6-1-2013

Physician Couples: A Qualitative Inquiry Focused on Gendered Power and Marital Equality

Sarah C. Stuchell
Loma Linda University

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

Physician Couples:
A Qualitative Inquiry Focused on Gendered Power and Marital Equality

by

Sarah C. Stuchell

A Dissertation submitted in partial satisfaction of
the requirements for the degree
Doctor of Philosophy in Marriage and Family Therapy

June, 2013

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.

_____, Co-Chairperson
Carmen Knudson-Martin, Professor of Counseling and Family Sciences

_____, Co-Chairperson
Colwick Wilson, Adjunct Professor of Counseling and Family Sciences

_____
Elisabeth Esmiol, Assistant Professor of Marriage and Family Therapy

_____
Curtis Fox, Chairman and Professor of Counseling and Family Sciences

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to Dr. Carmen Knudson-Martin and Dr. Colwick Wilson who have been incredible mentors throughout my entire doctoral education. Both have provided me with invaluable opportunities and have been a catalyst for my success. I could never thank them enough for the numerous teaching, writing, and research opportunities they provided me throughout the years.

I would like to thank Dr. Curtis Fox and Dr. Lisa Esmiol for their interest and enthusiastic involvement in my dissertation project. Their expertise in physician research, theory and gender have challenged me to hone analytic skills and generate a project I am proud of. I would also like to extend a special thank you to the Physician Family Research Team: Dr. Carlene, Dr. Nishana, Dr. Ben, Tone, St. Clair, Dr. Eva, and Dr. Ruthie for the many hours of meetings, interviews, coding, and laughs. I am grateful to have had wonderful professional peers to collaborate with on such a special project.

To my family and friends, your love and support through this long endeavor has been greatly appreciated. I would also like to thank my clients who have allowed me to hone my therapy skills as I apply theory and research in my clinical practice. Finally, this dissertation is dedicated to the first woman physician and her husband that I interviewed, who ended up delivering my baby a couple years later.

CONTENT

TABLES

Tables Page

ABSTRACT OF THE DISSERTATION

Physician Couples:
A Qualitative Inquiry Focused on Gendered Power and Marital Equality

by

Sarah C. Stuchell

Doctor in Philosophy, Graduate Program in Marriage and Family Therapy
Loma Linda University, June 2013
Dr. Carmen Knudson-Martin, Co-Chairperson
Dr. Colwick Wilson, Co-Chairperson

How couples "do" gender and power in their marriages is a relevant topic for today's couples. Despite social changes toward equality in many realms, gender continues to organize relationships in ways that give husbands more power than wives. However, some contemporary couples make conscious decisions to resist forces toward organizing according to stereotypical gender ideals and to "do" gender differently in their relationships. For couples in which one or both is a physician, power is also deeply embedded in the physician status, with families tending to organize around the physician's demands. While these effects reinforce male dominance when the husband is the physician, they pull opposingly when the wife is the physician, which is increasingly common as greater numbers of women enter the medical profession. We do not know how forces of gender and physician status interplay and play out in physician marriages. This qualitative study uses a social constructionist feminist theoretical lens to examine data from 36 physician interviews to explore how gender and power organize physician family life. Using a grounded theory approach, we found that couples' "undoing" gender was a core category around which three couple types emerged: traditional, gender-conflicted, and de-gendering. How couples manage gender and power depends on

whether they continually counteract stereotypic gender roles, particularly by un-gendering their interactions. Among the couples in this study, even the most egalitarian ones, gender never gets completely undone; there are no cases in which women gain the kind of organizing power that men have. This study demonstrates how couples respond to societal pressures to conform with gendered expectations, from traditional couples, who continue to do gender in conventional patters, to gender-conflicted couples, who struggle with traditional ideals in the face of unconventional circumstances, to de-gendering couples, who adopt purposeful strategies to resist the societal pressures to conform to traditional gender ideals.

CHAPTER ONE

INTRODUCTION

Ideas about men and women have evolved at a societal level and have received increasing attention over the past several decades of research with an increased focus on how gender influences marriage, especially in terms of power and equality. Equality is becoming a mainstream ideal in contemporary couple relationships for many good reasons (Coontz, 2005; Knudson-Martin & Mahoney, 2009b; Sullivan, 2006). Studies have found the rewards of equal relationships for couples include: less depression or anxiety for both men and women, an increase in intimacy, better communication, greater satisfaction and improved marital stability (e.g., Amato, Johnson, Booth, & Rogers, 2003; Gottman & Silver, 1999; Steil, 1997; Whisman & Jacobson, 1989). In contrast, unequal relationships often cause individuals to feel they have little influence with their partner and to suffer distress, including higher levels of anxiety and depression compared to their significant other (Steil, 1997; Steil & Turetsky, 1987).

Studies on physician marriages have not been entirely excluded from this discussion. Although the application of a gendered power and marital equality framework has been understudied in research on physician marriages, most studies have shed light upon couple issues that would benefit from a focused critical exploration of gender and power in these relationships. For example, historically the male physician marriage was commonly one in which his wife sacrificed or postponed her own personal and career goals for the sake of his, and they adopted rigid gender roles of stay-at-home mom, and his of breadwinner (e.g., Gabbard & Menninger, 1988; Glick & Borus, 1984; Robertson, 1986; Vincent, 1985). These women often were treated for psychological issues, including anxiety or depression, and in some cases were medicated by their

physician husband (e.g., Evans, 1965; Krell & Miles, 1976). Although this depiction is representative of an early era of studies into physician marriages (1960's – 1980's), more recent research has also brought forth gender issues in physician marriages. Recent studies have found that female physicians struggle significantly more than male physicians with role strain, and carrying the full burden of family responsibilities in addition to their work responsibilities - an indication that old gender stereotypes that promote inequality may still be at play in physician marriages (e.g., Sobecks, et al., 1999; Sotile & Sotile, 2004; Starner, 2010). To explore this issue, this dissertation study will employ a social constructionist framework to understand how gender and power are constructed in a sample of physicians and their spouses.

Background and Significance

The literature on medical marriages and families has noted meaningful gender differences and reflected these differences according to the interests and perspectives that were relevant during each particular period of time, and as the profession as a whole gained influence from more women entering a male-dominant profession. The focus of this dissertation is on physician marriages and the role that gender and power and the concept of marital equality may play. Studies on medical marriages have reflected more gender awareness since the late 1990's and 2000's as more women have entered the profession as a whole. Some studies have suggested that women's influences on the medical profession are likely to be positive for physician marital and family relationships for both male and female physicians. Other studies have examined the effects of the medical profession, which still tends to be male dominated and in some instances caters more to men's needs, on physician marriages and child rearing. For example, one study

found that female physicians are less likely compared to their male counterparts to achieve their career goals due to family reasons, and this occurs at a higher rate among female physicians married to other physicians than to female physicians married to other professionals (Sobecks, et al., 1999). Female physicians also experience slower career advancement, reduced pay when deciding to have children, and reduced publication for those in academic settings compared to male physicians (Boulis, 2004; Brian, 2001; Schroen, Brownstein, & Sheldon, 2003; Straechley & Longo, 2006).

Physician marriages may be particularly fragile due to the dedication and work ethic of the profession. For example, physicians are devoted professionals, who often put aside personal needs or marital relationships because of their commitment to the professional and their drive to succeed (Vincent, 1985). Physicians are also known for their adoption of delayed gratification and sacrificing personal or marital happiness, for other secondary benefits such as financial security or social status (Garvey & Tuason, 1979). These issues have often been cited as contributing to poor marriages of physicians. However, other research has found that physicians may have lower divorce rates and higher marital satisfaction than the general population for both men and women physicians (Doherty & Burge, 1989; Garvey & Tuason, 1979; Ricer, 1983). While it seems reasonable to assume that working long hours away from home can have an adverse effect on a physician's marriage and contribute to marital problems (Myers, 2004), studies have failed to find this expected association between long work hours and decreased marital satisfaction (e.g., Gabbard, Menninger, & Coyne, 1986). Physician couples may have developed other strategies to handle their marital relationships (e.g., Barnett, Gareis, & Brennan, 1999) and further inquiry into the relational processes or experiences that physicians and their spouses have adopted is warranted.

While further research is needed to understand how and why medical marriages attain high levels of marital satisfaction in the face of such challenges, one main gender difference does exist between men and women physician's level of marital satisfaction. A significant finding is that women physicians experience more role strain or stress than men physicians due to the conflicting demands of their professional and familial obligations (Straehley & Longo, 2006; Warde, Moonesinghe, Allen, & Gelberg, 1999). A study comparing male and female physicians with children found that men had higher levels of marital satisfaction associated with having a helpful and cooperative wife, and lower levels of role conflict (Warde, Moonesinghe, Allen, & Gelberg, 1999). Many female physicians experience guilt over being a working mother (Boulis, 2004; Brian, 2001; Clarke, 2011) and appear more likely than men to indicate dissatisfaction with not having enough time with their children (Cujec et al., 2000).

Although physicians are often viewed in the larger social context as being dedicated, hard working, professional, logical, knowledgeable, compassionate healers, research has not always portrayed them this favorable in their familial context. For example, early research (1950's – 1970's) that mostly sampled white male physicians and their spouses, blamed certain characteristics, such as being cold and distant, to explain marriage problems (e.g., Evans, 1965). As more women physicians entered the profession, studies became more distinct in their depictions of male and female physicians, however still followed suit and pathologized certain female characteristics, such as having passive communication with her spouse, or ambiguity in her self-image, as causing marital problems (e.g., Myers, 1984). However, these approaches of pathologizing characteristics of physicians were soon challenged by more rigorous

studies that examined the context of the profession and its effect upon physician family life.

Issues of gender and power seem rampant in the medical profession as a whole and in society at large, and thus must inevitably trickle into and shape the marital relationships of its constituents, the physicians. Not enough current research exists to fully understand the picture of gender and power in physician couple relationships, and certainly not since more non-traditional physician couple types have emerged (e.g., minority, cohabitating, gay or lesbian, blended or step families). This dissertation aims to fill this gap in the literature by using a qualitative approach to explore in an in-depth manner, issues of gendered power and marital equality in a sample of physicians and their spouses.

Objective of the Study

This dissertation study is part of a larger ongoing study conducted by the Loma Linda University Department of Counseling and Family Sciences that examines physician marriages and families. Within the contexts of professional families and medical professionals, the goal of this larger study is to better understand the unique experiences within physician family life. This dissertation aims to make a unique contribution within this larger study by its focus on issues of gendered power and marital equality in physician couples.

Rationale

One of the more notable gaps in the literature on physician marriages is the extent of the literature that is dated, thus making it difficult to assume these early studies are still

relevant for today's contemporary physicians. While the early studies provided rich deep descriptions of the marriages and experiences of physicians and their spouses, these studies were also limited in their sole focus on male physicians and their spouses. As more women became physicians, studies were conducted from a quantitative methodology, and although important gender differences were observed, a deep rich description and understanding of contemporary female (and male) physician marriages is lacking. Therefore, the rationale for studying marital equality and physician marriages together is based on an extensive search of the literature on physician marriages that tends to primarily examine male physicians and their wives, studies that do highlight gender differences between men and women physicians but warrant a more in-depth exploration, and a need for more current research on contemporary physician marriages in general. Also, few studies on marital equality have sampled physicians and their spouses

Contributions

This qualitative study will use a social constructionist framework with a critical feminist lens to explore and understand the ways in which gender, power, and equality are constructed within the physician marriage and influenced by the larger social contexts. Given that society at large, and the medical profession in general, have a strong history of gender privilege, it should prove beneficial to use a social constructionist perspective in viewing the issues of gender and power within the physician marriage. In examining the ways in which the couples themselves create meaning and organize their relationships, the concepts of male privilege, invisible power, and relationship equality will guide the analysis. The main contribution is to develop grounded theory that

provides a deep, rich explanation of the gender, power and equality issues that have been somewhat noted in other studies on physician marriages. The results are expected to guide therapists and helping professionals in their work with these couples, contribute to theory regarding how gender intersects with other sources of power, and provide additional areas of inquiry for further research.

Research Questions

The aim of this dissertation is to explore and develop grounded theory around issues of gender, power, and equality in physician marriages. The following set of questions will guide the analysis: In what ways are marital equality and gendered power related to a physician's marital relationship? How do these couples "do" gender? What are the gender discourses that seem to influence the physician and his or her spouse? Does the relationship favor one spouse's needs, well-being, goals, etc. over the other? Is the relationship constructed in such a way that there are certain benefits for one spouse at the expense of the other? What does power look like in these couples; is power overt, covert, or invisible? How do these issues relate to the overall self-reported success or challenges of the physician marriage?

CHAPTER TWO

CONCEPTUAL OVERVIEW

This dissertation project will be integrating social constructionist theory with an emphasis on critical feminist theory as they relate to gender and power and couple relationships. Whereas social constructionism gives attention to the way knowledge, truth, and meaning are constructed by human interaction, critical theory requires that we pay attention to the power dimension of these processes. Adding a feminist lens brings gender as a patriarchal issue to the forefront as an area of inquiry. While this framework has been sufficiently represented in research on marital equality and the critical analysis of gendered practices (e.g., Knudson-Martin & Mahoney, 2009b; Walker, 2009) it has only been slightly represented in current research on physician marriages (e.g., Esmiol, 2011). In order to understand these concepts more clearly, this section will provide an overview of social constructionism and critical theory, discuss key concepts such as gender, gender privilege, power, and marital equality, and explore how these concepts may be applied to this present study.

Social Constructionism

Social constructionism is a dynamic, creative and social view of people. It is the view that reality is understood and created through social interaction (Burr, 2003; Davis & Gergen, 2005; Deutsch, 2007). The way we know the world is "a product not of objective observation of the world, but of the social processes and interactions in which people are constantly engaged with each other" (Burr, 1995, p. 15). Compared to a predominant modernist view, that asserts reality is an objective and discoverable nature of the world that lies outside of human judgment, a social constructionist view asserts

that an objective reality does not exist outside of human interaction and subjectivity, and reality is embedded deeply within history and culture (Baber, 2009). "Knowledge and meaning are constructed and reconstructed over time within the social matrix" (Rosen 1996, p. 20). Reality therefore depends upon the perspectives one brings to a situation, and these perspectives are informed and constructed within a culture laden with values and biases. Reality is created and understood through social processes and interactions in which people are constantly engaged with one another, and language creates what we take the world to be (Davis & Gergen, 2005). The primary assumptions underlying a social constructionist and critical theory orientation as outlined by Baber (2009) include: "there is no objective truth because knowledge and our understanding of the world are socially constructed, social constructions are developed and maintained through discourse, power relations are established and perpetuated through these discursive strategies and tend to reinforce binary and oppositional thinking, and deconstructive processes offer possibilities for challenging what has come to be seen as normal and natural and for initiating emancipatory actions" (p. 57). These assumptions will be explained in further detail below.

Critical Theory and the Social Construction of Knowledge and Power

One aspect of social constructionism is the critical analysis of the ways in which social structures have power over human experiences (Walker, 2009). Foucault (1978) was one of the first to note how "truths" act to turn people into objects through the practices of systematizing and universalizing political and scientific theories. Perceptions of reality are created and maintained through the selection and organization of

information; knowledge, truth, power, and social relations are socially constructed (Baber, 2009). "The idea that knowledge and what is assumed to be 'natural' is socially constructed implies that knowledge claims are, at best, partial, fragmented, and incomplete and that there are multiple ways of experiencing and understanding the world and social relations" (Baber, 2009, p. 57).

Discourses are historically and socially constructed in ways that reflect the prevailing power structures and are reinforced through social institutions, laws, and modes of thought; they articulate what we think, say, and do, and have the power to identify what is nameable, seeable, doable, speakable, or writable (Baber, 2009). Critical theory asserts that any discourse that promotes the supremacy of one idea over another is an act of social control; it proclaims what is normal and abnormal among society's individuals. Discourses are constructed in such a way that they limit and constrain thinking, act as hierarchical ordering devices, and rule out multiplicity and nuance (Baber, 2009). A critical approach therefore stresses the importance of historical context, variations among people, and the multiplicity of norms, practices, and relations that evolve through social transactions and that are influenced by power differentials (Baber, 2009). Feminism is one branch of critical theory that specifically examines the institutionalization of gender.

Gender, Gender Privilege, and Power

Critical theory recognizes the constitutive power of language and discourse, however it is only with the addition of the feminist lens that the focus shifts to the ways in which the social institution of gender has become a relational category of domination (Baber, 2009). Gender is a socially created concept consisting of the expectations,

characteristics, and behaviors considered appropriate for men and women in a culture or setting (Baber, 2009; Knudson-Martin & Mahoney, 2009b). "Every society has a gender structure, in the same way that every society has an economic structure. The gender structure has implications at the level of individual analysis, in shaping interactional expectations that are at the heart of doing gender, and at the institutional level in the organization and policing of social groups" (Risman, 2009 p. 83). A social constructionist perspective of "gender" recognizes this recursive process between what people do and the social structure(s) (Deutsch, 2007; Risman, 2009; Walker, 2009). As a social structure, gender is embedded within language and processes that maintain masculine or feminine identities and interpersonal interactions (Baber, 2009; Walker, 2009). Gender norms emerge over time as the expected behaviors and taken for granted assumptions about men and women. The language and activity of everyday life reinforces what individuals experience to be true about gender, often informing them of how they should live their lives as a man or a woman. These gender ideals appear to operate below conscious awareness often going unnoticed, and feeling "natural" or "normal" (Knudson-Martin & Mahoney, 2009c). They are deeply embedded in all other institutions, such as law, education, economics, and medicine, and are rarely questioned in everyday life. As people conform to gender norms and societal expectations, the gender structure is reproduced (Deutsch, 2007; Risman, 2009; Walker, 2009).

A feminist social constructionist perspective supposes gender is relational and situational; something one "does" rather than a personality characteristic or genetic predisposition (Baber, 2009; Deutsch, 2007; Risman, 2009). Gender is a product of social interaction; it is the social exchange that generates the categorical identities, and therefore the differences, as well as the way that men and women experience themselves

(Baber, 2009). Rather than seeing gender as a persistent unified category, a social constructionist view focuses on the "doing" or "undoing" of gender (e.g., Deutsch, 2007; Lorber, 2006; Risman, 2009). Many recent feminist scholars have argued for "de-gendering" practices as this would shift the focus away from the *differences* between men and women (e.g., Deutsch, 2007; Lorber, 2006; Risman, 2009).

This social constructionist approach to gender is different from others. For example, socialization theories assume individuals internalize gender norms that were rewarded and modeled by parents, teachers, and other authority figures, and structural accounts assume that gender differences arise from the different resources to which men and women have access to or the different social locations they occupy (Deutsch, 2007). However, a social constructionist approach views gender as an ongoing emergent aspect of social interaction, highlighting the *interactional* level of analysis (Deutsch, 2007; Risman, 2009).

