says:

> Haley: We have a mutual understanding of what it takes, particularly me for my husband. Me for understanding why his hours, why be away from home. I am not in the OR with him, but I've been in the OR. I know what it takes, I know what it means that you don't leave once you get out of that surgery. You don't leave that patient alone until you are assured of how they are doing. I know what it is to be called at night and you're sleeping and you say 'I need to go. This is something I can't solve over the phone, I need to go there.' So I understand that… it bothers me because you wish he was here, but I understand and I think I also understand the level of stress…

Haley's experience in the OR makes it easier to understand why her husband has to go into work or can't leave work when he had planned to. As one might expect, couples that had similar specialties appeared to provide each other with greater license to work. Similarly, many couples expressed that it was a huge reward that they had taken rotations that were the same or similar to the specialty of their spouse, as it gave them a deeper understanding of the demands of that particular specialty. When consulting the data, license to work appeared to be most useful for couples that worked the most unpredictable hours.

Another point of interest mentioned by Haley is that it still bothers her when her husband is unavailable. Yet, her empathy seems to lead to a measure of acceptance that is echoed by many participants in the study. When asking a couple what their thoughts were regarding the demands of their spouse's profession, Crystal stated that "(i)t was informed consent." Adam replied with "We'd both been through medical school by the time we got married, we'd both been residents. We knew what doctors did."

This level of informed consent from the beginning of the relationship appeared to be an important aspect of license to work enjoyed by many of the participants in this study. This is especially valuable given the amount of time and energy put into becoming a physician. Thus license to work means that physicians are provided with greater flexibility in their home lives so they can pursue their medical careers. Participants appeared to be all the more aware of rewards such a license to work, when they compared themselves with other couples.

How Do We Compare?

Asking *how do we compare* often resulted in participants having a deeper awareness of the rewards that they have and the costs that they are able to avoid. Don exemplifies this when he says:

> Don: I think I would have a hard time being with somebody that doesn't understand what it's like to be a physician. And talking to colleagues of mine who don't have, are not physician couples, I see that they are always being pulled on that end. The long hours, the demands, what it does.

As Don demonstrates, when male participants compared themselves with others that were not in dual physician couples they tend to be more appreciative of the fact that they are

provided with license to work. In fact, one could make the case that dual physician couples might be more inclined to take license to work for granted, were in not for the fact that they often hear their colleagues complaining of spouses that are less than supportive of their careers.

Female physicians reported somewhat similar responses, as the following quote illustrates.

> Interviewer: Well and if I understand right, some of cutting back to two days a week had to deal with wanting to be able to spend more time with the kids doing other things… So in essence it's just having both (career and family time)?
> Ann: Exactly. Which I think I am very lucky because I know that there are friends and colleagues of mine, who go wow you know that's so great that you can do part-time.

As Ann demonstrates, female physicians also reported appreciating the fact that they were able to go part time while still maintaining the identity and status of being a physician. Female participants seemed to perceive that they were getting fewer costs and greater rewards than other female physicians as well as more freedom to choose a balance of work time and family time that is more comfortable for them. This was partially because their husbands made enough money to provide the family with a good income and partially because these respondents had husbands that were supportive of their decision to go part time.

Thus, asking *how do we compare* means that participants tend to have a deeper aware of the rewards that they have and the costs that they are able to avoid. This kind of comparison means having a better appreciation for the blessings of the dual physician life.

My Grounded Theory: Confusing Exchanges

As noted, four major themes, struggle for what's important, empathy, license to work and how do we compare, were derived from the data. Sifting through the data available from the interviews, there seems to be a central core that surfaces in a very distinct way. I would refer to it as a theory on confusing exchanges which has to do with the fact that the costs and rewards associated with the dual physician relationship are such that these couples tend to be pulled in several directions. For example, dual physician couples recognize the costs that work can have to their families, but the benefits of work is so significant and absorbing that a struggle exists in which these couples must give effort to spend time with family. Similarly, female physicians strive to stay home the better to take care of kids, yet they struggle to defy gender issues at the same time. The exchange is based on rewards and cost, but the whole setup is convoluted, because they would like the prestige of being able to stay home while maintaining gainful and significant employment for both. It is also of great interest that in among the costs and rewards that are negotiated, the couple relationship and physical intimacy, which one might assume would be a priority, tends to receive little time and energy.

Also confusing are the gender norms of these couples, as they tend to have a combination of traditional and non-traditional gender roles. For example gender norms are shifted towards non-traditional territory, because the dual physician couple does not depend on each other financially and much of the unpaid family work is hired out. Thus, the usual gender battlegrounds of finance and unpaid family work are shifted towards an exchange that appears to be more flexible. Yet, this flexibility is often used in a very traditional way such that females make greater adjustments to their work schedules than

their male counterparts, so they can be available for the children. Adding further confusion to this situation, females in dual physician couples tend to claim that they have achieved gender equality and that they were lucky to be able to go part time and take care of their children. As a result of this, dual physician couples are destined to experience confusing exchanges throughout their relationships.

Discussion

As indicated in the results, one grounded theory, called conflicting exchanges, emerged from the data, along with four major themes: struggle for what's important, empathy, giving license to work, and how do we compare. In the discussion to follow, these results will be examined with regards to their connections to the larger research. This discussion will start first with exploring the grounded theory called confusing exchanges.

One of the most significant findings of this present study was the emergence of a grounded theory now referred to as confusing exchanges. Coming out of social exchange theory, that purports the significance of costs and rewards in human transactions, this grounded theory attempts to explain the conflicting nature of dual physicians in their work and family experience. For several reasons, this poses challenges on many fronts. One of those includes the notion of the marriage gradient; specifically the tendency of men to marry down and women to marry up appears to be shattered in the real world experience of dual physician ecology.

Ordinarily, women are more likely to reduce work hours to care for family, earn less, work less prestigious jobs, and to have less formal education than their spouses. For

those and other reasons men tend to have a dominate position. With dual physician couples the women in these relationships appear to shatter the male dominant position and the accepted sociological reality of gender roles and relationships. Therefore, in a gendered world these relationships become somewhat complex, even confusing. Actually they are confusing on several levels, the high job prestige, and income potential for women physicians often disallow her being relegated to the domestic sphere as her sole place of influence. So here they are, living in the environment, but in a subculture of it. In this subculture, these families, or she alone, can provide material resources to buy out her time and energy from the humdrum of home affairs. This buyout may well be mistaken for gender equality and indeed some couples referred to their relationships in such a manner, which would have been consistent with previous research (Sobecks et al., 1999).

On closer examination the data showed that much of the appraisal of their own management of work and family demands showed that they were more egalitarian. However, based on their real life interviews of these couples it was the female physician who worked part time, and was more invested in the needs associated with childcare than the male physician. This appeared to run contrary to the findings of Sotile and Sotile (2000) that dual physician couples tended to compete with each other to see who could work more hours.

To be clear, the preponderance of material resources endemic to these couples, which was noted by Sobecks et al. (1999), does create some flexibility, such as employing paid help to manage burdens of family life. It seems clear that this creates a measure of confusion in social exchanges. So what we see here is not necessarily

egalitarian relationships as described by the couples as much as we see the ability to use available material resources to reorganize role responsiblies in families. This was often reinterpreted by couples to create attitudes shaped by the belief of equality in their ecology, which is consistent to the notion of family myths reported by Hochschild and Machung (2003). Hence, the theory of confusing exchanges appeared to have been a significant theory that describes the relationships of dual physician couples.

Four Themes

With regard to the theme, the struggle for what's important, there seemed to have been an ongoing succession of dilemmas in these families to choose between the demands that are very important and those even more so. Physicians deal with issues of life and death on a daily basis and their work consumes them. It is unconscionable to suggest that what they do is not most important. On the other hand, the family is important and relationships in it predict personal wellbeing for all, including that of the physician (Shrier, Shrier, Rich, & Greenberg, 2006). Children need to be nurtured and cared for and the vitality of marriages must be preserved, so in the whole mix, negotiating these demands seems beyond humanity. The data showed the precarious nature of dual physician ecology that consisted of limited time. As per the results, the present study showed that children were placed first, work second, and marital relationship third. Even in this, there is a refrain of having little time, as reported by Yandoli (1989), as well as limited energy outside of work. These limited resources of time and energy were spent more for the nurture of their children and much less so for the nurture of their spousal relationship.