Gender is not neutral, rather it is deeply embedded with judgments and evaluations that place one gender, often the male, as superior to the other (Knudson-Martin & Mahoney, 2009). Feminist theorists believe it is the gender system that both causes and sustains oppression and target gender as an area for change in order to bring greater equality to societies (Baber, 2009). Patriarchy refers to the cultural beliefs rooted in male superiority and female inferiority that lead to the formation of a society based on male dominance and privileges male characteristics and work as superior to that of women's and grants unearned societal benefits and advantages to men based solely on their biological sex (Dolan-Del Vecchio, 1998; hooks, 2000; Knudson-Martin & Mahoney, 2009 Silverstein, 2003). Power, inequality, and hierarchy are embedded in, and perpetuated by, traditional conceptualizations of gender and gender relations enacted

in our everyday lives, often without reflection or question (Baber, 2009). Some patriarchal practices may be apparently overt, but most of the time, patriarchy operates below people's conscious awareness, and is embedded in their everyday activities. "Gender differs from other axes of oppression because many of the inequities women suffer occur in everyday interactions of their own homes…interactions in families are often the proximal causes of women's being overworked, underfed, and/or victims of violence" (Deutsch, 2007, p. 121).

Among other things, gender and power structures family life and relationships (Baber, 2009; Leslie & Southard, 2009; Walker, 2009). In heterosexual couple relationships, researchers have documented that men continue to have more power than women (e.g., Knudson-Martin & Mahoney, 2009; Knudson-Martin, 2009; Moghadam & Knudson-Martin, 2009). Gender ideals established within the larger social context dominate couple relationships causing power imbalances often disguised as normal couple interactions or natural ways that women and men interact (Knudson-Martin & Mahoney, 2009). These processes are not the result of biological determinism, but a product of gender socialization, or gendered interactions that give the appearance of the way things ought to be and have privileged the interests of men over women (Knudson-Martin & Mahoney, 2010). Therefore, marital power is mostly invisible and latent, operating below the couple's conscious awareness (Deutsch, 2007; Knudson-Martin & Mahoney, 2009; Tichenor, 2005). When power is invisible, the less powerful person feels less entitled to have or express personal needs or goals, is more likely to notice and attend to their partner, and usually automatically accommodates to their partner (Knudson-Martin & Mahoney, 2009). When relationships are not equal, relationship schedules and decisions tend to reflect the interests of the dominant partner. When power

differences are well ingrained, compliance occurs without overt power struggles and conflict; the less powerful person simply accommodates the other (Tichenor, 2005; Mahoney & Knudson-Martin, 2009).

Gendered power is an important piece of a relationship and restricts a couple's capacity for mutual attending and nurturance (Dolan-Del Vecchio, 2008). Gendered power also structures the ways in which couples make work and family decisions (Baber, 2009; Leslie & Southard, 2009). The outcomes of those decisions have implications for how gender and marriages are constructed for individual couples and the larger society (Walker, 2009; Zvonkovic et al., 1996). "As marital norms become more egalitarian, we need to be able to differentiate when husbands and wives are doing gender traditionally and when they are undoing it – or at least trying to undo it" (Risman, 2009, p. 82). In marital inequality, power is conceptualized as the ability of one partner to influence *the relationship* mostly toward his or her own goals, interests, and well-being, as well as an ability to influence discussions and negotiations (Mahoney & Knudson-Martin, 2009).

Equality and Marriage

Relationship equality is frequently defined in terms of shared power, equal access to resources (e.g., money, time, etc.) and shared household and child-rearing responsibilities (e.g., Knudson-Martin & Mahoney, 2009; Quek, 2009; Tichenor, 1999). However, defining equality has proven difficult because needs and expectations are often implicit rather than explicit, and society continues to define the gendered roles of couples in relationships as well as how couples should think, feel, respond, behave, etc. in these relationships (Deutsch, 2007; Knudson-Martin & Mahoney, 2009; Steil, 1997). Marital

equality therefore evolves out of the social processes between partners, and the larger social context, values, and beliefs that the couple is part of.

Equality in a marriage emerges out of the interactions of both partners, what equality "means" to both partners, and the larger social ideas that influence the way couples shape their relationships. The definition of relationship equality being used in this marriage study is that of Mahoney & Knudson-Martin (2009). The authors describe equal relationships as those in which two individuals participate in mutual exchange and mutual recognition where one is both affecting the other and being affected by the other. Both parties have and express their desires, are active and empowered, and the relationship is characterized by mutual respect. Equality involves the perception of mutual give and take over the long term rather than just an immediate comparison of specific outcomes. These authors developed a four-dimension model of equality that includes the following concepts: relative status, attention to other, accommodation patterns, and well-being. Their definition is grounded in findings as well as theory that have shown how traditional gender socialization has discouraged men from sharing power and empathically listening and responding to the needs of others, and for women, has discouraged them from speaking up and asking for what they need. The four concepts of this definition are outlined below.

Relative Status (Mahoney & Knudson-Martin, 2009, p. 11-12) is conceptualized as who in the relationship gets to define what is important, and who has the right to have, express, and achieve goals, needs, and interests. Traditional gender socialization encouraged men to feel entitled towards these things and for women to put family needs before their own. Therefore, to the extent that men and women absorb these expectations, even if unconsciously, they set themselves up for unequal status. Relative

status asks whether both partners have the ability to use the relationship to support their interests, and whether both partners have power to define the agenda of the relationship.

Attention to Other (Mahoney & Knudson-Martin, 2009, p. 12) is conceptualized as both partners being emotionally present for and supportive of each other. Traditional gender socialization has generally left the emotional attending of the relationship or significant other up to women. Therefore, in an egalitarian model for relationships, both partners are attuned to the needs of the other and are responsive to their emotions and stresses.

Accommodation Patterns (Mahoney & Knudson-Martin, 2009, p. 12) are a necessary part of couple life. Accommodation is balanced when both partners equally influence the relationship over time. Traditional gender socializations have tended to place expectations upon women for accommodating their schedules around her husband's schedule. Although accommodation by the lower status spouse may feel natural and may happen automatically, it does not foster an equal relationship.

Well-Being (Mahoney & Knudson-Martin, 2009, p. 12-13) is supported equally in both the short and long term and by both partners in equal relationships. Do the relationship patterns equally support the well-being of each partner physically, emotionally, and financially? When a disparity occurs, both partners acknowledge it and work together to equalize it.

Summary

Social constructionism with a critical theory feminist lens will be used to explore and understand the ways in which gender, power, and equality are constructed within the physician marriage and are influenced by the larger social contexts. Given that society at

large, and the medical profession in general, have a strong history of male privilege, it should prove beneficial to use a social constructionist perspective in viewing the issues of gender and power within the physician marriage. In examining the ways in which the couples themselves create meaning and organize their relationship, the concepts of male privilege, invisible power, and relationship equality will guide the analysis. The hope is that by using this framework and guiding concepts in analyzing the data, a deep, rich explanation of the gender issues that have been somewhat noted in other studies will be further understood through this grounded theory approach.

The aim of this study is to explore and examine gendered power and equality in the physician marriage; how gender is constructed, how couples interact in ways that create gendered meanings in their relationship, and how larger social discourses of gender trickle down and influence their couple relationship. The concept of gender privilege is expected to help inform the analysis. Past and current studies have documented "male privilege" in both the medical profession at large (e.g., Boulis, 2004; Brian, 2001; Schroen, Brownstein, & Sheldon, 2003; Straechley & Longo, 2006) and the marriages of physicians (e.g., Elliott, 1979; Evans, 1965; Gabbard & Menninger, 1988). How do these larger contexts influence what it *means* to be a man or a woman to them? On a couple level, gender will be explored by how the physician and his or her spouse *negotiate, reconstruct, or create meaning* around gender in their marriage and family life. For example, a question that will influence the analysis will be: how do these couples "do" or "undo" gender?

Focusing on the interactional level of analysis can illuminate the possibility of change. The study of the interactional level could expand beyond simply documenting the persistence of inequality to examine: when and how social interactions become less

gendered, not just differently gendered; the conditions under which gender is irrelevant in social interactions; whether all gendered interactions reinforce inequality; how the structural (institutional) and interactional levels might work together to produce change; and interaction as the site of change (Deutsch, 2007). Feminist scholars have urged researchers to pay careful attention to whether research is documenting different kinds of gender, how doing gender may be changing, or whether it is being undone (Risman, 2009).

Discourse identification and examination is also expected to guide the analysis, for example gender "truths" or "norms" will be questioned and examined in their effect upon the relationship and couple functioning. By questioning the taken for granted gender ideas, for example, that men are supposed to be breadwinners and women are nurturers, this study will seek to find alternative gender constructions as well as explore the effects of all gender constructions on the couple relationship. Finally, the concept of relationship equality presented by Mahoney & Knudson-Martin (2009) will influence the analysis with the following set of guiding questions:

Relative Status: "Whose interests shape what happens in family life? To what extent does each feel equally entitled to express and attain personal goals, needs, and wishes? How are low status tasks like household handled?" (p. 13)

Attention to Other: "To what extent do both genders notice and attend to others needs and emotions? Does attention go back and forth between adult partners? Does each give and receive? When attention is imbalanced do partners express awareness of this and the need to rebalance?" (p. 13)

Accommodation Patterns: "Is one partner more likely to organize his or her daily activities around the other? Does accommodation often occur automatically without

anything being said? Do partners attempt to justify accommodations they make as being 'natural' or the result of personality differences?" (p. 13)

Well-being: "Does one partner seem to be better off psychologically, emotionally, or physically than the other? Does one person's sense of competence, optimism, or well-being seem to come at the expense of the other? Does the relationship support the economic viability of each partner?" (p. 14).

CHAPTER 3

REVIEW OF THE LITERATURE

This section will review the literature on physician marriages and feminist studies of marital equality and power. In general, the extant of the literature on physician marriages tends to be dated, with deep rich descriptions of physician marriages occurring in early research (1960-1980's). These early studies often assumed physicians were White and male, and lacked in providing information on female, minority, or dual physician marriages. However, feminist studies in the marital equality and power literature have continued to evolve since the 1960's, with current research reflecting contemporary couple advancements around the issues. In this section, I will first present studies about research on gender in physician marriages, or research that has noted gender differences between men and women physicians as it relates to their marital relationships, and then I will turn to the feminist literature and look more broadly at how power and marital equality have been studied. I will conclude with a summary of how the research on gendered power and marital equality can prove beneficial to this study on physician marriages.

Physician Marriages

Marriage and Divorce Rates

Gender differences in marriage and divorce rates between male and female physicians have been noted in the literature. Early studies found that men physicians often married later, stayed married longer, and divorced less often than other men and most other professionals (Rosow & Rose, 1972) and when compared to the general population, men physicians had lower divorce rates, filings, or complaints (Doherty &

Burge, 1989; Garvey & Tuason, 1979; Heins et al., 1977; Rosow & Rose, 1972). Early studies found the opposite among women physicians: that women physicians were less likely to marry and more likely to divorce than men physicians (Rosow & Rose, 1972) and had a higher divorce rate than the general population (Heins et al., 1977). However, as more women entered the profession, women physicians seem to be following a similar pattern to men physicians in marriage and divorce rates. For example, one study found that the proportions of men and women physicians who marry are similar (Sobecks et al., 1999) and another found that women physicians divorce at a lower rate than the general population (Doherty & Buerge, 1989); a similar pattern noted earlier among male physicians (e.g., Rosow & Rose, 1972).

The specialty of a woman physician has been noted in possibly playing a role in the noted lower marriage rate among women physicians. Some studies have found that certain specialties are characterized by a higher proportion of men and by lower marriage rates of the women in the specialty (e.g., Caniano, Sonnino, & Paolo, 2004; Kaplan et al., 1996). For example, surgery, academic medicine, or pediatric surgery tend to have higher proportions of men and lower marriages rates of women physicians compared to nonsurgical pediatrics, family medicine, or psychiatry, which tend to have higher proportions of women who are more likely to be married (Caniano, Sonnino, & Paolo, 2004; Kaplan et al., 1996).

Early studies documented high divorce rates among physicians and the perception was that these marriages were wrought with problems, including substance abuse or addition and mental health problems (e.g., Glick & Borus, 1984; Evans, 1965; Fabri et al., 1989; Gerber, 1983; Glick & Sargent, 1981; Krell & Miles, 1976; Lewis, 1965; Miles, Krell, & Lin, 1975; Robertson, 1986; Taylor, 1983; Vaillant, Sobowale, &

MacArthur, 1972; Vincent, 1985). However one study with a small sample size and unequal distribution among categories found no significant association between divorce and medical specialty, number of children, spouse's employment, or spouse's education (Garvey & Tuason, 1979). Given that these studies are all fairly dated, it is hard to know whether the findings are still relevant today.

Physician Spouse Characteristics

Most early research (1960's – 1980's) on the spouses of physicians tended to be on the wives of white male physicians, since most physicians were men and studies targeted male physicians. Samples of physician wives tended to include mostly those being treated for psychological or relationship issues due to convenience sampling reasons. A common view of physician wives that trended into the 1980's was that these women sacrificed and/or postponed their own careers and personal needs to help their husbands achieve and manage their professional and personal goals, often resulting in problems for themselves and the marriage (e.g., Gabbard & Menninger, 1988).

A study of the records of 50 wives of physicians being treated in a psychiatric hospital revealed that most of these women had been successful and bright in the early years of their marriages, even through the difficult years of their husbands' medical training, and it was only after their husband had become well-established that they developed illness (Evans, 1965). As they felt abandoned and neglected by their physician husband, and excluded from his professional life, many developed problems of depression, somatization, and addiction. Another study found that physician wives reported feeling overburdened by their mostly single-handed responsibility for home and childcare and had feelings of intense loneliness (Elliot, 1979). The descriptions of these

marriages seem to represent common depictions of issues of gendered power and marital equality well documented in the feminist literature. During this time period, there was very little, if any, research on the husbands of female physicians.

As more women became physicians, more studies included spouses of female physicians, and the most recent literature (1990's – 2000's) also includes studies of dual-physician and other dual-career marriages (e.g., Esmiol, 2011; Fider, 2011; Starner, 2010). More and more wives of male physicians have been employed outside of the home as professionals, sometimes as physicians however the majority remain as homemakers (Fabri et al., 1989; Gabbard, Menninger, & Coyne, 1987; Sobecks et al., 1999; Sotile & Sotile, 2004). Women physicians tend to be married to other professionals and especially other physicians more often than men physicians (Fider, 2011; Heins et al., 1979; Sobecks et al., 1999; Starner, 2010). Studies have noted that approximately 50% of women physicians tend to marry other physicians (Fletcher & Fletcher, 1993; Myers, 1984; Schroen, Brownstein, & Sheldon, 2004; Sobecks et al, 1999; Woodward, 2005), with the proportion of dual-physician marriages around 25% (e.g., Brotherton & LeBailly, 1993). As social norms and values become more egalitarian, the dual-physician marriage seems an interesting place to study men and women physicians' marriages in light of how they "do" gender, including issues of gendered power and marital equality. In a dual-physician marriage, all things being equal, for example, status, occupation, sometimes pay, etc., the one primary difference would be gender. Examining gendered power processes in the dual-physician marriage may prove especially interesting even as it is compared to a male physician marriage or female physician marriage.

Marital Quality, Problems and Satisfaction

Although the early studies on physician marriages reported low marital quality (e.g., Vaillant, 1972; Yandoli, 1989), later studies reported higher levels of marital satisfaction (e.g., Lewis, Barnhart, Nace, & Carson, 1993; Sotile & Sotile, 2004). This section will discuss the research pertaining mostly to problems in physician marriages and then turn to the research on marital satisfaction with an emphasis on gender differences.

Marital Distress and the Male Physician

Many of the early articles on physician marriages noted the relationship between the physician's (usually male) negative characteristics and marital distress (e.g., Gabbard, Menninger, & Coyne, 1987; Gabbard & Menninger, 1988; Gerber, 1983; Glick & Borus, 1984; Krell, & Lin, 1974; Krell & Miles, 1976; Lewis, 1965; Evans, 1965; Myers, 2004; Ricer, 1983; Robertson, 1986; Sargent, 1981; Taylor, 1983; Vincent, 1985). For example, Vincent (1985) described male physicians as being self-critical, critical of others, insecure, adopting an unemotional approach, having an excessive need to be valued, competitive, preferring the demands and rewards of professional life to those of family life, and having a high tolerance for delayed gratification, all of which proved to be problematic for achieving intimacy in marriage which requires emotional closeness and expressiveness. Similarly, Gabbard and Menninger (1988) described male physicians as being perfectionistic, having self-doubt, guilt, chronic emotional impoverishment, difficulty managing aggression and dependency, a limited capacity for emotional involvement, and using patient care to avoid marital demands and arguments as especially problematic for physician marriages.

The majority of these articles tended to acknowledge that the attitudes and interactional styles of these physicians were caused by personal characteristics as well as an effect of medical training that was adaptive and often required in the medical field but incompatible with the interactional styles required for satisfying marital and familial relationships. While physicians are encouraged to be authoritarian in their professional lives, spouses and children do not appreciate being treated like underlings, and their professional training to show detached concern, if carried into personal life, is not conducive to intimate relationships (Grant & Simpson, 1994).

In early research (1960 – 1980) the service ethic of the physician, that patients' needs took precedence over personal and family needs, was also punctuated in the literature as explaining conflict in physician marriages. This body of research depicted the male physician as working long hours that resulted in his lack of time with his spouse (e.g., Elliot, 1979; Evans, 1965; Linn, Yager, Cope, & Leake, 1985; McCue, 1982; Rhoads, 1977; Vincent, 1969, 1985). It was also thought that the physician was well intended, yet his identity was so closely tied to the world of medicine that those medical demands would inevitably take priority over familial demands (Ziegler, 1992).

In a study of physician wives from unhappy marriages who had been hospitalized for psychiatric illness, most described their husbands as cold, passive, stern, domineering, compulsive, and perfectionistic (Evans, 1965). Similarly, another study of physicians' wives described their husbands as emotionally detached, aloof, controlling, and rigid (Miles, Krell, & Lin, 1975). Finally, in a small study of ten physician couples in marital therapy, the authors found that the wife carried the emotional affect for them both, and they found the physicians to be obsessive, emotionally aloof, intellectualized, having a stronger commitment to work than to family or self; they frequently neglected their own

emotional problems, self-diagnosed, and self-treated with psychoactive drugs (Krell & Miles, 1976). Although these studies consisted of samples of people in psychotherapy and may not be representative of all physicians, they did represent the dominant discourse and prevailing attitudes around physician marriages during that time, and do seem to represent gendered power issues.

Marital Distress and the Female Physician

Similar to the early research into marriages of male physicians, many of the first articles examining the marriages of female physicians also explored and targeted personal attributes. For example, in a small sample of 16 female physicians in psychotherapy for marital problems, Myers (1984) described the common problem areas for women physicians as follows: work-family role strain, delayed help seeking, self-blaming attitude, ambiguity in self-image, passivity in communication with spouse, unmet needs of spouse, competitiveness, and intimacy-sexuality problems. Five married or divorced women physicians responded to Myers' article saying they had agreed, however added that a significant stressor unique to the female physician was that after a day of giving to patients, the male physician arrives home expecting to have his personal needs fulfilled, but the married female physician arrives home and is required by her family and herself to be a loving, supportive wife and mother. They felt that the resulting lack of time for themselves can lead to "dissatisfaction, depression, and a sense of futility" (McKay, Alboszta, Bingcang, Dickson, & Kraman, 1986, p. 114). In a later study, Myers (1986) found that a large proportion of women physicians reported that they and their partners had communication difficulties and insufficient time together, and that they argued over finances, work, and domestic responsibilities. Other problems of female physicians have

been that their marriages are particularly vulnerable to problems, including: society's unrealistic demands on female physicians, marital competition, managing children and household tasks, and self-image while balancing multiple roles (Segraves, Segraves, & Woods, 1987).

It seems that there is some overlap of problems in the marriages of male and female physicians, however there are differences that seem to be related specifically to gender issues. For example, women physicians describe role strain as particularly problematic for them especially when they have children (e.g., Myers, 1982). Similarly, during that time, role strain was seen as particularly problematic to professional women in general (e.g., Johnson & Johnson, 1976) whereas men's identities may be more tied to their career and thus the physician role takes precedence over others.

Marital Conflict

Studies on the marital quality of physician marriages began to shift away from the earlier ones that focused on the physicians' personality, to exploring situational sources of marital conflict. Researchers proposed that the stressful demands of medical practice coupled with long work hours were the source of strain in physician marriages (e.g., Sotile & Sotile, 2004). And others said it wasn't the long work hours that made for poor physician marriages, but rather relationship issues such as poor communication and intimacy within the marriage itself (e.g., Yandoli, 1989).

Studies seem to point to at least one critical point in the physician marriage: the period shortly following medical training. Studies have found that the physician marriage seems to be prone to breakdown in the period shortly following training, with divorce often occurring in the time period when the physician is establishing his or her

practice, rather than during one's training or later in one's career (Berman, Sacks, & Lief, 1975; Clements, 1981; Rosow & Rose, 1972). Physician divorce rates are highest when couples are in their mid-thirties to forties (Rosow & Rose, 1972; Vincent, 1985). Authors have used an "archetypal narrative" to depict this phenomenon that centered around the traditional marriage of a male physician (e.g., Edwards, 1986; Gabbard & Menninger, 1988; Glick & Borus, 1984; Robertson, 1986; Vincent, 1985). The narrative went as follows: when a male physician married his beloved wife sometime during medical school or residency, his wife decidedly carried the burden of family and home responsibilities, often postponing much personal and material gratification with the expectation that this was a temporary arrangement. The physician wife built high expectations for what would occur after training ended, for example, to have more time with her husband, to receive expected rewards, and to have a realignment of roles, however the problems arose when the physician's desire to build a professional practice directly followed the end of his training. At this point, the physician expected his wife to continue to run the family as he worked on his professional career. At this time, the physician wife found herself depressed and the marriage suffered from much conflict (Evans, 1965; Glick & Borus, 1984; Vincent, 1985) and to avoid conflict at home, the physician worked longer hours (Gabbard & Menninger, 1988). While this narrative represents the breakdown of the traditional male physician marriage of that particular time, there was no similar narrative on breakdown in the medical marriages of women or other couple types (e.g., gay, blended family, etc.) or on contemporary physician marriages.

Long work hours soon became a focus of study for the breakdown in physician marriages. Researchers proposed that the stressful demands of medical practice coupled

with long work hours were the main source of strain in physician marriages (e.g., Sotile & Sotile, 2004). However, the research shows a mixed picture when it comes to work hours with some studies finding no association with marital conflict or divorce (e.g., Garvey & Tuason, 1979). For example, in an exploratory study of 240 physician couples who attended a marriage workshop and were asked to rate in importance 15 proposed sources of marital conflict and 12 proposed problems perceived in his/her spouse, the number one ranked source of marital conflict for both physician and spouse was "lack of time for fun, family, and self" (Gabbard, Menninger & Coyne, 1987). The number two source of marital conflict for physicians was "amount of time away from home at work" which spouses ranked eighth, however physician spouses ranked "lack of intimacy" as second, which physicians ranked seventh. The number one ranked perceived problem in spouse by physicians was "is not interested in sexual activity," which spouses ranked ninth, and the number one ranked perceived problem in physician by spouses was "doesn't talk to me enough," which physicians ranked eighth.

The authors concluded that the physicians' complaint of insufficient time to attend to their own or their spouses' needs appeared to be more of an excuse for marital discord than a problem. They suggested physicians externalized problems within the marriage by blaming long work hours, a factor outside the marriage. They also claimed the causal direction was in the reverse: that working long hours reflected the physician's desire to avoid marital problems in a poor relationship. However, the rankings also seem to shed light on gender issues, especially around the wife's control over sexual activity and her desire for more communication.

Other issues of gender and power emerged in study findings. Glick and Borus (1984) conducted marital therapy with 13 male physicians and their wives and found

most marital conflict related to issues of role, status, power and priority. They found that rigidified role divisions of work and family created conflict especially when these roles became unsatisfying and there was little communication between partners to renegotiate. Power issues also emerged as being problematic, since the physician's high status in his profession and community was often in contrast to his wife's felt one-down position. The power issues started to manifest through the physician's flexibility and control over money and through the physician wife's influence in family relationships and the couple's sexual relationship.

Other problematic issues in physician marriages especially from the physician spouse perspective were documented in studies. Drawing on their experiences in counseling over 2500 physician couples, Talbott, Angres, Gallegos, Bettinardi-Angres, & Collins (1991) described common problems in physician marriages: physician spouses complained the physician was a workaholic, could talk about nothing but medicine, and that the activities and friends of the physician spouse seemed trivial compared to the physician's daily life and death struggles with patients. Physician wives have reported to feel overburdened by their almost single-handed responsibility for home and childcare, and experienced intense loneliness (Elliot, 1979).

Marital Satisfaction

Though studies on the problems in physician marriages are well documented, other studies indicate a more positive picture. Studies finding higher marital satisfaction in physician marriages seem to shed light on what makes a good physician marriage. For example, high levels of marital satisfaction are associated with emotional support for self and career (Spendlove, Reed, & Whitman, 1990; Warde, Moonsinghe, Allen, & Gelberg,

1999) high work satisfaction, low work stress, high family competence, and fewer psychological symptoms such as anxiety, depression, substance abuse, and social withdrawal (Lewis et al., 1993). Spendlove, Reed, & Whitman (1990) found that physician spouses scored higher than physicians in marital adjustment, and that female physicians scored higher than male physicians. Perceived personal and professional emotional support were the most important factors associated with marital adjustment. Mutual support for each other's careers (including homemaking) and hours spent alone together were identified as important predictors of positive marital adjustment (Spendlove, Reed, & Whitman, 1990). Time spent talking to each other also appears to be related to positive marital quality (Gabbard, Menninger, & Coyne, 1987).

Physicians' higher marital satisfaction was found to be associated with older age (over 48 years) (Lewis, Barnhart, Nace, Carson, & Howard, 1993; Warde, Moonsinghe, Allen, & Gelberg, 1999), fewer hours worked per week, and more vacation days per year, but not related to gender or income, and spouses' marital satisfaction was found to be related to physicians' work satisfaction, but not associated with age, gender, spouses' work hours, vacation time, or income (Lewis, Barnhart, Nace, & Carson, 1993). Although gender was not found to be associated with higher marital satisfaction in the above studies, other positive findings, such as mutual support for each other's careers including homemaking, perceived emotional support and time spent talking together were all important in creating a positive marital relationship for physicians and their spouses. Although not stated explicitly in these studies, these elements are all pieces of marital equality that have been shown in the feminist literature to generate mutually beneficial and positive marriages for both men and women. Given that they have been identified

briefly in these studies, a further deeper analysis of these issues would prove beneficial to understand how physician couples attain these qualities in the face of unique challenges.

One significant gender difference does exist in the marital satisfaction studies. Marital satisfaction appears to not be related to number of hours worked, but rather to the intervening variable of role conflict, with women more likely than men to experience moderate to high levels of role conflict (Warde, Moonsinghe, Allen, & Gelberg, 1999). Women physicians appear to experience more stress and strain than men physicians related to the demands of their career and family responsibilities (Bowman & Allen, 1990; Straechley & Longo, 2006). This may help to explain why no gender differences existed between men and women physicians who reported similarly high levels of marital satisfaction, on average; however, household help was employed more often by women physicians than men physicians and there was no association between household help and marital satisfaction (Grant & Simpson, 1994). Additionally, female physicians in dual-physician marriages tend to have primary or equal responsibility in the care of their children (Sobecks, et al., 1999). Role conflict experienced by female physicians seems mostly related to the unfair unequal burden of responsibility for both the home and paid work, something physician men have allocated to a stay at home wife. However there are also gendered issues pertaining to the physician wife.

In a study of physician wives, Sotile & Sotile (2004) found that higher marital adjustment was associated with higher age of oldest child, fewer husbands' work hours, more time spent together, and wives' work outside the home, whereas lower marital satisfaction was associated with her husband being irritable or tired from work, his un-ableness to do the things she would like, and too little involvement in family life. Her degree of work/family conflict and the degree to which she felt she had sacrificed her

own career for the sake of family or her husband's career was also associated with declining marital satisfaction (Sotile & Sotile, 2004).

Loma Linda University Physician Family Study

Given that the extant of the literature on physician marriages and families is dated and it is hard to know whether these early studies are still relevant today, the Loma Linda University Department of Counseling and Family Sciences developed a qualitative research study of physicians and their spouses in an effort to fill this gap. While the data have not yet been analyzed from a social constructionist, critical theory feminist lens, and gender, power and marital equality have not been exclusively examined, some interesting gendered findings have been noted in other study results.

Gendered Findings

Starner (2010) examined the stressors and coping strategies of married female physicians (n=27) from a structural functionalism theoretical perspective. Two main categories, system challenge and system adaptation emerged, with work demands, home demands, childcare demands, self-imposed demands, reaching out and reaching in as subcategories. Starner found that female physicians do the majority of caretaking for their children, child-planning, and household tasks like dinner, and also have self-imposed and socially imposed traditional roles as home-maker in addition to their professional roles. She was, "surprised that female physicians, who have broken the societal molds in many ways, are still steeped in traditional gender expectations" (p. 98).

Clarke (2011) used a family systems theoretical perspective to examine the experiences of married minority female physicians (n=21) in order to understand how

they manage work and family, with a focus on how gender and race impact their experiences of these roles and responsibilities. The resulting grounded theory of the Work-Family Accommodation model included six categories: work demands, multiple role demands, role expectations, motherhood guilt, couple nurture, and accommodation. Motherhood guilt was defined as the guilt that these physician mothers felt about not having more time for their children. Couple nurture referred to how participants made time for the couple dyad in the presence of work demands and multiple role demands. Accommodation referred to the family and/or physician making adjustments with work demands to allow for family time. The gendered findings noted in this study included motherhood guilt, some husbands taking on the primary role of caretaking (accommodation), and self-imposed gender role expectations of the women. The author noted it was the competing roles of physician and mother that often lead to these women experiencing guilt. These finding emerged out of 21 interviews of minority female physicians, and only 7 in which her spouse was also present for the interview. The author noted a future need to use more family or dyadic data, instead of the physician as key informant (single unit of analysis).

Fider (2011) examined how dual career couples in which one spouse is a physician managed their role expectations and demands at home and at work from a structural functionalist theoretical perspective. The resulting grounded theory of couples' ability to navigate two careers included one main category of the couples' ability to put the physician career first (regardless of gender), with three subcategories of familial support, non-traditional parenting and domestic roles, and paid help. While gender was not a specific area of focus, some gendered findings emerged: the career that was always placed first was that of the medical doctor regardless of physician gender; couples were

willing to adopt more fluid domestic roles and female physicians more than their male counterparts were the one who would be catered *towards*; and couples could adopt non-traditional roles. While these findings are interesting, there were no data provided on the number of male versus female physicians in the analysis, and it was a somewhat small sample size (n=15). For example, only 5 out of the 15 quotes used in the results section came from male physicians and/or their spouses. It seems there may have been an oversampling of female physicians for this study, which could have contributed to more "gender neutral" or gender "non-traditional" results. The author also states that, "It must be understood that the non-traditional roles that these couples adopted was not the cure to their dilemma, but it certainly did assist in making the challenges more manageable" though there was not further explanation of what this meant. The author also raises the question (as a limitation) of whether putting the medical career first is an expression of how the medical profession is viewed in the larger social context or the result of the personalities of *female* physician spouses.

Esmiol (2011) used a relational feminist perspective (Fishbane, 2007; Knudson-Martin & Mahoney, 2009) in tandem with grounded theory to examine how marital experience and spirituality interact in the lives of physician couples. Results indicated that gender and power seemed to affect couples' experiences with God and their spouse. Egalitarian couples with non-gendered power-sharing interactions perceived God and their spouse as caring, and had more intimacy as well as bi-directional communication. Male-dominated power-imbalanced couples perceived God and their spouses as critical, related to their spouses and God in dutiful ways, and communication was more unilateral. Couples seemed to structure their relationships around either male-dominated or non-gendered patterns of interaction yet none of these couples described female-dominated

relationships. Physician couples' non-gendered, relationship-oriented, power-sharing ways of engaging with their spouse carried over to their spirituality and enabled a more intimate experience with God. These findings suggest that egalitarian, relational patterns of interaction may actually foster a more relationship-friendly spirituality, however the analysis was limited to using only couple interviews, and not those in which the physician was interviewed alone as key informant.

Zinke (2012) used social exchange theory coupled with constructivist grounded theory to examine the experiences of dual physician couples as they negotiate multiple work and family roles. Four themes emerged: a struggle for what is important, empathy, giving license to work, and comparing themselves to each other. This study found that dual physician couples juggled the competing demands of children, spouse and work, in an effort to reach the most optimal balance for themselves and their families. They often organized their lives around their children, and favored spending time with their children over their career advancement. Framed by the author as a way to reduce costs to their relationship and family life, these dual physician couples established non-traditional roles to complete household and childcare tasks. It was noted that these couples sometimes started out with traditional roles but later changed these roles out of a need to be practical. The study found that although couples appeared to talk as if they were fairly equal, women physicians still were more likely to work part time and spend more time on household and childcare tasks, so it was "difficult to call this equality" (p. 82). The author notes that these dual physician couples have a combination of traditional and non-traditional gender roles: "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 children" (p. 88-89). Therefore, "confusing exchanges" occur throughout their relationship. While this analysis provides interesting data on gendered patterns in these couples, it was focused solely on dual-physician couples, and did not include any breakdown of couples in which she did not cut back her work hours or in which they did not resort back to traditional gender norms.

The few studies that have emerged from the Physician Family research project at Loma Linda University do provide good reason for a critical theory feminist lens to be applied to the data with a purposeful examination of gender, power and equality issues in these marriages. While gender issues have been noted in these previous studies this dissertation project aims to build upon these findings to provide deeper analysis of the issues.

Feminism and Studies of Relationship Equality and Power

Although studies of marital equality in the physician literature are scarce, feminists have been studying issues of power in other clinical and non-clinical couples for many years (Lyness & Lyness, 2007). Conceptualizations of relationship equality have evolved over several decades of research and though there is little consensus to a set definition, most share similar ideals. Some of the first studies highlighted the organization of relationships around male power and ideas of traditional versus non-traditional types of couples (e.g., Gilbert, 1985; Peplau, 1983). Follow-up studies were done from the perspectives of equality as fair exchange, balance of power, sharing household labor and child care, equal status and shared decision-making (e.g., Deutsch, 1999; Dienhart, 1998; Risman, 1998; Schwartz, 1994). Inequality was highlighted by a

women's disproportionate investment in the work of the home (e.g., Ferree, 1991; Nyquist, Slivken, Spence, & Helmreich, 1985; Pleck, 1985) and less say in decision making relative to that of her husband's (e.g., Blumstein & Schwartz, 1983). More recently, studies of equality have addressed emotional and organizational labor (e.g., Zimmerman, Haddock, Ziemba, & Rust, 2001); and couple processes, such as attuned responsiveness, validation, accommodation, and adjusting the self in order to promote the relationship (e.g., Greenberg & Golden, 2008; Siegel, 2007; Knudson-Martin & Mahoney, 2009).

The most recent conceptualization of relationship equality has been that of Mahoney & Knudson-Martin (2009) and espouses that partners hold equal status, accommodation and attention to the other in the relationship is mutual, each spouse has roughly the same capacity to get the other to cooperate in order to allow the attainment of his/her goals, and the well-being (both short and long-term) of partners is mutually supported. Going beyond simple measurement of "who does what," "who has the final say" and "who has more resources," this definition appears to be more comprehensive and attempts to get at gendered power practices that underlie relationships and impact how couples interact with each other in powerful or powerless ways. Equality is viewed as multi-dimensional, comprising attitudinal, behavioral, and process components (Steil, 1997). Researchers have applied this framework in a variety of heterosexual couples studies, including, African American couples (Cowdery, Scarborough, Lewis & Seshadri, 2009), immigrant couples (Maciel, Van Putten, & Knudson-Martin, 2009), Iranian couples (Moghadam & Knudson-Martin, 2009), how couples construct motherhood (Cowdery, Knudson-Martin, & Mahoney, 2009), dual-career Singaporian couples (Quek,

2009), diabetic couples (Knudson-Martin, 2009), and gay and lesbian couples in committed relationships (Jonathan & Knudson-Martin, 2009).

Marital Equality and Relationship Outcomes

Scholars have consistently found that relationship equality (e.g., shared power, decision-making, and household and child-rearing tasks) is associated with higher levels of relationship satisfaction, commitment, and emotional well-being for married women (Gottman & Silver, 1999; Moller, Hwang, & Wickberg, 2008; Steil, 1997; Whisman & Jacobson, 1989, 1990; Zimmerman, 2000) and marital inequality appears to be associated with increased levels of depressive symptoms in married women (Steil, 1997; Whisman & Jacobson, 1989). In particular, feminist research has found that women's rates of depression are highly associated with whether or not childcare tasks are shared (Lennon, 1996; McGrath, Keita, Strickland, & Russo, 1990). A number of studies have shown that women in dual earner households continue to do the majority of housework and maintain overall responsibility for household management and childcare (e.g., Coltrane, 2000; Jacobs & Gerson, 2004; Zimmerman, Hadock, Ziemba & Rust, 2001) and even in households where participants consider themselves egalitarian and rejecting of traditional ideals (e.g., Blasure & Allen, 1995; Knudson-Martin & Mahoney, 2009).

Evidence suggests that equality contributes to relationship success (Amato, Johnson, Booth, & Rogers, 2003; Gottman, Coan, Carrere, & Swanson, 1998). In their analysis of a national probability sample in the US, Amato et al. (2003) found that equal decision-making was a critical factor in explaining relationship stability. Gottman et al. 1998 found that male willingness to be influenced was highly predictive of marital

success. Marital inequality negatively impacts overall couple satisfaction as well as male partners' relationship satisfaction (Gray-Little et al., 1996; Whisman & Jacobson, 1990).

Early studies suggest that some married couples are able to create equal relationships (Blaisure & Allen, 1995; Deutsch, 1999; Risman, 1998; Schwartz, 1994). According to earlier scholars, the likelihood of marital equality increased when wives had equal or higher education, income, and status (Jump & Haas, 1987; Perry-Jenkins & Crouter, 1990). More recent scholars suggest open negotiation, assertive expression of each partner's opinion and the ability to address conflicts are central to couples successfully attaining equality (Knudson-Martin & Mahoney, 1998; 2005). In a study of African American couples facing external obstacles and challenges, Cowdery et al. (2009) found that couples suspended idealized gender roles and achieved equality due to a practical concern that everyone needed to pitch in to do what was necessary for the good of the family.