The theme of empathy was also an interesting finding in this present study and was consistent with previous research (Smith, Boulger, & Beattie, 2002; Sobecks et al., 1999). Empathy was used to refer to the solid understanding perceived of each other's work. In their very complex and demanding work lives, the need for a spouse to understand their involvement, over-engagement, and commitment seemed very necessary. Perhaps, no better person could give so much empathy than one involved in it as well. Such empathy surfaced as a very important theme as physician couples tried to talk about how their work and family lives are balanced.

The theme, license to work, appears to be a related concept to empathy, but involves the passive permission granted to the spouse to be involved, over-involved, or over extended to the sacrifice of other commitments that are equally important. For example, a female physician knowing the importance of the healing art of medicine not only understands that, as in empathy, but makes an accommodation to even giving the spouse license to sacrifice other important demands. This license to work as described by the couples in the sample seemed to have contributed to minimal time and energy to nurture the spousal relationship. This seemed to have been a dominant issue with these families and appeared to be a new concept to the literature.

The last of the four themes that emerged from the analysis of this present study was how do we compare? This theme represents the tendency of the physicians in the sample to evaluate their present work and family balance issues with those of their contemporaries. Often these comparisons created a relativity that left them feeling that there was hardly a need to change their involvement or over-involvement in work, because they were doing better than their peers. In order to maintain a healthy

adjustment in their lives in relation to work and family, the physicians in the sample sought to minimize the costs and maximized the rewards associated with their relationships. For example, some of the dual physician couples interviewed reported having a better experience with their physician spouse than that of their colleagues who were not in dual physician couples. The data suggested that this was because dual physician couples became aware that they were able to share much more material resources, flexibility, empathy, and were given that license to work that they wished for.

Addressing Research Questions

Considering the results and the above discussion, answers can now be given to the two research questions that were the focus of this study. The first question had to do with how dual physician couples experience the rewards and the costs associated with their multiple roles. Data from this study suggest that dual physician couples tended to experience a relatively unique ecology that has positive effects, but does provoke some significant confusing exchanges within the gender drama of their lives together. Further, participants reported that they tended to feel positive about their relationships when compared with that of their contemporaries.

The second research question had to do with how dual physician couples establish healthy and workable adjustments in family living and work contexts. The participants in this study reported that they were able to achieve some measure of balance between rewards and costs in their struggle for what is important. They tended to favor time with their children and family while still leaving at least some time for fulfilling work lives. While couples tended to give each other license to work, as well as empathy, there was a

tendency among participants to neglect their romantic relationships. In spite of that, some couples were able to avoid this by consciously arranging quality couple time that was separate from the children and at a time when they both have energy.

Strengths and Limitations

Some might argue that the use of qualitative methodology is a limitation of this study. Yet, the attention to detail provided by qualitative analysis produced very meaningful results that could not be achieved through quantitative analysis (Guba & Lincoln, 2008). Furthermore, the current study provides an opportunity to answer the call for qualitative research on dual physician couples (Schrager, Kolan, & Dottl, 2007; Sobecks et al., 1999) and addressed successfully the research questions. Also, qualitative methodology appeared to have been an ideal approach to explore how physicians attempt to create balance in their lives, which has been associated with greater creativity, more energy and a better quality of service provided to patients (Shrier, Shrier, Rich, & Greenberg, 2006).

Some may consider the sample size of this study to be a limitation as larger samples are needed in order to make generalizations. Yet Sandelowski (2001) points out that qualitative researchers needn't be apologetic about having small sample sizes, because their data often include hundreds of pages of raw data comprised of interview transcriptions and memos. Furthermore, grounded theory is not concerned with generalizability, but focuses on quality exploration and theory creation regarding its sample (Charmaz, 2006).

One limitation is the fact that the study had a large number of Protestant Christians and relatively few participants from other religious groups. This may be a result of using snowball sampling, which may have impacted the results of the study. For example, it is possible that the tendency to put children first might be associated with the religiosity of the participants. Naturally, it is up to the reader to decide to what extent this limitation impacts the transferability of these results. Yet, it should be noted also that the results of this study described one way of balancing work and family demands that appeared to be successful for participants and that might be applicable to others in the dual physician community.