Conclusion

The research on physician marriages seems ready to bridge with the gendered power and marital equality literature for several reasons. Gender differences have been highlighted and discussed in study findings, yet there is little explanation given as to why the differences exist, what should be done about them, or how couples have overcome them. The research on physician marriages is mixed, with early studies somewhat qualitative in nature, but only focused on describing the experiences of male physicians and their spouses, and later studies are mostly quantitative in nature, with no in-depth description of female (or contemporary male) physician experiences or their spouses' experiences. While it is interesting that research has found gender differences through

quantitative analysis, a qualitative analysis would prove helpful to truly understanding the experiences and meanings contemporary physician couples make of their marital and familial challenges, especially with regards to the gender differences. Finally, many of the gender differences found in the physician marriage literature have been found and understood in the marital equality literature as gendered power processes, and therefore using a gendered power and marital equality framework to analyze and interpret some of these findings in physician marriages would prove helpful in furthering the understanding and meaning of these results.

CHAPTER 4

METHODS

This dissertation project aims to develop grounded theory regarding gendered power and marital equality in a sample of physician couples. The project will use data already collected from a qualitative methodological design. A social constructionist critical feminist lens will be guiding the methodological procedure and analysis. In this section, I will first present background on the Parent Study, the Loma Linda University Physician Family Study, and then I will discuss the qualitative grounded theory approach I will be using for data analysis. I will follow this discussion with issues of methodological rigor, such as validity, reliability, generalizability and trustworthiness. I will conclude with making my background and assumptions explicit, following true social constructionist form, since I am considered an integral part of the data collection and creation process, as well as limitations for the study.

Parent Study

This dissertation study is part of a larger ongoing study of physician families conducted by the Loma Linda University Department of Counseling and Family Sciences. Within the contexts of professional families and medical professionals, the goal of this larger study is to better understand the unique experiences within physician family life, including physician marital life, family life, stressors, spirituality, and gender issues. The parent study has been ongoing since 2008, and has been approved by the Institutional Review Board (IRB) at Loma Linda University. The study has the intention of being a mixed method design, and has nearly completed its first phase, a qualitative phase. Qualitative methodologies and analytic approaches are often used to study

relational phenomena grounded in the lived experience of people, often exploring behaviors, emotions, experiences, feelings, and cultural and societal phenomena (Marshall & Rossman, 1999). Qualitative research designs and analyses are unique in that they depend on the use of a set of procedures that are open-ended and rigorous, that do justice to the complexity of the social setting that is under study, and look at the complexities of social interactions and the meanings that participants attribute to these interactions (Janesick, 2003). This dissertation aims to make a unique contribution within this larger study by analyzing data already collected with a focus on issues of gendered power and marital equality in physician couples.

Research Team

The Physician Family Study research team consists of 3 faculty and 8 doctoral students. One faculty was a physician from the Medical School, and the other two faculty and students were from the Department of Counseling and Family Science. All researchers had completed the U.S. Department of Health and Human Services', "Human Participant Protections and Education for Research Teams" certification. The doctoral student researchers all had previously taken graduate level classes on qualitative research methods and received additional training related to qualitative research specific to this project. The Physician Family research team met weekly throughout the entire process, to discuss review of the literature, to develop the demographic questionnaire, to develop the qualitative interview questions, for initial data analysis and coding, for interview questionnaire revisions, and for presentation of final results. Each team member contributed their own area of interest to the project, for example, since I was interested in issues of gender, power and equality, as well as parenting, I contributed to the project by

reviewing the literature on these issues, and created qualitative and demographic questions around these issues. Other team members contributed in identical ways for different topics, such as minority physician, dual physician marriages, spirituality, stress, and female physicians. Throughout the data collection and analysis process, the research team met to compare and discuss the coding and categories that were emerging and when necessary, made revisions to the interview guide as new categories emerged.

Interview Guide

The interview guide is structured to ask physician couples about their lives together, for example, how they share household responsibilities, how much time they spend together or apart, etc. (see Appendix C for a copy of the interview guide). Questions were created based on each research member's area of interest, and questions were revised and edited by the group as a whole, and especially if participants felt a question was difficult to answer or needed more clarity.

Participants and Inclusion Criteria

Participants for the parent study included adult medical doctors aged 21 and older who had at least one year of residency and who were married at least two years. Participants had to have been married for at least two years to avoid the 'honeymoon effect' in which newlyweds may display different relationship dynamics (Carrere et al., 2000; Strong, DeVault & Cohen, 2011). While the study aimed at having both the physician and his or her spouse participate, in cases where the spouse could not be present, the physician was interviewed alone, as the key informant.

Sampling and Recruitment

A purposive snowball sampling technique was used in this study. The research team faculty member from the medical school provided the research team with a master list of physician names and phone numbers to call regarding participation in the study. This master list was divided between team members at random. Participants were also recruited by fliers posted in medical centers and through 'word-of-mouth' and referrals from participants at the end of their interview. In recruitment, the interview was described as an invitation for couples to 'share their stories' about their 'marriages and family lives.' At the end of the interview, participants were asked if they could refer other physicians to participate in the study.

In the qualitative analytic approach, sample size is determined by reaching saturation (Strauss & Corbin, 1998). Therefore, sampling continued until the data being gathered, analyzed, and placed into categories appeared to be showing no additional new information and it could be assumed saturation had been met (Strauss & Corbin, 1998). For example, when the responses of participants were well-varied and the categories seemed to be well established, theoretical saturation was achieved and the resulting theory is assumed to be precise and evenly developed (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

Data Collection Methods

Participants were contacted by members of the research team and once they verbally agreed to participate, the researcher scheduled the interview at a place of convenience for the physician and his or her spouse. Interviews often took place in participants' homes or offices. During the interview process, the researcher first

reviewed informed consent and had participants sign a consent form (see Appendix B). During the informed consent process, participants were informed that their participation in this study was strictly voluntary and they may chose to withdraw their participation at any point during the interview. They were also informed that if they experienced any discomfort as sensitive topics were discussed, they could skip the question. Interviewers were prepared to supply three referrals to family therapists or counseling centers if requested by participants.

After informed consent was obtained, participants completed a short informative demographic form (see appendix A) before completing their qualitative interviews (see appendix C). The interviews were semi-structured and included numerous probes to ensure more detailed responses. Participants were able to speak in detail about their experiences as the interview guide provided direction on conversational threads. Interviews lasted approximately 60-90 minutes. Interviewers kept analytic memos, so that they documented what they saw or experienced during the interview that could not be captured in the audio-recording, for example, participant body language. The qualitative interviews were audio-recorded and transcribed. Participant identifying information was removed from the transcripts, and each participant received a de-identified number. Electronic transcriptions of the interviews are stored on a secured server on the University campus and in a secured locked computer in the department Research Building. Tape recordings and physical records are stored in a locked filing cabinet in the Research Building.

Sample

This study will use all available data from the parent study. This includes 36

interviews, of which 9 are male physicians married to non-physician spouses, 18 female physicians married to non-physician spouses, and 9 physicians married to other physicians. The final sample is 66.2% female and 33.8% male of which 93.9% are in their first marriage compared to 6.1% who are in a second marriage. Participants are 8.1% Asian, 51.0% Black or African American, 4.1% East Indian, 8.2% Hispanic or Latino, and 28.6% Caucasian. Religiosity of the sample is as follows: 2.0% Baptist, 6.1% Catholic, 4.1% Christian, 4.1% Hindu, 2.0% Lutheran, 73.5% Seventh Day Adventist and 8.1% are not religious. The majority of the sample fell into the age range of 28-38 (40.8%), followed by 50-66 (30.6%), 40-49 (26.5%), and 67 and older (2.1%) (see Appendix D for additional demographic information).

Data Analysis

The qualitative data analysis will follow a constant-comparison approach to the development of grounded theory (Corbin & Strauss, 2008). In this methodology, the researcher follows a systematic process to analyze the data, and theory is developed out of the participants' experience through repeated observations of the realities found in the data (Charmaz, 2006). Grounded theory emerges from a three-step process: line-by-line open coding, axial coding, and theory building.

Line-by-Line Open Coding

Grounded theory begins with line-by-line open coding with no predetermined codes; rather data is taken in its raw form and analyzed on its characteristics or traits (Corbin & Strauss, 2008). Each line of the interview is reviewed and coded or given a name that describes what is happening, making note of repeated phrases, words or

examples used by participants. Similar phenomena will be given the same code, and when new data do not fit those responses already identified, new categories will be created. For example, if a participant answered a question regarding time spent together by stating, "We never spend time together, his job always comes first," the phrase, "never spend time together" may be labeled "no time together" and the phrase "his job always come first" may be labeled "work is prioritized over relationship." The focus of this level of analysis is to carefully label through coding what participants are saying, or to put an initial name to the participants' words.

To ensure that coding is contextually accurate, the analysis should keep in mind the meaning and context of what participants say. Line by line open coding should begin without any predetermined codes; however coding will be based on theoretical sensitivity to previous analyses in the larger study and the critical feminist lens that guides this study. Therefore, some of the same codes that have emerged in other studies may be used if they emerge as relevant. For example, in Clarke (2011), the code of "Motherhood Guilt" was used, and may be used in this study if relevant.

Axial Coding

Line-by-line coding is followed by axial coding, which organizes or groups the codes into more abstract categories, and relates concepts or categories together (Corbin & Strauss, 2008). Axial coding looks for the range or the variability in responses and is the process of trying to piece together data that was broken apart during open coding (Corbin & Strauss). During this step in the analysis, the researcher is constantly comparing the codes with the transcripts to make sure the voice of the participants is accurate with the researchers' interpretation of their responses and makes sense in relation to the overall

interview. The researcher is seeking a deeper level of analysis and identifying relationships between the codes and categories that were identified in line-by-line coding (Corbin & Strauss). It is a move from "text" to "concepts" that are emerging from the data. For example, if a participant's response to a question on household duties was, "My job as a wife is to take care of all the household chores" and was coded in the line by line coding phase as "wife's job is household chores," in the axial coding, this may be linked to a broader concept as "traditional role" or "gender stereotype" or "social discourse." Forming a category to conceptually explain the participant's response allows for a deeper understanding and furthers a theoretical understanding of what is occurring.

Theory Building

The final level of analysis, theory building (Corbin & Strauss, 2008) or selective coding (Daly, 2007) considers how the identified categories are linked together to explain the larger phenomena under study. In this study, I will be seeking to explain gendered power and marital equality in physician marriages. An outcome of this process is the development of a central theme around which the other codes are organized, resulting in theory. In general, analysis moves from simple categorization to determining how the categories are related to each other. Hypotheses from one case are brought to another to see in what ways they do or do not explain the next case. No attempt is made to generalize in the statistical sense.

Issues of Validity, Reliability, and Trustworthiness

Issues of validity, reliability, and trustworthiness in qualitative research center around descriptive precision, and how well the results fit the experiences, meanings, and

understandings of the participants in a particular context (Corbin & Strauss, 2008; Daly, 2007). Replicating a qualitative study is sometimes impossible and usually difficult because the data are situated richly within a particular context (Morse & Richards, 2002). The cornerstone of qualitative research is the rich descriptions of the persons, places, phenomena under study and validity refers to whether the explanation is credible within these contexts (Janesick, 2003). Therefore, qualitative researchers generally replace traditional concepts of reliability and validity for trustworthiness and dependability, with an emphasis on credibility of the inquiry and dependability of the results (Lincoln & Guba, 2003).

Morse & Richards (2002) outline a 4-fold process to ensure validity and reliability in qualitative research: 1) the researcher should be appropriately prepared as an instrument in the process; 2) the researcher should possess an appropriate view of the literature – knows what is known, recognizes the findings in the field, doesn't manipulate the data to fit the theory, and brackets knowledge about the subject matter; 3) the researcher should think qualitatively while thinking inductively by asking analytic questions, challenging assumptions and making the implicit overt; and 4) the use appropriate methods and design.

The use of triangulation ensures trustworthiness and dependability of research findings in qualitative research (Creswell, 2003; Daly, 2007; Janesick, 2003). There are four main ways to achieve triangulation: 1) obtain a variety of data sources; 2) use different researchers or evaluators; 3) use multiple perspectives to interpret the data; and 4) use multiple methods to study a single problem. Crystallization is another form of triangulation that incorporates the use of other disciplines, such as art, sociology, history, dance, medicine in the process (Janesick, 2003). Credibility can be achieved by

examining the credibility of the procedures used in a study, including how the researcher takes notice of the ways data are created and analyzed, and the processes through which evolving hypotheses are questioned and verified in the data (Daly, 2007).

This study will incorporate several of the aforementioned forms of triangulation. For example, the project used a variety of researchers during the entire process from the beginning stages of project development to the final stages of data analysis and presentation of results. The research team consisted of 8 doctoral student researchers, 2 doctoral professors within the Department of Counseling and Family Sciences, and 1 medical doctor within the School of Medicine. Multiple perspectives were used to interpret research findings of previous studies (Clarke, 2011; Esmiol, 2011; Fider, 2011; Starner, 2010) and will continue to be used during this study. For example, the research team continued to meet and discuss the emerging categories during the analysis of other studies (e.g., Clarke, 2011; Esmiol, 2011; Fider, 2011; Starner, 2010). This dissertation study will use multiple perspectives to interpret the data, since along with the primary researcher, the dissertation chair(s) and committee member(s) will also be looking at the findings, allowing for different questions to be raised, as well as different perspectives and interpretations to be offered. By incorporating triangulation throughout the entire research process from development to analysis, results are expected to generate a fuller picture and strengthen the study's credibility and trustworthiness.

Generalizability

Generalizability refers to the "predictive" ability to explain what might happen in given situations (Strauss & Corbin, 1998). Qualitative research takes a cautious approach to generalizability since it focuses mainly on the social representations of the data instead

of the statistical representations found in quantitative approaches (Daly, 2007). Generalizability has the potential to do damage to the individual in the social context where people live and struggle (Janesick, 2003). For example, many of the limitations noted in recent studies published from the Loma Linda University Physician Family Study have cautioned that the samples of physicians have been primarily recruited from Southern California and from a religious medical facility (e.g., Clarke, 2011; Esmiol, 2011; Fider, 2011; Starner, 2010). One should use caution therefore in generalizing the findings to all physicians, or physicians who do not have a religious background, or who do not reside in Southern California. Whereas quantitative research studies samples to make generalizations about larger populations, qualitative research studies brings to light the processes of society and the self or identifies regular phenomena of an experience (Daly, 2007).

Researcher as Instrument

From a social constructionist viewpoint, research is an interactive process between the participants and researchers, and the researcher is not an objective bystander in the research process (Corbin & Strauss, 2008; Daly, 2007). Data are co-constructed between the researcher and participants. Because of this intimate connection, the researcher does not pretend to avoid bias, but rather makes their biases known by being transparent about one's own thoughts, feelings, values, experiences, assumptions, etc. they may have about the population being studied or how these may impact the study in general (Denzin & Lincoln, 2003; Flick, 2006; Lincoln & Guba, 2003). Some practical ways to make biases transparent are to document with analytic memos, one's thoughts, feelings, or reflections, during the entire research process and throughout the data

analysis. Another means is to make present a researcher's background and experiences that may influence her interest and interpretation of the data.

Researcher's Background and Personal Experiences

Being transparent about one's background, experiences, values and/or biases is an essential part of ensuring credibility and trustworthiness in a social constructionist qualitative study (Denzin & Lincoln, 2003; Flick, 2006; Lincoln & Guba, 2003). In this section, I will discuss my personal upbringing and life experiences that cause me to have a particular interest in gender, power and marital equality issues. By being open and reflecting upon my life experiences, I am hoping to bring more credibility and trustworthiness to the study, and an understanding of how these things may influence the research process.

I am a single Caucasian woman in her early 30's. I was born and raised in a suburb of Detroit, Michigan and lived there until I left for college at age 18. I came to California for college and have resided and worked in California ever since. I was raised in a middle class family, with two professional working parents, and a sister who is one year older. I have attended church and private religious schools from kindergarten through my doctoral studies.

My mother felt it was important to raise my sister and I to be very independent and by age 11 they had sent us traveling on our own with church groups to do mission work in other countries. I continued to travel to different countries through college on missions work with churches and other religious organizations. She also encouraged us to experience most sports and in my younger years she enrolled us in tap, jazz, dance, ballet, t-ball, swimming, gymnastics and skiing, and in junior high and high school I played

softball, tennis, basketball, cross-country running, and continued to ski and swim on a national competition league. I was always the team captain or co-captain of my high school softball and basketball teams. She also felt it was important to develop our music and art skills, so I played the saxophone and piano since elementary school through high school, and had attended art classes at various prestigious art institutes in Detroit and the surrounding suburbs.

My parents were very influential in my life, in particular to how they negotiated their "gender" roles. My father started off teaching high school in Detroit and later earned his CPA. My mother started off teaching special education for the severely mentally handicapped, and later became the principal of various "at-risk" elementary schools in Detroit and the surrounding areas. My dad settled into a CPA position with a company in Bloomfield Hills, Michigan and stayed there for around 30 years, whereas my mom has had a career of going into failing schools every 1-2 years, turning them around, and then moving on to the next school. She continues to do consulting work for Detroit Schools in her retirement.

My parents didn't seem to organize the family or household tasks around any traditional or set gender roles or expectations, although a few remained. For example, my dad always drove us to school and if we were sick and needed to come home, he would come pick us up. This was primarily because my mother worked farther away, and my dad's office was closer to our school. His boss often made comments to him about that being a "wife or mother's job" not his. We learned later that his boss was jealous of the close relationship my dad had with us. My mom seemed to "wear the pants" in the family, and had no problem expressing or voicing her feelings or thoughts – even if it was at our expense. My dad was more quiet, reserved, sensitive, nurturing,

although he didn't always "step-up" to help out or take initiative, he always just did whatever my mom told him to do. My mom always felt he was incapable of "thinking on his own" or "figuring things out" and that the burden always fell on her. My mom always deferred to my dad regarding the finances, yet it was important to her that she work, so that she had her own money to spend, since she grew up with very little. It seemed that although my parents had broken the mold in some gender stereotypes, there were still others that remained.

We were not raised according to gender stereotypes around being girly, or dressing "pretty," rather my mom was more practical with us. For example, because we swam competitively from age 8-16, we had short hair cuts like boys sometimes, whereas other girls our age had beautiful long hair. We often competed against boys in our swimming, skiing, and tennis. I never remember feeling like I ever had to impress a boy or change who I was for a boy, or that a boy was better than me.

Being raised in a dual-career family was exciting for me. I was proud of my mom for the work she was doing and the example or role model she was to me. My sister preferred a more traditional family, where the mom stayed home, which interestingly, is how she is organizing her own family now. I prefer to work and have independence and a strong voice. In fact, people have told me in the past that they don't expect to see such an independent voice from such a petite pretty girl. I have felt like in my early 20's I was somewhat intimidating to boys because they were not used to such a strong girl. I tend to agree more with the social construction idea of gender – that who we are as boys, girls, men, and women has more to do with how parents "do" gender with their children, and how spouses "do" gender with each other, and how society "does" gender with us.

In summary, the attitudes, values, and experiences I grew up with influence how I interact in my personal life and view the world. My upbringing and life experiences influence my interest in this research topic and I remain curious about how and why couples "do" gender in the ways that they do. Making my background transparent will help me be more reflexive during my analysis and ensure that I am bringing the participant's voices to the forefront. This awareness of making my biases transparent will help to increase the study reliability, validity, and transferability.

Limitations

This study is limited in that it is examining gender, power, and equality in the marriages of a small sample of physicians. This study had a high percentage of minority participants, and most participants were from a localized community in Southern California. Thus, the experiences of these physicians in this particular ethnic and geographical context may not transfer to physicians in other settings. Given the high percentage of minority participants, future studies should examine the intersections of ethnicity and racial status with gender. The cross-sectional design is only able to offer perspectives about what is occurring at one point in time, and it only provides retrospective, limited access to participant's long-term, evolving thinking over multiple years. The snowball sampling technique employed in this study may have provided a relatively homogenous sample, and a more varied sample in future work might provide a greater variety of perspectives. Additionally, triangulating the participants' perspectives with the results from a focus group could improve reliability and validity of the results.

Implications

This study has several significant contributions to make in the areas of theory, research, and practice. It builds upon previous literature in all three areas and expands the existing studies as discussed below. One paper will be written from this dissertation, focused on the results from the qualitative analysis that is expected to make theoretical and clinical contributions, as well as indicate future areas of research.

Theoretical

This project will expand the current theory in both the physician marriage and relationship equality bodies of literature and hopefully be one of the first to demonstrate a link between the two. In general, there is limited systemic theory in physician family literature. Most research in this area that has illuminated gender issues in physician marriages has been quantitative, or if qualitative, is earlier research and limited in only focusing on male physician marriages. Among other things, results from this study should generate theory around how physicians overcome gendered power issues, or whether or not they are able (and how) to establish more equal marital relationships. Conceptual models in the physician marriage literature have paid little attention as to whether couple power processes influence the physician marriage. Additionally, this project will contribute to theory development within the relationship equality literature by studying gendered power and relationship equality within a new population, physicians and their spouses.

Clinical

By understanding the experiences and processes underlying physician marriages,

clinicians will be better able to assist these couples in achieving desired marital outcomes. For example, clinicians should be able to identify those beliefs, or interactions that inhibit or prevent couples from achieving their desired relationships, and help them overcome these limitations. By examining gender, power and equality processes in the couple relationship, results can inform treatment interventions.

Research

The final area of contribution is in the area of research. This study will first contribute to the established research on physician marriage research by making a current or contemporary contribution that focuses on male and female physician marriages. Since most current research on physician marriages has tended to be quantitative, this qualitative study should help explain the experiences and meanings around some of the gender differences that have been found. Finally, after understanding the experiences of physicians in their marriages around issues of gendered power and marital equality, direction for future studies is indicated. For the marital equality literature, this study will expand research in this area by exploring an important sample of physician couples that may also be representative of professional couples in general.

CHAPTER 5

PHYSICIAN COUPLES:

A QUALITATIVE INQUIRY FOCUSED ON GENDERED POWER AND MARITAL EQUALITY

Abstract

How couples "do" gender and power in their marriages is a relevant topic for today's couples. Despite social changes toward equality in many realms, gender continues to organize relationships in ways that give husbands more power than wives. However, some contemporary couples make conscious decisions to resist forces toward organizing according to stereotypical gender ideals and to "do" gender differently in their relationships. For couples in which one or both is a physician, power is also deeply embedded in the physician status, with families tending to organize around the physician's demands. While these effects reinforce male dominance when the husband is the physician, they pull opposingly when the wife is the physician, which is increasingly common as greater numbers of women enter the medical profession. We do not know how forces of gender and physician status interplay and play out in physician marriages. This qualitative study uses a social constructionist feminist theoretical lens to examine data from 36 physician interviews to explore how gender and power organize physician family life. Using a grounded theory approach, we found that couples' "undoing" gender was a core category around which three couple types emerged: traditional, gender-conflicted, and de-gendering. How couples manage gender and power depends on whether they continually counteract stereotypic gender roles, particularly by un-gendering their interactions. Among the couples in this study, even the most egalitarian

ones, gender never gets completely undone; there are no cases in which women gain the kind of organizing power that men have.

Introduction

Interest in how the partners in a physician marriage coordinate their careers and private lives has been increasing over the past few years, sparked by trends of more women entering the profession, more women working in general, and the rise of dual-career families. At the same time, gender and power have been cited as forces that continue to define couple relationships (Coontz, 2005; Knudson-Martin & Mahoney, 2009b; Sullivan, 2006) and have strong implications for husbands' and wives' ability to pursue professional goals, responsibility to attend to the demands of family life, and marital satisfaction in general. The study of how physician couples organize their family lives in relation to the status accorded the physician role and increasingly egalitarian gender ideals (Sullivan) offers an opportunity to examine the nuances and potential transformation of gendered power in heterosexual couple relationships.

Early studies found that the male physician's marriage commonly entailed his wife's sacrifice or postponement of her own personal and career goals for the sake of his, and these couples adopted rigid gender roles of stay-at-home mother and breadwinner father (e.g., Gabbard & Menninger, 1988; Glick & Borus, 1984; Robertson, 1986; Vincent, 1985). More recent studies have found that female physicians struggle significantly more than male physicians with role strain as they carry the full burden of family responsibilities in addition to their work responsibilities—indicating that old gender stereotypes that promote inequality may still be at play in physician marriages (e.g., Sobecks, et al., 1999; Sotile & Sotile, 2004; Starner, 2010). The current study

explores these issues by employing a social constructionist feminist lens to understand how gender and power organize physician families' lives.

Literature Review

Physician Couples

Physicians are expected to put aside personal or relationship needs to fulfill their commitment to the profession (Vincent, 1985), and may sacrifice personal or marital happiness in exchange for financial security and social status (Garvey & Tuason, 1979). In early research (1960–1980), the physician's identity was seen as closely tied to the world of medicine (Ziegler, 1992), and the service ethic that patients' needs take precedence over physicians' personal and family needs was punctuated in the literature as explaining conflict in physician marriages (e.g., Elliot, 1979; Evans, 1965; Linn, Yager, Cope, & Leake, 1985; McCue, 1982; Rhoads, 1977; Vincent, 1969, 1985).

Historically, the wives of male physicians sacrificed or postponed their own careers and personal needs to help their husbands achieve and manage their professional and personal goals, often resulting in problems for themselves and their marriages (e.g., Gabbard & Menninger, 1988), such as feeling overburdened by single-handed responsibility for home and child care (Elliot, 1979). Wives from unhappy marriages described their husbands as cold, passive, stern, domineering, compulsive, perfectionistic, emotionally detached, aloof, controlling, and rigid (Evans, 1965; Miles, Krell, & Lin, 1975). These wives felt they carried the emotional affect for the relationship and that their husbands had stronger commitments to work than to family or self (Krell & Miles, 1976). More recent research suggests that physician's wives who work outside the home tend to report higher marital satisfaction (Sotile & Sotile, 2004). They experience lower

marital satisfaction when their husbands are unable to be involved in family life, when the degree of work/family conflict is high, and when wives feel they have sacrificed their own careers for the sake of family or their husbands' careers (Sotile & Sotile, 2004).

Female physicians reported that after a day of giving to patients, they arrived home and were required by their spouses and their own expectations to be loving, supportive wives and mothers (McKay, Alboszta, Bingcang, Dickson, & Kraman, 1986). Women physicians cited communication difficulties, insufficient time with their spouses, and arguments over finances, work, and domestic responsibilities as major problems (Myers, 1986) while balancing multiple roles (Segraves, Segraves, & Woods, 1987).

A higher proportion of female than male physicians are married to other professionals, especially to other physicians (Fider, 2011; Heins et al., 1979; Sobecks et al., 1999; Starner, 2010; Zinke, 2012). These women may be more supported in their professional lives than other women physicians because the career of the medical doctor is prioritized (Fider, 2011). Nonetheless, many women physicians continue to report self-imposed and socially imposed traditional roles as homemakers in addition to their professional roles, and do the majority of caretaking and planning for their children as well as household tasks like preparing dinner (Sobecks et al., 1999; Starner, 2010; Zinke, 2012) leading to guilt when conflicts are irresolvable (Boulis, 2004; Brian, 2001; Clarke, 2011). Thus, work-family role strain among physicians is gendered, with women experiencing considerably more strain than men (Bowman & Allen, 1990; Straehley & Longo, 2006; Warde, Moonesinghe, Allen, & Gelberg, 1999). Women physicians with children also appear less likely to achieve their career goals (Sobecks, et al., 1999) and experience slower career advancement, reduced pay, and reduced publication in academic settings, compared to men physicians (Boulis, 2004; Brian, 2001; Schroen, Brownstein,

& Sheldon, 2003; Straechley & Longo, 2006). Despite the power associated with the physician role, few studies describe female physician-dominated relationships (Esmiol, 2011; Zinke, 2012).

Marital satisfaction in physician marriages is associated with emotional support for self, career, and homemaking, including time spent talking with each other (Spendlove, Reed, & Whitman, 1990; Warde, Moonsinghe, Allen, & Gelberg, 1999; Zinke, 2012). Although gender was not addressed explicitly in these studies, these elements are all pieces of marital equality shown in the literature to generate mutually beneficial and positive marriages for men and women.

Gender, Power, and Marital Equality

Although studies of physician's marital equality are scarce, feminists have intensively explored issues of power in clinical and non-clinical couples (Lyness & Lyness, 2007). Conceptualizations of relationship equality have evolved over several decades of research. Early studies highlighted the organization of relationships around ideas of male power and traditional versus non-traditional couples (e.g., Gilbert, 1985; Peplau, 1983). Subsequent studies examined equality in terms of fair exchange, balance of power, sharing household labor and child care, equal status, and shared decision making (e.g., Deutsch, 1999; Dienhart, 1998; Risman, 1998; Schwartz, 1994). Inequality was highlighted in women's disproportionate investment in the work of the home (e.g., Ferree, 1991; Nyquist, Slivken, Spence, & Helmreich, 1985; Pleck, 1985) and their having less say in decision making than their husbands (e.g., Blumstein & Schwartz, 1983). Recent studies of equality addressed emotional and organizational labor (e.g., Zimmerman, Haddock, Ziemba, & Rust, 2001) and couple processes of attuned

responsiveness, validation, accommodation, and adjusting the oneself to promote the relationship (e.g., Greenberg & Golden, 2008; Siegel, 2007; Knudson-Martin & Mahoney, 2009). Evidence is mounting that equality contributes to relationship success (Amato, Johnson, Booth, & Rogers, 2003; Gottman, Coan, Carrere, & Swanson, 1998; Knudson-Martin, 2013).

Some married couples do create egalitarian relationships (Blaisure & Allen, 1995; Deutsch, 1999; Risman, 1998; Schwartz, 1994). The likelihood increases when wives have equal or higher education, income, and status to their husbands' (Jump & Haas, 1987; Perry-Jenkins & Crouter, 1990), such as in dual-physician marriages. Open negotiation, assertive expressions of each partner's opinion, and addressing conflicts are central to couples' successfully attaining equality (Knudson-Martin & Mahoney, 1998; 2005). Among African American couples facing external obstacles and challenges, couples were able to suspend gender roles and achieve equality through a practical orientation that everyone must pitch in to do what is necessary for the good of the family (Cowdery et al., 2009).

Theoretical Framework

This study integrated social constructionist theory with an emphasis on critical feminist theory as they relate to gender and power in physician couple relationships. Social constructionism gives attention to the way knowledge, truth, and meaning are constructed by human interaction, and critical theory requires that we pay attention to the power dimension of these processes. Adding a feminist lens brings gender as a patriarchal issue to the forefront as an area of inquiry.

A social constructionist perspective of gender recognizes the recursive process between what people do and the social structure(s) (Deutsch, 2007; Risman, 2009; Walker, 2009). These gender processes typically operate below conscious awareness and often going unnoticed, feeling "natural" or "normal" (Knudson-Martin & Mahoney, 2009c). They are deeply embedded in all institutions, such as law, education, economics, and medicine, and are rarely questioned in everyday life. As people conform to gender norms and societal expectations, the gender structure is reproduced (Deutsch, 2007; Risman, 2009; Walker, 2009).

A feminist social constructionist perspective supposes gender is relational and situational: something one "does" rather than a personality characteristic or genetic predisposition (Baber, 2009; Deutsch, 2007; Risman, 2009). That is, rather than seeing gender as a persistent unified category, a social constructionist view focuses on the "doing" or "undoing" of gender (e.g., Deutsch, 2007; Lorber, 2006; Risman, 2009). Power, inequality, and hierarchy are embedded in and perpetuated by traditional conceptualizations of gender and gender relations enacted in our everyday lives, often without reflection or question (Baber, 2009). Though some patriarchal practices are overt, most of the time, patriarchy operates below people's conscious awareness and is embedded in their everyday activities. When power is invisible, the less powerful person feels less entitled to have or express personal needs or goals, is more likely to notice and attend to the partner, and usually automatically accommodates to the partner (Knudson-Martin & Mahoney, 2009). Marital equality thus evolves from the interactions of the partners, what equality means to both partners, and the larger social ideas that influence how couples shape their relationships.

In examining how couples create meaning and organize their relationship, the concepts of male privilege, invisible power, and relationship equality guide the current analysis. By using this framework in analyzing the data, a deep, rich explanation of the gender issues that have been preliminarily identified in earlier studies will be further understood through this grounded theory approach. The concept of relationship equality presented by Mahoney and Knudson-Martin (2009) influences the analysis with the following set of guiding questions:(a) Whose interests shape what happens in family life? (b) To what extent does each feel equally entitled to express and attain personal goals, needs, and wishes? (c) How are low status tasks like household handled?" (d) To what extent do both genders notice and attend to the others' needs and emotions? (e) Is one partner more likely to organize his or her daily activities around the other? (f) Does one person's sense of competence, optimism, or well-being seem to come at the expense of the others'? (p.13-14)

Methods

This study explored issues of gendered power and marital equality in physician couples through a qualitative grounded theory approach. The study is part of a larger ongoing study of physician families at Loma Linda University that aims to understand the unique experiences of physicians, including marital life, family life, stressors, spirituality, and gender issues, within the context of professional families and medical professionals. The research team consisted of eight doctoral student researchers, two doctoral professors in the Department of Counseling and Family Sciences, and one medical doctor in the School of Medicine.

Participants

Participants were adult medical doctors aged 21 and older with at least one year of residency training who had been married at least two years. The inclusion criterion of being married for at least two years was defined to avoid the "honeymoon effect" on relationship dynamics (Carrere et al., 2000; Strong, DeVault & Cohen, 2011). While this study aimed to interview both the physician and the spouse, in cases in which the spouse could not be present, the physician was interviewed alone as the key informant. This included one male physician married to a non-physician spouse, 9 female physicians married to a non-physician spouse, and 3 dual physicians.

The final sample included 36 interviews, of which 9 are male physicians married to non-physician spouses, 18 female physicians married to non-physician spouses, and 9 physicians married to other physicians. Participants are 66.2% female and 33.8% male of which 93.9% are in their first marriage compared to 6.1% who are in a second marriage. Participants are 8.1% Asian, 51.0% Black or African American, 4.1% East Indian, 8.2% Hispanic or Latino, and 28.6% Caucasian. Religiosity of the sample is as follows: 2.0% Baptist, 6.1% Catholic, 4.1% Christian, 4.1% Hindu, 2.0% Lutheran, 73.5% Seventh Day Adventist and 8.1% are not religious. The majority of the sample fell into the age range of 28-38 (40.8%), followed by 50-66 (30.6%), 40-49 (26.5%), and 67 and older (2.1%).

Sampling and Recruitment

A purposive snowball sampling technique was used. A research team faculty member from the medical school provided the research team with a master list of physician names and phone numbers to invite participation in the study. This master list was divided among team members at random. Participants were also recruited through

fliers posted in medical centers, word-of-mouth, and referrals requested from participants. In recruitment, the study was described as an invitation for couples to "share their stories" about their "marriages and family lives."

In the qualitative analytic approach, sample size is determined through the concept of saturation (Strauss & Corbin, 1998). Here, sampling is continued until the data being gathered, analyzed, and placed into categories shows no new or additional information, and the investigators decide that saturation has been reached (Strauss & Corbin, 1998).

Data Analysis

The qualitative data analysis in this study followed the constant-comparison approach in the development of grounded theory (Corbin & Strauss, 2008). Theory was developed from the participants' experiences through repeated observations of the realities found in the data, following a systematic process (Charmaz, 2006). I worked closely with the research team and constantly compared and discussed the coding and categories being formed. The analysis began with line-by-line open coding, followed by axial coding in which more categories and subcategories were formed, and ended with theory building, in which one main category emerged around which other categories were organized to develop the final theory.

Through the coding process, many categories and subcategories emerged. After going back to the data, the categories were redefined, clarified, reorganized, and merged, resulting in one central category—whether couples could un-gender their relationships—and three sub-categories—breadwinner role, motherhood, and decision making.

In the line-by-line open coding, the data were analyzed in their raw form for characteristics or traits (Corbin & Strauss, 2008). For example, if a participant answered a question regarding time spent together by stating, "We never spend time together, his job always comes first," the phrase, "never spend time together" may be labeled "no time together" and the phrase "his job always come first" may be labeled "work is prioritized over relationship." This coding began without any predetermined codes; however it was theoretically sensitive to previous analyses in the larger study as well as the social constructionist feminist lens guiding this study.

Axial coding followed the line-by-line coding, in which the codes were organized or grouped into more abstract categories, and concepts or categories were related together (Corbin & Strauss, 2008). During this step in the analysis, I constantly compared the codes with the transcripts to make sure the voices of the participants were accurately represented in the various researchers' interpretations. For example, if a participant's response to a question on household duties was "My job as a wife is to take care of all the household chores" and coded in the line-by-line coding phase as "wife's job is household chores," then in the axial coding this could be linked to a broader concept such as "traditional role," "gender stereotype," or "social discourse."

The final level of analysis, theory building (Corbin & Strauss, 2008) or selective coding (Daly, 2007), considered how the identified categories were linked together to explain the larger phenomena under study. Hypotheses from one case were brought to another to see in what ways they did or did not explain the next case. No attempt was made to generalize in the statistical sense.

Issues of Validity, Reliability, and Trustworthiness

From a social constructionist perspective, data were co-constructed by the researcher and participants (Daly, 2007). The researchers' thoughts, feelings, values, experiences, and assumptions about the physician couples and gender were made transparent with analytic memos throughout the entire research process (Denzin & Lincoln, 2003; Flick, 2006; Lincoln & Guba, 2003). Issues of validity, reliability, and trustworthiness centered around descriptive precision and how well the results fit the experiences, meanings, and understandings of the participants in this particular context (Corbin & Strauss, 2008; Daly, 2007; Janesick, 2003). Triangulation was used to ensure trustworthiness and dependability of the findings (Creswell, 2003; Daly, 2007; Janesick, 2003).

Results

The aim of this study was to explore and develop grounded theory regarding how gender, power, and equality issues influence and shape physician family life. The core category, around which all other categories in this analysis are organized, is the couples' ability to un-do gender. The analysis indicates that couples respond to gender and power in three different patterns: "traditional," "gender-conflicted," and "de-gendering" (see Table 1 for categorization of couples). These are not discrete categories; rather, couples gender their relationships along a spectrum ranging from adhering to traditional ideals on one end to transforming gender ideals on the other, with gender-conflicted exchanges happening in between.

Couples were categorized according to how they defined roles, such as who was the breadwinner and who was in charge of household and childcare tasks, how parenting

Table 1.