Another limitation of this study has to do with the inclusion criteria. Two groups that did not meet the inclusion criteria and thus are not represented in this study are dual physician couples that have divorced and dual physical couples with one physician who has retired. These individuals were excluded, because they were not thought to have recent experiences on which they could speak, yet may also be able to provide insights in future studies. For example, an exploration of dual physician couples that are divorced might help us better understand which costs tend to be associated with the breakup of these relationships.

One very important thing to note about this study is the fact that the term theory was used in different ways and thus had the potential for readers to be confused regarding the use of the term. First, theory was used to refer to the grand framework or social exchange. Social exchange theory was the lens through which the researcher viewed and explained the data. The grounded theory referred to the method of analysis used by the researcher to ensure that the data are properly analyzed to produce accurate results. One

of the results of this analysis is grounded theory called confusing exchanges. This grounded theory was co-constructed by the researcher and the participants. Thus, efforts have been made so that the reader can more easily understand which theory is being discussed.

Future Studies

As has been mentioned, it is incumbent upon the reader to decide to what extent the findings of this study are generalizable and transferable. Thus, future research efforts would benefit from quantitative studies that could answer the extent to which these findings are generalizable. For example, quantitative studies could answer to what extent dual physician couples are prone to prioritizing their children over work. Further, a quantitative study could answer which specialties are more prone to give or make use of license to work.

Also, future qualitative and quantitative studies might benefit by sampling individuals that were eliminated from this study by the inclusion criteria. For example, it would be useful to have a study on what happens when dual physician couples divorce so as to better understand the forces that sometimes pull these couples and families apart. Similarly, the literature would benefit from more studies on dual physican couples when a physician retires early or take a planned schedule time off to have and raise children. From the review of the literature, very little was found regarding divorce among physicians. Further studies regarding this phenomenon need to be forthcoming. Also, more studies need to be done on physician divorce rates in relation to the career choice of the spouse. For example, it would be of interest to discover how dual physician divorce

rates differ from that of physicians married to other professionals or physicians married to non-professionals.

Implications

This present study offers important implications with regard to theory, research and practice involving dual physician couples. This study is certainly one of the first dual physician studies to make use of family theory. As such, it integrates family theory into this new body of literature, thus showing how the costs and rewards of these relationships are thought out.

Some of the earlier studies examined for the literature review of this present study called for qualitative inquiry in their study of these families. The rich descriptions derived from the data illustrated the benefit of this approach, thus validating this approach for examining the data. In this way, the present study has done much to fill this gap in knowledge.

With regard to practice, this present study established the complexity of the work and family environment of dual physician couples. As such there are important implications here for policies that can help to shape a better family life balance even while participating in their work environments. Also, the data informs family life educators and mental health professionals regarding the complex nature of these arrangements, who may in turn provide their dual physician clients with more informed interventions on the journey of life.

Conclusion

Dual physician couples are an increasing phenomenon just as the number of female students graduating from medical school is increasing. It is hoped that as a result of this study, more is now known of these family with regard to how they navigate the competing demands of their lives. If these couples are able to maximize the rewards and minimize the costs as noted, it is quite possible that they could experience the ideal medical marriage despite some confusing exchanges, or at least a fulfilling one in the maze of challenges and uplifts.

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APPENDIX A

COMPLETE QUALITATIVE QUESTIONAIRE

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 being 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. Probe: During medical school, residency training, early practice, established practice? (ASK ONLY IF APPLICABLE)

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

1. How would you describe your current relationship?
    a. Probe: What aspects of your current relationship do you find most satisfying?

    b. Probe: In terms of

        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 the most challenging or how might you wish it to be different?

2. What aspects of being in a physician relationship most impact your marital life?

3. How does being married to your spouse affect your work life?
    a. Probe: How does your spouse support your career goals?

    b. How does your spouse support you with the demands of your profession?

    c. Probe: (to the physician) What are some areas in which physicians have expressed a need for more spousal support?

4. Can you talk about how you make major decisions?
    a. Probe: How are house work (and childcare) responsibilities divided? What is it that way?

    b. Probe: Would you say that one person's professional goals take precedence over the others? What is that?

5. How do the two of you handle disagreements or conflicts between yourselves?

D. Spirituality Questions (for physician and spouse)

Worldview

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?

Attunement

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?

Authenticity

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?)

Relational Responsibility

4. How would you describe your impact on God?
    a. Probe: Describe your how your choices, thoughts, behavior affect God?

Influence

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?