Breakdown of Couple Types

		Occupations	Children	Ethnicity
Traditional Couples				
1	Dr. David & Anne	Public Health	Yes	Caucasian
2	Dr. Ben & Kamie	Anesthesiologist/SAH & Artist	No	Afr Amer
3	Dr. Devaughn & Keesha	Surgeon/Retired	No	Afr Amer
4	Dr. Karl & Karoline	Orthopedic surgeon/SAH	Yes	European
5	Dr. Kamal & Aiesha	Preventive Med/SAH	Yes	Afr Amer
6	Dr. Isaiah	Psychiatrist/Nurse	Yes	Afr Amer
7	Dr. Jack & Maria	Psychiatrist/SAH Runs his business	Yes	Caucasian
8	Dr. Mike & Judy	Dr/SAH	Yes	Caucasian
9	Dr. Nora & Lucas	Dr/Researcher/Businessman	Yes	Caucasian
10	Dr. Charnita	Dr/Ex-Pastor & Business Owner	Yes	Afr Amer
11	Dr. Britney	OB/GYN/Lawyer	No	Caucasian
12	Dr. Gabi	Physician Radiologist/Computer IT	Yes	East Indian
13	Dr. Joseph	Psychiatrist	No	Afr Amer

(n=13)

Table 1. *Continued*

Gender-Conflicted Couples				
14	Dr. Wil & Mercy	Dr/SAH	Yes	Afr Amer
15	Dr. Allyah	Dr/Professor	Yes	W Indian
16	Dr. Cynthia & Bill	Dr/Teacher	Yes	Caucasian
17	Dr. Diana & Philip	PT Dr/FT	Yes	Caucasian
18	Dr. Debra & Mark	Internal Med/Gov't	Yes	Afr Amer
19	Dr. Makayla	OB/GYN/state trooper	Yes	Afr Amer
20	Dr. Jiyun	Psychiatrist/business owner	Yes	Korean
21	Dr. Ladawnah	Emergency Med	Yes	Afr Amer
22	Dr. Gracilyn	Family Medicine	Yes	Afr Amer
23	Dr. Nisha	Dr/Dr	Yes	W Indian
24	Dr. Jamal	Dr/Dr	Yes	W Indian
25	Dr. Aahba	Dr/Dr	Yes	W Indian
(n=12)				
De-Gendering Couples				
26	Dr. Ella & Nathaniel	Ophthalmology/he works	No	Afr Amer
27	Dr. Michele & Thomas	Podiatrist/Business Partner	Yes	Afr Amer
28	Dr. Ebony & Marcus	Dr/CPA	Yes	Afr Amer
28	Dr. Patricia & Daniel	Surgeon/SAH	Yes	Afr Amer
30	Dr. Grace & Tom	OB/GYN/Teacher-SAH	No	Afr Amer
31	Dr. Serena	Dr	Yes	Afr Amer
32	Dr. Neel & Dr. Rachael	Dr/Psychiatrist	Yes	Caucasian
33	Dr. Jerome & Dr. Latreece	ER/ER	Yes	Afr Amer
34	Dr. Nadir & Dr. Hilal	Dr/Dr	Yes	East Indian
35	Dr. Jasmin	Dr/Dr	Yes	Afr Amer
36	Dr. Phil & Dr. Chrissie	Dr/Dr	Yes	Caucasian
(n=11)				

Table 2.

Comparison Chart of Couple Types

Traditional Couples	Gender-Conflicted Couples	De-Gendering Couples
Adherence to traditional gender ideals	Regression towards traditional gender ideals	Transformation of gender ideals
They see gender issues as biological/natural	Some acknowledgment and challenge to gender roles but no good alternative	His contribution may not be valued socially, except by his wife
Doubling effects of gender and status	Gender trumps status	Leveling of gender and status
Women married to men of greater status	Women who would make as much or more than spouses if worked full-time	Couples in uncommon marital arrangements (SAH Fathers)
Male status so high women drop out of work force altogether	Women cut back their work hours and professional endeavors	Men relieve domestic burden and women maintain professional endeavors
Women give up careers, goals and identities for his	Women give up careers, goals, identities for family first, work second	Partners share in co-creating mutually beneficial goals & identities for the good of the family
"Doctor's Wife" – women evaluated through his status	Mother Guilt – women evaluated as "good mothers"	Husbands attend to or eliminate mother guilt as they assume more parent role
Distinct division of labor: his breadwinning, her domestic and childcare	Preservation of discourses supporting division of labor	Re-gender provider role and value her in professional role
His status & income traded for domestic and caring work (seen as equitable)	Traditional gender practices subvert link between status & income for women	Women's status does buy her shared power in marital contract
She handles day to day tasks, he has little involvement	Women work a "second shift"	He participates at least equally in domestic chores
He has final say, she accommodates in decision-making (unresolved conflicts)	His dominance, her deference in decision making (more overt power struggles)	Pragmatic, cooperative, family-first decision making
She accommodates his needs	She defers to him so as to not emasculate him	She values his contributions and give him a great deal of appreciation and credit
Absent Father (maternal gatekeeping)	Glorification of mother role	Focus on shared parenting – convergence of mothering and fathering practices
Wives and husbands may feel distant, misunderstood, divergent perspectives	Emotional closeness is hit or miss	Shared family life experience enriches both wives and husbands

was experienced, and how couples made decisions. A determination that gender was in the process of being "un-done" depended on the presence and degree of intentionality, a family focus, and a rejection of the societal expectations around masculinity and physician status (see Table 2 for a comparison of the three couple patterns). The other couples described relational processes that preserved gendered family life, even when women held physician status and contributed substantial economic resources.

Traditional Couples

Traditional couples express traditional gender ideals. Whether or not women hold professional roles, the division of labor is distinctly gendered, with the husband defined in the breadwinning role and the wife in domestic and childcare roles. His status and income are traded for her domestic and caring work, which is usually seen as equitable by both spouses. His professional status coupled with his gender has a doubling effect on his status and power such that family life organizes around him. He maintains final say in decision making, and she accommodates his needs. Women marry men of greater status than their own, and in most cases his status is so high that women have either dropped out of the work force altogether or minimized their careers. These women give up their careers, identities and goals for their husbands'. Many describe an inflated sense of social power as a "doctor's wife" yet hold little or no power within the marriage.

There were 13 traditional couples made up of 4 configurations: 6 male physicians married to women not employed outside of the home, 3 male physicians married to professional women, 1 of which was a dual-physician marriage, and 4 female physicians married to professional men. They used a traditional framework with stereotypical gender talk to organize and describe their lives. Husbands described being attracted to

their wives based on stereotypical gendered ideals of beauty, innocence, and caretaking: "She's naturally beautiful, so if you're a man, you want for your wife to be as beautiful as possible." Wives described being attracted to strong, intelligent men who would take care of them. Dr. Charnita said, "He was very powerful…he was a strong person, and I knew I needed him." These couples focused on experiences that confirmed and justified traditional gender identities, and information that threatens their stability was averted from consciousness. This contrasts with the gender-conflicted couples, who may not have believed in traditional gender ideals but regressed toward them in organizing their family life, and with the de-gendering couples who held transformed gender ideals in which family life was not organized around traditional masculine or feminine ideals.

Men's Breadwinner Status

Because they privileged the man's traditional breadwinning role, traditional couples organized family life around his professional status. Dr. David expressed his role as breadwinner:

> I'm the only one working, a lot of times. I think, "Ok, let me work more"…I'm trying to make sure there's enough money for everything to get paid and for them to go to private school and all of that.

These men often put their work first, and even though it is *for their families*, it comes at the *expense of* their families. Kamie, a physician's wife, described her situation: "Sometimes I end up eating his meal for two or three days." When he would get called in to work, she said she would say to him, "Rather than going home to drop me off just take me with you." She recalled, "I spent the first couple of years of our marriage in a waiting room with my book." Dr. Karl commented on the long hours, "It gives me

stress, and I come home late. I do not have the opportunity to work with the kids, help them with their homework or be there to discipline." Dr. Nora described her experience:

> He has devoted all of his hours at work…I always felt that his mind was in other places…He's not good at saying "no" to telephones, and he would use his laptop very freely…I don't like it…we always have to compete for his attention.

Family life is organized around his professional status and family members find they fit into his needs. For example, Dr. David viewed his spouse as a benefit to him: "She's a nurse—it's good to be. If I come home and talk about something, she understands it. . . It's good also because she makes sure my scrubs are ready . . . and with some of the scheduling things that we do." Even female physicians in this group found themselves fitting into their husbands' professional needs, rather than vice versa: "I have always been the one who would adjust for whatever his needs would be for working," explains Dr. Nora who was married to a very successful businessman, "In our family his career and his responsibilities and his needs have been given priority."

Women's Domestic and Childcare Roles

Couples in the traditional category adhere to traditional gender ideas of her domestic and child-care roles. To enact these gender scripts, women often had given up their education, professional goals, and identities after marrying their spouses. They attained social power by having their identity established through his, though it came with a cost of making personal sacrifices and having extra responsibilities. Physician wives in this group also followed this pattern by marrying professional men with greater status than their own. Dr. Charnita, a physician who married a former-pastor-turned-businessman, explained:

> I had huge expectations. I was going into it as a pastor's wife. I was excited about that. That is what I wanted to be. I really thought it was my calling as well. So at that point in my life I just, well, totally dropped my plans and went into that.

Aiesha, a physician's wife, explained her situation similarly:

> Like being a minister, it [being a physician] is a calling. . .and you have to be supportive of their commitment. . . …there's a lot of women who like the status of being married to a physician, but they certainly don't like the responsibilities.

A doctor's wife has to conduct herself in a way that brings glory and recognition to her husband, first, and when his status changes, hers does too. Dr. Karl gave up orthopedic surgery to have more time with his family, yet his wife was not supportive of this decision since it meant a change in her identity and status:

> Dr. Karl: "The career change, I think, was a negative for Karoline in that she had always envisioned me being a surgeon in the OR. I think she looked up to me because of my career, and I think she is disappointed to think I'm not that person anymore."
> Karoline: "…there is a lot to weigh, that he finally laid all surgery aside, that I think was harder for me to let go of."
> Dr. Karl: "You were never supportive of what I did…She was not supportive of my decision."
> Karoline: "Okay, maybe I wasn't."
> Dr. Karl: "She was concerned about what other people would think about why I stopped and so forth."

In some cases, the power of the male status is so high that women drop out of the workforce to focus completely on family needs and enable their husbands to opt out on them. Dr. Nora explained, "I'm the one who has gone in a reduced position, remembered that there are kids, remembered that there are two lives in our lives who are supposed to be picked up." Karoline discussed how challenging it was to have given up her own career and education to be a stay-at-home physician's wife:

> It took a while to be comfortable in my new role as just a mother at home. That was harder than I thought it would be. . . I feel sometimes so useless and undefined. He will help remind me that being home and being the house manager is a very big job.

Aiesha shared the expectation of her as a woman growing up: "As a black West Indian woman, we grew up and we were taught that you stand on your own two feet…you saw your role not only as a child bearer, but you saw your role as a breadwinner." She said her husband Dr. Kamal wanted her home: "He says, 'No you have to be home with the kids.'" However, it was difficult for her to follow a traditional gender script in lieu of the unconventional one she was taught, "So again, I have to resolve that in the back of my head. 'Your role is here, you are doing your job.'"

These men do not share in domestic or childcare responsibilities, because traditional gender scripts assign these tasks to women. Though some women may secretly desire more help, they do not receive it: "While the kids were small I think he went to work just to not be expected of anything at all," shared Dr. Nora, who also guided him to be a more involved parent, "I feel I have managed him into his father's role over the years." Many of these women followed a traditional script of being the driving force behind their husband's success, with little credit received. Dr. Nora described how she supported her husband,

> In his career and in his fight for companies. And though he hasn't been able really to give me credit for it in everyday life, he has said that quite many times over the past few years at least. So I think he acknowledged me as an important person for him. Both with regards to have a complete and complex life with family and social life and with regards to many specific things going on in his company and quite many processes he has been in his company. I've participated as the invisible tutor, helper…

These women are not necessarily resentful or disappointed with their roles in their relationships, but rather see them as fulfilling expectations they had for themselves. Dr. Britney explained,

> And I am okay with it at this point in my life. I don't begrudge it. I don't resent the fact that I am a female. I don't resent the fact that I have these additional responsibilities. Being married was something that I wanted that was important

> for me to feel fulfilled in my life. And in general I appreciate and am happy that I have the opportunity.

Decision Making: Women's Accommodation and Divergent Perspectives

Couples organized by traditional gender ideals tend to follow male-dominant power patterns in their decision-making processes: she accommodates and he has the final say. For example, Dr. David said, "You see, being a man is about control. So if you feel like you're not in control of the situation, as a man, you usually get upset. And I'm no different… I usually solve the problem." In these couples, there was not usually a power struggle, men simply got their way. This couple illustrated the inherent taken-for-granted power of his final say in decision-making:

> Anne: "I think we make it [decisions] together…We just have to hear each other's opinions about why."
> Dr. David: "We do or we don't…I think I commandeer control a lot of times to try and get done what I want to get done…"

A wife may have questioned her husband but eventually found herself adopting his point of view and agreeing with him. Anne said,

> I question a lot what he is thinking. Sometimes I question his decisions, and then I have to sit down for a while and picture it out in my mind. I think why is he doing this? But then it comes clear to me. Maybe he's right.

Often, conflict cannot be resolved because there is no way to deal with the differences in the hierarchical system. When women are not accommodating men, men are not changing their decisions, and conflict is unresolved. In these cases, men and women may avoid raising the issue, "We haven't had very many open conflicts," stated Dr. Nora, "what happens is that I retract." Dr. Ben shared a similar experience, "For the most part I tend to probably to a detriment maybe try to just keep quiet and hope it goes

away." While Dr. Devaughn said that he "loves arguments," he followed up by saying his wife "doesn't talk period." The silence apparent in these couples is evidence of an inability to deal with the hierarchy in the marital relationship. This pattern is in contrast to the gender-conflicted couples, who have more on-going power struggles.

Avoidance of conflict is common in the traditional couple type because gender and professional status constrict these couples' ability to find resolutions to their conflicts. The doubling effects of gender and status may prevent negotiation, and conflict is left unresolved. Dr. Karl illustrated this point, "Earlier she said, 'Well, we are kind of digging into our ways.' True, we are not sometimes totally agreeing on some of the ways we handled children issues, and we are not compromising. So it causes some stress between us." Because these couples were frequently unable to come to a meaningful consensus, their divergent realities led to emotional disconnect. Karoline reflected this when she said: "I suppose we don't talk about things that really matter. We don't take the time to really get to the bottom of things." These couples find it difficult to find consensus. Dr. Britney highlighted their divergent perspectives, "We were still at opposite ends of the spectrum."

Gender-Conflicted Couples

Gender-conflicted couples live in contemporary circumstances with both spouses earning an income. Unlike the traditional couples, they do not aspire to traditional gender ideals. Yet instead of un-doing gender, they regress toward male dominance and end up enacting many patterns similar to the traditional couples. Even though both spouses are breadwinners, they preserve the division of labor; only he is considered a breadwinner, and she is considered primarily a wife and mother, with her work as secondary. Women

cut back their work hours and professional goals because they see their identities first as wives and mothers and second as physicians. There is glorification of the mother role, and women work a "second shift" (Hoschild, 1989) in addition to their professional one. In contrast to traditional wives, these women experience a significant amount of mother guilt, and they are left carrying an overwhelming burden of domestic and childcare responsibilities in addition to their professional responsibilities. These couples demonstrate how his gender trumps her professional status because traditional gender processes subvert the link between status and income for women. Money and professional status do not bring her much power in the marital contract.

There are 12 gender-conflicted couples in this study comprised of 3 configurations: 1 male physician married to a woman not employed outside of the home and 11 female physicians married to professional men, of which 3 are dual-physician marriages. In general, the female physicians are married to professional men and make as much as or more than their spouses, or could if they worked full-time. They are considered "gender-conflicted" since they do not necessarily adhere to traditional gender ideals in their belief systems and in reality live untraditional lives, but they find themselves devolving toward traditional ideals in the ways they structure their family lives and interact with their spouses.

Maintaining Men's Breadwinner Status

The gender-conflicted couples are considered dual-earner or dual-career because both spouses work; however, they consider only the husband to be the breadwinner because they have not found a way to deal with a disruption in the traditional gendered script. Therefore, although both spouses *should* logically be considered breadwinners,

these couples regress toward traditional ideals as though the husband performs the breadwinning role and the wife performs the domestic and childcare roles. To achieve this fiction, women often cut back on work hours and/or take on more housework or child care duties, downplaying their status, while men often increase their involvement in paid work and/or avoid housework and child care duties, emphasizing their provider status.

For example, Dr. Debra made more money than her husband, Mark, who worked as a field representative for a congressman. She said, "I think sometimes the attention or prestige that is given to a female who is a physician might be a stress point." Dr. Diana's husband Philip did not want to be married to a full-time physician, and so she reduced her hours. He said, "It helps that she's not the full-time physician…I would not like that." She said she made this relationship work through "the sacrifices that I've been willing to make…I love my work. I love what I do tremendously." But she accommodated his wishes, which she said he stated: "'I want you to be there for kids, I want you to be home, I want you to be available.'" She described making this change for him: "I had to understand before I even got married that work was a secondary thing. And it was a difficult transition for me." This process had been a long-term struggle for her: "It's taken me all this time to get to a point where I say I love being a mother and I want to be home with my kids."

Philip spoke about seeing *himself* as the breadwinner after the children were born: "I have more mouths to feed, so I take it more seriously." He saw his physician wife's primary role as mother, rather than physician. Dr. Diana reinforced his role not only as breadwinner but in financial planning and decision making: "He always said, 'It's not how much you make, it's how much you keep.' What I noticed with him is he is excellent at budgeting." Thus, traditional gender ideology shaped their relationship to

preserve his economic dominance in the marital contract. Gender trumps physician status and money. In addition to the financial consequences to the family of not accessing her earning power, one has to wonder what the consequences are to her self-esteem, professional advancement, and personal well-being. Dr. Diana acknowledged this arrangement came with a personal consequence: "So anytime I do look for work I let them know *even at my detriment* that I am not willing to work more than part-time."

Instead of using their unconventional circumstances to alter the traditional balance of power, these couples' relational processes reproduce the husband's dominance. They avoid labeling the wife as the family provider and construct identities consistent with normative gender expectations, robbing physician women of the institutional power associated with being providers and assigning it to their husbands. Thus, these couples avoid deconstructing conventional power dynamics in their relationships, which undermines a move toward equality.

Preserving Women's Identities as Mothers and Home-Makers

Among gender-conflicted couples, the earning power of being female physicians does not buy them much relief from child care or household labor. Wives in these partnerships work part- or full-time, earn as much or more than their husbands, and are still responsible for the lion's share of domestic labor. They work a "second shift" (Hoschild, 1989), unlike many of their male counterparts. Often, their identity as mother or wife is glorified, and their identity as physician is downplayed. Diana seemed to take pride in stating, "At home, I'm just Mommy." When there is conflict between their professional role and family role, they speak of choosing their family over their work. These women often make sacrifices in their professional careers for the sake of their

families: "I hold my mothering responsibility as very important… And I think a woman has to sacrifice some of her profession," explained Dr. Gracilyn.

Like their more traditional counterparts, some of these women physicians embrace domestic labor as a way of presenting themselves as good wives and mothers. They may downplay their physician status or financial contributions to their families and instead emphasize their mother identity and role, judging themselves by how much housework they are able to perform or how much time they are able to spend with their children. Dr. Diana seemed to downplay her children's pride in her profession: "I tell you that my kids will say, 'My mom is a doctor.' They, for some reason in their mind, appear to be proud of me and what I do. But in large I am just Mommy at home." She reiterates, "I am supposed to be my child's primary caretaker." Dr. Debra similarly shared, "My career, for me at this moment, is basically a means, it's a way of supporting my family." She made her priorities clear:

> I certainly do my best to take good care of my patients, and to be sympathetic, and I like my patients and all that, but if I had to choose between my family and my career, my family always wins out in that decision.

Many physician wives struggle with resistant husbands and use gender expectations as a rationale to resign themselves to doing the bulk of the domestic work instead of accessing some of their power and forcing his participation. Dr. Diana shared, "He helps me out as much as any man can help out somebody. In the house and with the kids, which is a big deal." But she emphasized her traditional role: "I suppose I really just take care of him and the family and let the house run like a well-oiled machine so he doesn't have to worry about it." She privileges his work, even though she makes more money: "He goes to work and comes home, and he can eat and sleep, and he can have a happy family."

Other women mention this as a point of contention in their marriage. Dr. Debra, who made more than her husband Mark, said:

> Once there were kids, I hardly went with him at all, and he would often be out late every night. So that would cause some stress because everything was typically left on me, you know. In terms of all the housework, all the child care, the laundry, everything you can think of was pretty much left for me to do. So that created some strain.

Many of these wives mentioned wanting more help than their husbands were willing to give. Even though she raised the issue early in her marriage, Dr. Debra's husband never stepped up to the plate when it came to sharing in household and child care duties. She shared, "Um, my marriage is not (satisfactory) because I probably would have expected more working together than we do." She described watching a show with her husband many years ago about the roles of men and women and household roles, and that "he turned to me and he said, 'I always think of those things as roles of women.'" She said she responded, "'Well then, what do you think your role is? Because if I'm working also, then, you know, what is your role? How can I do all of these things?'" She provided a detailed account of what it was like for her:

> Like today, when I leave work, I've got two children doing horseback riding, one at 4:00 and one at 4:30, and my mother takes them, but I have to go and pick them up. There is soccer practice for the other one at 6:00, so then when we are finished with that, and we are home by 7:30 or 7:45, then there is clarinet practice for one, flute practice for another, piano practice for the third, and not to mention that in the midst of all of these activities, they have to eat and do their homework and then get some rest.

Dr. Debra pointed out the difficulties this caused in meeting her professional goals:

> So when do I do my research project? When do I even think about it? While I'm working, what happens is, 'Mom do you know where so and so is?' or 'Mom can you help me with my project?' and 'Mom can I go over my friends house?' or my mother calls and asks, 'What's for dinner today?'

Yet she described clearly her belief that her role in the family took precedence: "Even if, as a female physician, you have someone doing all the family things, it is still your responsibility to coordinate all that. To figure out how everything is going to happen." She contrasted this with the experience for male physicians: "Male physicians go home, put their feet up, and read the newspaper." In this vein, Dr. Makayla said:

> The other thing I tease some of my colleagues with is that I need a wife. Because we have to do what you do and then go home and do what a wife does. And so they probably would lose their minds if they did everything we do. So maybe their lives are a little less stressful because they have someone at home to help with the kids, you know, the meals are taken care of, the errands are done. I have to do all of that plus practice medicine.

Some of these female physicians, despite already shouldering the majority of the household and child care tasks, felt pressure that they should be doing even more. Dr. Jiyun described this sentiment,

> Just because you are working does not exempt you from all the other obligations of being a mom, cooking nutritious meals for your children, cleaning, making sure this is clean clothes for them. You know what I am saying? My husband helps out but ultimately I am the one that's responsible. I am the one that sort of guides him. I am the one that reminds him, today is such and such, you need to this. So I feel ultimate responsibility.

Motherhood guilt was experienced in the majority of these physician wives, explained Dr. Debra: "I remember talking to my kids' pediatrician who was a friend of mine and I said, 'You know, I feel guilty.' And she said, 'Guilt must be the life blood of mothers, especially working mothers."

It is notable that there was no mention of fathers' feeling guilty for not doing more domestic or child care tasks. In fact, some of these women responded to their feelings of guilt by feeling they should take on even more domestic responsibility, instead of trying to increase their husbands' participation. Husbands supported their wives in their attempts to emphasize mothering in their identity constructions by glorifying their

"mother role" and speaking about them as being "good mothers," despite the demands of their profession. The traditional gender discourse has a strong taken-for-granted pull, especially when reinforced by husbands and societal expectations of what a "good mother" is. Thus, for this group of women, achieving a feminine identity as a loving, caring "good mother" took precedence over the physician identity. The money she earned did not make up for the care her family might have been missing while she was away at work. Many felt they were not living up to the cultural standard of being a good mother or doing enough and experienced feelings of guilt or failure.

Decision-Making: Men's Dominance and Women's Deference

In the gender-conflicted couples, husbands of female physicians maintained dominance. The wives often deferred to their husbands in the decision-making process instead of using their substantial resources to make claims to power. They even seemed reluctant to resist their husbands' decisions or make their opinions known when there was disagreement; husbands often "put their foot down." These gender patterns were asymmetrical, meaning he did not defer to her or refrain from making his wishes unknown. For example, Dr. Diana made it clear that the power in decision making belonged to her husband; she cut back to part-time work because her husband did not want to be married to a full-time physician, and she described what he allowed her to do:

> He allows me to still do what I like to do. He does tell me when "Okay, that's enough" so as not to impinge upon our family life, so he still has to put the reigns on and say, "I will support you but that's enough."

She goes on to say that she supports him by deferring to his decisions:

> I support him, I trust his judgments. He listens to me if I have anything I want to say regarding any decisions he has to make, but I pretty much trust his judgment calls if he wants to do something for the family. I support him that way.

De-Gendering Couples

De-gendering couples are characterized by organizing their relationship and family life around transformed gender ideals, marital equality, and a balance of power. They illustrate a leveling of gender and power. In the 11 de-gendering couples, 3 configurations were present: 3 female physicians married to men who were not employed outside of the home and 8 female physicians married to professional men, 5 of which were dual-physician marriages. Some couples had started out with egalitarian ideals, whereas others had not. Those who initially held stereotypical gendered beliefs described a continual process of changing these gendered ideas and had been able to evolve their relationships toward gender equality.

These couples were able to re-gender the provider role and value her professional role. Men relieved the domestic burden from their wives, and women were able to maintain their professional endeavors. He participated at least equally in the domestic and childcare tasks and in some cases assumed primary responsibility. Whereas men in gender-conflicted couples contributed to female guilt, de-gendering husbands attended to their wives and worked toward eliminating their worries or guilt. Wives expressed great emotional gratitude.

The de-gendering couples had evolved their parental roles to reflect their families' changing needs as they responded to various economic and social pressures. Since she did not relinquish her parenting role, there appeared to be a convergence of mothering and fathering practices; couples de-gendered their parenting skills. These couples relied on pragmatics and cooperation to create equitable and fair family arrangements, and children were often a focal point of cohesion.

Shared Breadwinning, or Elimination of Breadwinning Status

In de-gendering couples, spouses work together to *eliminate* the traditional breadwinner title and its hierarchical position. Men describe a process of overcoming their entrenched gendered beliefs and coming to accept their wives' professional status. Marcus, a CPA, explained, "I was not prepared to be married to a physician. You know, the pedestal that a physician is on. I wasn't prepared mentally for that. . . so instead of saying something I just ignored her." He acknowledged having to overcome the social stigma, "There is that social aspect that is still there as far as the doctor's husband. But I made peace with that before I ever said 'I do.'" Nonetheless, societal gender scripts remain a constant presence, "So," he continued, "that I had to deal with a long time ago. So that's still there, but it's not a problem."

Similar to the gender-conflicted couples, de-gendering physician women still may downplay their status so as to not emasculate their spouses. Dr. Ebony explained, "What has helped, though, is I don't glorify that [her physician status]." He chimed in, "She doesn't do that at all. She's very much, when she walks into a new environment and they ask, 'Who are you?' It's 'I'm Ebony'…the fact that she handles it that way makes it, you know, obviously nice." That these women still spoke of having to downplay their status illustrates the inherent institutional inequality afforded to powerful women. Contrast this with male physicians who are glorified by their wives, female staff, and others. In de-gendering couples, husbands go through a process of coming to accept their wives' professional status and accommodating and organizing around it. Thus, her status *does* buy her shared power in her marital contract.

In de-gendering couples, the female physician breadwinners do not appear to operate under the same assumptions of *power through position* in their homes as do many

male breadwinners. For example, wives do not seem to hold significantly more power in decision making, finances, or household labor. What is apparent in most of these couples is that husbands do not want their working wives to worry about child care and household duties. In response to this challenge to traditional gender expectations, wives demonstrate great appreciation. These husbands actively make life easier for their career wives by supporting their schedules, relieving them of stress around children's care, and/or reducing their involvement in housework.

Because these female physicians' status is acknowledged and appreciated, these physician's husbands do step up and take an active role in household and child care duties, often assuming a primary (stay-at-home) role, or at least sharing equally. These fathers seem to value their increased involvement in child care in ways that may reduce gender differences in parenting. They seem to come to appreciate daily care of children and develop a range of parenting skills, including nurturing and communication. These couples often experience convergence in their parenting experiences since these women do not relinquish involvement with their children.

Shared Domestic and Parenting Experiences

In de-gendering couples, both spouses participate in defining a "good mother" and share in the motherhood experience. Husbands take responsibility for relieving their wives' motherhood guilt and assume domestic roles that have historically been assigned to women. Many female physicians in this category describe incorporating the idea of "working" into their conceptions of "good mothering." As these couples participate in deconstructing constraining gender ideology, what seems to help is a process of shedding all gendered expectations. They do not organize family life around traditional gender

ideology, and there are no gendered expectations. Dr. Ebony explained, "We didn't have any expectations of me, and then with that it made it so much easier so I could really concentrate on what I needed to do (work)." Husbands acted to reduce their working wives' guilt. Her husband Marcus said, "Her work hours were so extended she didn't have to feel guilty about not being home." However, this may come at a cost to women's sense of mothering, especially around issues of child care. These women physicians do continue to express disappointment about being taken away from time with their children: "Which I really do not relish because it takes away from me, from Marcus, and from the kids," Dr. Ebony explained.

Unlike their male counterparts who are only minimally involved in child care and household duties, these female physician mothers continue to prioritize their children and share in the child-care responsibilities and active parenting. However, they may compare themselves to their husbands, who may be more involved in child care. They may wonder whether they are spending enough time with her children or having enough influence on them, compared to their spouses. There is an ongoing process of having to respond to the influence of societal gender messages.

These physician women often experience a change of importance in their parenting status as a result of their husbands' increased involvement. For example, Dr. Patricia remembered when her son used to call her Daddy:

> My first year, my son would call me Daddy, which caused me to cry because Daddy was who did everything for him. . . When I left, my son was sleeping, and when I came home, my son was sleeping, and sometimes the only opportunity that I had to see my son was I would give him breakfast and he would say, "Thank you, Daddy."

The de-gendering partners had both assumed responsibility for the domestic roles traditionally assigned to women. Some stated their roles had switched or they would simply pick up wherever there was a need. For example, Dr. Ebony said,

> Marcus will do laundry and iron so I don't have to worry about that. Marcus will get up and get the kids ready for school, so when I come in from work I don't have to worry about that, I can sleep. Our roles have switched.

However, these physician mothers take an active role in child care and housework, in contrast to many of the male physician fathers. Further, these couples have not simply reversed traditional roles; rather, they are sharing more responsibilities than couples traditionally have. The purpose of these role reversals or sharing of responsibilities is to increase the well-being of the female physician and to optimize the good of the family. One husband adopted a traditionally female role of managing the "big picture" at home while his physician wife focused on her own schedule:

> His calendar has my work schedule and the kid's activities and class activities, when he has to be room dad, etc, etc, etc…for me, I just have my work schedule on there, period. So he really is focusing on the big picture, and I'm just looking at what I have to do…

Husbands in de-gendering couples intentionally increase their involvement and domestic responsibilities to tend to their wives' well-being. Marcus explained he wanted his wife to be free from worry:

> My objective for her is that when she's out working, she should not have any concerns as far as having to worry about the kids' dressing, care, provisions, feeding, homework. That should not be her concern… If she wants to know, she can know. But she shouldn't have to worry about that…

His wife, Dr. Ebony, expressed her appreciation,

> That's very thoughtful, and that's very helpful because I can concentrate on work. Basically I go to work and come home. And he takes up the slack for everything else. For managing the household and the finances…he really had to pick up basically you know the "wife" in the relationship. . . It was tough to see him working so hard to make my life better, and I wasn't able to do the same thing for him.

Cooperative "Family-First" Decision Making

For the de-gendering couples in this study, children are a source of cohesion and the centerpiece around which most decisions are made. Decision making is described as cooperative and doing what is best for the family. Attending to all members' needs is important, and equality and fairness appear to be priorities for all family members. Nathaniel explained,

> Coordinating our careers so that we can have the outcomes we would like as a total. Not just as people and careers…These are joint decisions that both of us are doing. We really both need to feel good about this decision.

His wife, Dr. Ella, agreed:

> You start making your decisions together because you are no longer two separate people. You are one body, one decision maker. . .this is your family, this is who you are. We work through problems together; that's the function of a unit.

Thus, parents prioritize the needs of the children as more important than ascribing to specific gender roles. Dr. Ella illustrated this point, "We both try to make good decisions that are not really good for ourselves, but good for our families."

These couples make decisions based on the good of the family and often use logic or practicality. Marcus, a CPA married to a doctor, explained a practical reason for why they switched, "…we were living on my income for several years and then her residency income, which was still half of my income. And not until you got out of residency did we flip." These couples seem to use the logic of relative income to make decisions based on everyone's needs. This could be seen when Dr. Ebony said,

> Marcus likes to travel; he's very laid back, so it makes it so that I want to be off work more. That's one side of it, and on the other side of it, I want to work so we can have the income to actually take a nice trip together because he really likes to travel.

Their shared perspective was evident when Marcus chimed in, "We're blessed. We do a lot of travelling even now with the kids." For the de-gendering couples, moving toward

egalitarian marriages was seen in their decisions' being based on family needs rather than gender. It seems that, for these couples, "family values" means making family the top priority.

Discussion

The purpose of this study was to examine gendered power and marital equality in the experiences of physician couples. A qualitative grounded-theory approach yielded one central category: couples' ability to un-do gender in their relationships, around which three couple types emerged: traditional, gender-conflicted, and de-gendering.

The traditional couples cases illustrate how difficult it really is for heterosexual couples to counteract gender traditions and stereotypes when the husband is filling the powerful physician role. Counteracting the gender role pressures is very hard to do when the husband is a physician due to the power of that role adding to the power of the male role. The way the traditional couples deal with these influences is to glorify the conventional female roles of wife and mother and punctuate his traditional breadwinner role while seeing her as a co-facilitator of his calling and deferring to him for decisions. Most of these wives have given up their jobs, often reluctantly. In their family lives, she handles most of the day-to–day tasks and organization and he is not very involved, but she defers to him when there are decisions to be made. In a theoretical sense, the family organizes around the institutional and economic power that comes with the physician role, and he maintains a hierarchical position of authority.

The gender-conflicted couples are being pulled in opposite directions, toward both traditional and unconventional practices. These couples are female physicians married to physicians or other career men. Although the traditional ideals do not seem to

work for them, they are unable to construct a good alternative. This creates a struggle for them because they have not revised gender roles to match their reality that her earning power is as much or more than his, and they still view the male as provider and privileged and the female as primarily wife and mother. In gender-conflicted couples, women experience burdens of guilt and extra responsibilities.

In contrast, the de-gendering couples, comprised of dual-career, dual-physician, and female physicians with stay-at-home dads, are able to make a shift from traditional gender patterns: they re-gender the provider role and privilege family needs. They privilege fathering aspects as the husband moves from the narrow focus on a provider role to one that includes a shared role in family responsibilities. Simultaneously, they value the wife in her professional role while maintaining the importance given to her reconfigured roles as wife and mother, supported by her husband both instrumentally and emotionally. There is a consciousness in these couples to making these shifts. To assume their positions as physician's husbands, these men have made the decision that they are willing to challenge normal gender ideas by consciously resisting ongoing societal sanctions/pressure and embracing an egalitarian marital relationship. There is also a clear sense that what they are doing is not valued socially, except by their wives.

De-gendering wives give their husbands a great deal of appreciation and credit and deeply value their contributions. Family life and responsibilities become a shared experience, which seems to enrich both wives and husbands. While the wives continue to engage in family needs, their burden is reduced as their husbands assume multiple responsibilities and the couples strategize to manage. It is not that these women do not experience the guilt or pressure, but that they are able to counteract these forces, with their husbands' support. Compared to other couples, the wife has more power in the

relationship with a more egalitarian relationship with her husband. These couples do privilege the physician role, organizing around her professional needs to a moderate degree, but this does not give her the greater power in other aspects, and she is expected to be attentive to the family and other elements of the couple relationship.

In general, physician couples negotiate the dual issues of power arising from the physician role and traditional gender roles. How couples manage this depends on whether they continuously counteract stereotypic gender roles, particularly in relation to redefining/un-gendering. If they de-couple the provider role from the gender role, wives can be fostered in their professional lives and husbands can take on more varied responsibilities, even in some cases becoming primarily responsible for family needs. In the couples who achieve this, the ongoing power of the female physician's role is compensated for by her great appreciation for what he is doing. Also, both of them orient more toward family roles than work roles, in a sense giving greater privilege to the child and home care role, in opposition to societal influences to undervalue it. Women retain this valuing and continue to share family responsibilities, even as they organize around the physician role and what that job requires. These couples prioritize needs for family and togetherness as a couple. They have succeeded at de-coupling the provider and family caretaking roles from gender roles, and in the cases examined in this study, this success is only possible when the wives have the power and privilege of being physicians.

This study shows how difficult it is to transcend gender stereotypes when a male in a heterosexual relationship is in the physician role, redoubling expectations for power and privilege. When a woman is in the physician role, the forces of gender and physician power are in opposition, and how they manage these power issues depends on whether

they reach conscious agreements to share provider and parenting roles unconventionally and equitably. However, even in the most egalitarian couples, gender never completely gets undone. There are no cases in this study in which women have gained the kind of organizing power that men traditionally have. Even when the men become stay-at-home fathers, the women continue to share in the domestic responsibilities.

Gender-conflicted couples become organized by traditional gender ideas, even though they live in contemporary circumstances. They language and view the male as provider and the female as mother, even though she has the societally-valued position of being a physician. In these couples, gender is not un-done: her traditional gender role is not overtaken by the physician role as primary.

When couples transform gender roles, the outcome is a shared focus on family: both husband and wife make family a priority as they organize to work around their work schedules. But when they are not able to transform gender roles, wives retain the primary role in family life, even if they are physicians. Some of the female physician couples were able to create unconventional relationships that carried shared power and organization around the physician role. In no cases, however, did the female physician carry the same organizing power in the couple as in those in which the physician was a man.

Limitations

This study had a high percentage of minority participants, and most participants were from a localized community in Southern California. Thus, the experiences of these physicians in this particular ethnic and geographical context may not transfer to physicians in other settings. Given the high percentage of African American participants,

future studies should examine the intersections of ethnicity and racial status with gender. The cross-sectional design is only able to offer perspectives about what is occurring at one point in time, and it only provides retrospective, limited access to participant's long-term, evolving thinking over multiple years. The snowball sampling technique employed in this study may have provided a relatively homogenous sample, and a more varied sample in future work might provide a greater variety of perspectives. Additionally, triangulating the participants' perspectives with the results from a focus group could improve reliability and validity of the results.