Perceptions

7. How do you think God views you?
    a. Probe: What lets you know God views you a certain way?

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?

E. Stress (questions for the physician only)

1. What are your thoughts about the demands of your professional life?
    a. Probe: What are the demands?

b. Probe: How stressful are the demands?

2. What other demands or expectations do you experience apart from your job?
    a. Probe: What are those demands?

    b. Probe: How stressful are those demands?

3. How do you cope with stress?
    a. Probe: What works best?

    b. Probe: What does not work as well?

4. What kinds of support are available to you in managing the stressors in your life?
    a. Probe: 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?

F. Female Physician (ask both male and female physician about their experiences)

1. In your experience, have you observed that there are important differences for female vs. male physicians? What if any are the differences you have experienced?
    a. Probes: In the workplace? In marital life? In experiences of parenting?

2. Have you felt supported and empowered (as a woman) in your professional life?
    a. Probes: In the workplace? In marital life? In experiences of parenting?

G. Parenting (for those couples with children, only)

1. How did you make (are you making) the decision to become parents?

2. Has having children had an impact on 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. How do you achieve quality time as a family?

How do you balance work and family demands, as well as personal needs?

H. (See appendix B)

APPENDIX B

DUAL PHYSICIAN COUPLE QUESTIONS

H. Dual Physician Couples

1. Perhaps there are costs as well as rewards 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 rewards associated with your both being physicians?
    a. Rewards to work

    b. Rewards to family

    c. Rewards to self

    d. Rewards 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 relationship?

5. What are some of the contributions you perceive yourself making to your family work and to your relationship even as a highly trained professional?
    a. Family work is household chores such as laundry, dishes, childcare, etc.

6. What advice would you offer to others in dual physician relationships?

APPENDIX C

LETTER OF INTRODUCTION

Hello,

My name is _____. I am affiliated with the Department of Counseling and Family Sciences at Loma Linda University. I was referred by the principal investigators of the study to have a brief interview with you for a research study that seeks to understand the work life, family dynamics, and relational interactions of physicians.

The purpose of the study is to gather information from physicians and/or their spouses that will provide insights on the impact of relationship and professional practice on the quality of life of individuals in this demanding career. We hope that the results of the study will add to a better empirical understanding of physician life, and will eventually influence work and family policy that govern workplace settings. Your participation will be invaluable.

This study is endorsed by Dr. Colwick Wilson and Dr. Curtis Fox of Loma Linda University who are researchers and advocates for family enrichment and policy development among career families and workplace settings.

We kindly ask for your participation and look forward to sitting with you for that brief interview. One of the researchers will make contact with you in order to set up an appointment for the interview. To facilitate that process, they would like to know what is the best number to contact you at, as well as the best time to do so.

If you have further questions about the study, please feel free to contact Dr. Curtis Fox at (909) 558-4547, ext. 47010.

Thank you for your time and your willingness to help.

Respectfully,

Dr. Curtis A. Fox

APPENDIX D

CONSENT FORM

Medical Doctors and their Families: A Qualitative Inquiry
Loma Linda University Department of Counseling and Family Sciences

Consent Form

Thank you for choosing to participate in this study on physicians and their relationship 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 relationships 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
Relationship and Family Therapy Clinic
164 W. Hospitality Lane, Ste 15
San Bernardino, CA 92308
(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 E

MEDICAL DOCTORS AND THEIR FAMILIES: PHYSICIAN QUESTIONNAIRE

Please answer the following questions:

1. Gender: o Male o Female

2. Age.....

3. Race/ethnicity you most closely identify with:
   o Caucasian o Black/African American o Hispanic/Latino American
   o Asian American o Other……

4. Religious organization/denomination that you most closely identify with:
   .....

5. Year of graduation from medical school.....

6. Highest level of education completed:
   o Masters Degree o Doctorate Degree o Other.....

7. Medical specialty .....

8. Current place of work: o Private Practice
   o Community Hospital o University Hospital o Other.....

9. Marital Status: o First Relationship o Second Relationship o Other.....

10. Years in current relationship .....

11. Years in current relationship.....

12. Number of children.....

13. Number of children living at home .....

14. Children's gender and age:

Birth Order	*Gender (male/female)*	*Age*
First child		
Second child		
Third child		
Fourth child		
Fifth child		
Sixth child		

15. 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) .....

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