Implications

Theoretical

This study advances theory regarding gender, power, and equality in marriages by highlighting de-gendering processes (e.g., Deutsch, 2007; Lorber, 2006; Risman, 2009). Men in particular had to overcome societal messages associated with their status as breadwinner. The dominance of the male discourse was evident in the traditional couples, in which even for female physicians with professional status, his gender trumped her earning power. Men's willingness to examine their positions of power seemed essential to facilitating an egalitarian relationship with their spouse. And women had to not back down from voicing their needs in the face of his resistance.

This study highlighted the strength of the discursive power when gender intersected with professional status: men physicians tended to maintain the greater power in their relationships unless married to another physician. Women with physician status were able to obtain more power in their relationships relative to other couples, but no woman was able to attain the type of power through position that men had. This study

adds to the feminist social constructionist perspective that gender in fact is relational and situational; something one "does" rather than a personality characteristic or genetic predisposition (Baber, 2009; Deutsch, 2007; Lorber, 2006; Risman, 2009). This study adds to theory by highlighting the link between professional status and gendered power and emphasizing that couples can and do make progress in un-doing gender as the primary organizing structure, but it takes intentional and persistent effort.

This study's findings also help us understand what is happening to professional women that often drives them to drop out of the workforce (Stone, 2010). This study found that gendered expectations of a woman's mothering role take precedence over the requirements of her professional role, even when she has the status of a physician. Unless couples work together to un-gender the mothering discourse and husbands participate in domestic and child care responsibilities, sharing in the burden of "parenting guilt" (motherhood guilt), women cut back on their hours and professional endeavors to attend to the family needs, often alone. The de-gendered couples illustrate how families can accomplish family-first cooperative decision making by deconstructing these gendered discourses.

Clinical

By understanding the ways that couples can undo gendered power in their relationships and some of those benefits, clinicians can help couples in therapy create more egalitarian, family-first, cooperative relationships. Clinicians can help couples identify all sources of power—gender, professional status, relational, and individual—and how these interact to either maintain an imbalanced status quo or promote more equality. By understanding how couples deconstruct gendered practices, clinicians can

help couples examine: when and how their interactions become less gendered, not just differently gendered; the conditions under which gender is irrelevant in their interactions; whether all gendered interactions reinforce inequality; how the structural (institutional) and interactional levels might work together to produce change; and interaction as the site of change (Deutsch, 2007).

Research

Prior analyses of the data have found that female physicians do the majority of caretaking for their children and child-planning, face self-imposed and socially imposed traditional roles as home-maker in addition to their professional roles (Starner, 2010), and experience a great deal of motherhood guilt (Clarke, 2011). Most couples structure their relationships around either male-dominated or non-gendered patterns (Esmiol, 2011), and some can adopt more-fluid domestic roles, including non-traditional roles (Fider, 2011) with some husbands taking on the primary role of caretaking (Clarke, 2011). Dual physicians employ a combination of traditional and non-traditional gender roles; however, confusing exchanges occur when they are presented with an opportunity to behave in non-traditional ways, yet they follow traditional patterns (Zinke, 2012). A recent study found that even in dual-physician marriages, women physicians considered their partners' career as of greater importance than their own (Stamm & Buddeberg-Fisher, 2011).

This study builds on these previous findings by providing a deeper level of analysis into couple processes and the ways that couples "do" gender in their relationships, with its evolution of grounded theory and linking this to previous studies' findings. This study is also significant in that it draws upon the entire sample of

interviews and not just subsamples, for example, female physicians (Starner, 2010), minority female physicians (Clarke, 2011), dual-professional physicians (Fider, 2011), dual-physician (Zinke, 2012), or conjoint interviews (Esmiol, 2011).

This study adds to the larger body of literature on physician families, which is mostly quantitative, by illuminating what is actually happening in physician couples that may be causing physician women to cut back on their work hours or men physicians to increase their work hours. The gendered differences in work hours, career advancement, and professional choices seems to be explained by the gendered processes happening in the ways physicians organize their family lives, such as who is defined as the breadwinner and gets to pursue their career and who is responsible for family life. This study demonstrates how couples respond to societal pressures to conform with gendered expectations, from traditional couples, who continue to do gender in conventional patters, to gender-conflicted couples, who struggle with traditional ideals in the face of unconventional circumstances, to de-gendering couples, who adopt purposeful strategies to resist the societal pressures to conform to traditional gender ideals.

REFERENCES

Amato, P. R., Johnson, D. R., Booth, A., & Rogers, S. (2003). Continuity and change in marital quality between 1980 and 2000. *Journal of Marriage and Family*, 65, 1-22.

Anderson, N.B. & Anderson, P.E. (2003). *Emotional longevity: What really determines howlong you live*. New York, NY: Viking.

Baber, K.M. (2009). Postmodern feminist perspectives and families. In S.A.Lloyd, A.L. Few, & K.R. Allen (Eds.), *Handbook of Feminist Family Studies* (pp. 56-68). Los Angeles, CA: Sage.

Barnett, R. C., Gareis, K. C., & Carr, P. L. (1999). Fit as a mediator of the relationship between work hours and burnout. *Journal of Occupational Health Psychology.* 4(4), 307-317.

Baxter, J. (1992). Power attitudes and time: The domestic division of labour. *Journal of Comparative Family Studies, 23*(2), 165-182.

Berman, E., Sacks, S., & Lief, H. (1975). The two-professional marriage: A new conflict syndrome. *Journal of Sex & Marital Therapy.* 1(3), 242-253.

Blaisure, K., & Allen, K. (1995). Feminists and the ideology and practice of marital equality. *Journal of Marriage and the Family, 57*,5-19.

Blanton, P.W. & Vandergriff-Avery, M. (2001). Marital therapy and marital power: Constructing narratives of sharing relational and positional power. *Contemporary Family Therapy, 23*(3), 295-308.

Blumstein, P., & Schwartz, P. (1983). *American couples*: *Money, work, sex.* New York: William Morrow.

Boulis, A. (2004). The evolution of gender and motherhood in contemporary medicine. *Annals, American Academy of Political and Social Science.* 596, November, 172-206.

Bowman, M. A., & Allen, D. I. (1990). *Stress and women physicians, 2nd Edition*. New York, NY: Springer-Verlag.

Brezsnyak, M. & Whisman, M.A. (2004). Sexual desire and relationship functioning: The effects of marital satisfaction and power. *Journal of Sex and Marital Therapy, 30,* 199-217.

Brian, S. R. (2001). Women in medicine. *American Family Physician.* 64(1):174-177.

Brotherton, S. E., & LeBailly, S. A. (1993). The effect of family on the work lives of married physicians: What if the spouse is a physician, too? *Journal of American Medical Women's Association.* 48(6):175-181.

Burr, V. (1995). *An introduction to social constructionism.* New York, NY: Routledge.

Burr, V. (2003). *Social Constructionism*, (2nd Edition). New York, NY: Routledge.

Busby, D.M. & Gardner, B.C. (2008). How do I analyze thee? Let me count the ways: Considering empathy in couple relationships using self and partner ratings. *Family Process, 47,* 229-242.

Caniano, D. A., Sonnino, R. E., & Paolo, A. M. (2004). Keys to career satisfaction: Insights from a survey of women pediatric surgeons. *Journal of Pediatric Surgery.* 39(6), 984-990.

Carrere, S., Buehlman, K.T., Gottman, J.M., Coan, J.A. & Ruckstuhl, L. (2000). Predicting marital stability and divorce in newlywed couples. *Journal of Family Psychotherapy*, 14(1), 42-58.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Los Angeles, CA: Sage.

Clark, N. R. (2011). Minority Female Physicians' Family and Career Experiences: A Qualitative Inquiry. *Dissertations and Theses,* Loma Linda University.

Coltrane, S. (2000). Research on household labor: Modeling and measuring the social embeddedness of routine family work. *Journal of Marriage and the Family, 62,* 1208-1233.

Coontz, S. (2005). *Marriage, a history from obedience to intimacy of how love conquered marriage.* New York, NY: Viking.

Corbin, J. & Strauss, A. (2008). *Basics of qualitative research: Techniques & procedures for developing grounded theory.* New York, NY: Sage.

Cowdery, R.S., Knudson-Martin, C., & Mahoney, A.R. (2009). Mothering: Innate talent or conscious collaboration? In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 127-147). New York, NY: Springer Publications.

Cowdery, R.S., Scarborough, N., Lewis, M.E., & Seshadri, G. (2009). Pulling together: How African American couples manage social inequalities. In C. Knudson-Martin & A. R. Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 215-233). New York, NY: Springer Publications.

Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publications, Inc.

Creswell, J. (1998). *Qualitative Inquiry and Research Design; Choosing Among Five Traditions*. London, New Delhi, Thousand Oaks, Sage Publications.

Creswell, J.W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches.* Thousand Oaks, CA: Sage.

Creswell, J. W., & Clark, V. L. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: Sage.

Cujec, B., Oancia, T., Bohm, C., & Johnson, D. (2000). Career and parenting satisfaction among medical students, residents and physician teachers at a Canadian medical school. *Canadian Medical Association Journal.* 162(5), 637-640.

Daly, K.J. (2007). *Qualitative methods for family studies & human development*. Los Angeles, CA: Sage.

Denzin, N., & Lincoln, Y. (Eds.). (2003). *The landscape of qualitative research, 2nd ed.: Theories and issues.* Thousand Oaks, CA: Sage Publications.

Deutsch, F.M. (1999). *Halving it all: How equally shared parenting works*. Cambridge, MA: Harvard University Press.

Deutsch, F.M. (2007). Undoing gender. *Gender & Society, 21*(1), 106-127.

Dienhart, A. (1998). *Reshaping fatherhood: The social construction of shared parenting.* Thousand Oaks, CA: Sage.

Doherty, W. J., & Burge, S. K. (1989). Divorce among physicians: Comparisons with other occupational groups. *Journal of the American Medical Association.* 261(16), 2374-2377.

Dolan-Del Vecchio, K. (2008). *Making love, playing power: Men, women, and the rewards of intimate justice.* Berkeley, CA: Soft Skull Press.

Elliot, F. R. (1979). Professional and family conflicts in hospital medicine. *Social Science & Medicine.* 13:57-64.

Esmiol, E. V. (2011). Marital Experience and Spirituality among Physican Couples. *Dissertations and Theses,* Loma Linda University.

Evans, J. L. (1965). Psychiatric illness in the physician's wife. *American Journal of Psychiatry.* 122:159-163.

Fabri P. J., McDaniel, M. D., Gaskill, H. V., Garrison, R. N., Hanks, J. B., Maier, R. V., & Teleford, G. L. (1989). Great expectations: Stress and the medical family. *Journal of Surgical Research.* 47, 379-382.

Ferree, M.M. (1991). Beyond separate spheres: Feminism and family research. In A. Booth (Ed.). *Contemporary families: Looking forward, looking back.* Minneapolis, MN: National Council on Family Relations.

Fider, C. O. (2011). Navigating Multiple Roles: Physicians Married to Non-Physician Professionals. *Dissertations and Theses,* Loma Linda University.

Fishbane, M.D. (2007). Wired to connect: Neuroscience, relationships, and therapy. *Family Process,* 46, p. 395-412.

Fletcher, R. H., & Fletcher, S. W. (Ed.) (1993). Here Come the Couples. *Annals of Internal Medicine, 119,* 628-630.

Flick, U. (2006). *An introduction to qualitative research*, 3rd ed. London: Sage Publications.

Gabbard G., & Menninger, R. W. (1988). The psychology of postponement in the medical marriage. *Journal of the American Medical Association.* 261(16), 2378-2381.

Gabbard G., Menninger, R. W., & Coyne, L. (1987). Sources of conflict in the medical marriage. *American Journal of Psychiatry.* 144:567-572.

Garvey, M., & Tuason, V. B. (1979). Physician marriages. *Journal of Clinical Psychiatry*. 40(3), 129-131.

Gerber, A. (1983). *Married to their careers: Career and family dilemmas in doctors' lives.* New York: Tavistock Publications.

Gergen, K. (2009). *An Invitation to Social Constructionism*. Thousand Oaks, CA: Sage Publications.

Gerson, J.M, & Peiss, K. (1985). Boundaries, negotiation, and consciousness: Reconceptualizing gender relations. *Social Problems, 32*, 317-331.

Gilbert, L.A. (1985). *Men in dual-career families: Current realities and future prospects*. Hillsdale, NJ: Lawrence Erlbaum.

Glick, I. D., & Borus, J. F. (1984). Marital and family therapy for troubled physicians and their families: A bridge over troubled waters. *Journal of the American Medical Association.* 251(14), 1855-1858.

Gottman, J. M., Coan, J., Carrere, S., & Swanson, C. (1998). Predicting marital happiness and stability from newlywed interactions. *Journal of Marriage and the Family, 60, 5-22.*

Gottman, J.M. & Silver, N. (1999). *Seven principles for making marriage work: A*

practical guide from the country's foremost relational expert. New York, NY: John Wiley & Sons.

Grant, L., & Simpson, L. A. (1994). Marriage and relationship satisfaction of physicians. *Sociological Focus.* 37(4), 327-342.

Gray-Little, B., Baucom, D.H., & Hamby, S.L. (1996). Marital power, marital adjustment, and therapy outcome. *Journal of Family Psychology, 10,* 292-303.

Greenberg, L. S., & Goldman, R. N. (2008). *Emotion-focused couples therapy: The dynamics of emotion, love and power.* Washington, DC: American Psychological Association.

Gupta, S. (1999). The effects of marital status transitions on men's housework performance. *Journal of Marriage and the Family, 61,* 700-711.

Haddock, S.A., Zimmerman, T.S., & MacPhee, D. (2000). The power equity guide: Attending to gender in family therapy. *Journal of Marital and Family Therapy, 26*(2), 153-170.

Halloran, E.C. (1998). The role of marital power in depression and marital distress. *The American Journal of Family Therapy, 26,* 3-14.

Heins, M., Smock, S., & Martindale, L., Jacobs, J., & Stein, M. (1977). Comparison of the productivity of women and male physicians. *Journal of the American Medical Association. 237,* 2514-2517.

Heins, M., Hendricks, J., Martindale, L., Smock, S., Stein, M., & Jacobs, J. (1979). Attitudes of women and men physicians. *American Journal of Public Health.* 69:1133-1139.

Hochschild, A. & Machung, A. (1990). *The second shift.* New York, NY: Avon Books.

Huenergardt, D. & Knudson-Martin, C. (2009). Gender and Power as a Fulcrum of Clinical Change. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, Gender, and Power: Creating Change in Intimate Relationships.* New York, NY: Springer Publications.

Jacobs, J. & Gerson, K. (2004). *The Time Divide: Work, Family and Gender Inequality.* Cambridge: Harvard University Press.

Janesick, V. J. (2003). The choreography of qualitative research design: Minuets, improvisations, and crystallization. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 379-400). Thousand Oaks, CA: Sage.

Johnson, S. (2004). *The practice of emotionally focused couple therapy: Creating connection,* (2nd edition). New York, NY: Brunner-Routledge.

Johnson, F. A., & Johnson, C. L. (1976). Role strain in high-commitment career women. *Journal of American Academic Psychoanalysis.* 4:13-36.

Jonathan, N. & Knudson-Martin, C. (2009). Carrying equal weight: Relational responsibility and attunement among same-sex couples. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, Gender, and Power: Creating Change in Intimate Relationships* (pp. 79-103). New York, NY: Springer Publications.

Jump, T.L. & Haas, L. (1987). Fathers in transition: Dual-career fathers participating in child-care. In M. Kimmel (Ed.), *Changing men: New research on men and masculinity.* Beverly Hills, CA: Sage.

Kaplan, S. H., Sullivan, L. M., Dukes, K. A., Phillips, C. F., Kelch, R. P., & Schaller, J. G. (1996). Sex differences in academic advancement: Results of a national study of pediatricians. *New England Journal of Medicine.* 335:1282-1289.

Knudson-Martin, C. (2009). An unequal burden: Gendered power in diabetes care. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 105-123). New York, NY: Springer Publications.

Knudson-Martin, C., & Mahoney, A. R. (1998). Language and processes in the construction of equality in new marriages. *Family Relations, 47,* 81-91.

Knudson-Martin, C., & Mahoney, A. R. (2005). Moving beyond gender: Processes that create relationship equality. *Journal of Marital & Family Therapy, 31,* 235-246.

Knudson-Martin, C. & Mahoney, A. (2009a). Beyond gender: The processes of relationship equality. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp.63-78). New York, NY: Springer Publications.

Knudson-Martin, C. & Mahoney, A. (2009b). *Couples, Gender, & Power: Creating Change in intimate relationships*. New York, NY: Springer.

Knudson-Martin, C. & Mahoney, A.R. (2009c). The myth of equality. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 105-123). New York, NY: Springer Publications.

Knudson-Martin, C. & Silverstein, R. (2009). Suffering in silence: Idealized motherhood and postpartum depression. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 171-190). New York, NY: Springer Publications.

Krell, R., & Miles, J. E. (1976). Marital therapy of couples in which the husband is a physician. *American Journal of Psychotherapy.* 30(2), 267-275.

Le Feuvre, N. (1999). Gender, occupational feminization, and reflexivity: A cross national perspective. In Restructuring gender relations and employment, edited by R. Crompton. Oxford, UK: Oxford University Press.

Lennon, M. C. (1996). Depression and self-esteem among women. In M. Falik & K. S. Collins (Eds.), *Women's health: The commonwealth fund survey* (pp. 207-236). Baltimore: Johns Hopkins University.

Leslie, L.A., & Southard, A.L. (2009). Thirty years of feminist family therapy. In S.A.Lloyd, A.L. Few, & K.R. Allen (Eds.), *Handbook of Feminist Family Studies* (pp. 328-339). Los Angeles, CA: Sage.

Lewis, J. M. (1965). The doctor and his marriage. *Texas State Journal of Medicine.* 61:615-619.

Lewis, J. M., Barnhart, F. D., Nace, E. P., & Carson, D. I. (1993). Marital satisfaction in the lives of physicians. *Bulletin of the Menninger Clinic.* 57(4), 458-465.

Lincoln, Y. & Guba, E. (2003). *The landscape of qualitative research. Theories and issues*, 2nd edition. London: Sage.

Linn, L. S., Yager, J., Cope, D. W., & Leake, B. (1985). Factors associated with life satisfaction among practicing internists. *Medical Care. 24*(9), 830-837.

Lorber, J. (1999). Embattled terrain: Gender and sexuality. In *Revisioning gender*, edited by M.M. Ferree, J. Lorber, and B.B. Hess. Thousand Oaks, CA: Sage.

Lorber, J. (2006). A world without gender. In K. Davis, M. Evans, & J. Lorber (Eds.), *Handbook of gender and women's studies* (pp.469-474). Thousand Oaks, CA: Sage.

Lyness, A.M., & Lyness, K.P. (2007). Feminist issues in couple therapy. *Journal of Couple and Relationship Therapy, 6,* 181-195.

Maciel, J.A, Van Putten, Z. & Knudson-Martin, C. (2009). Pushing the gender line: How immigrant couples reconstruct power. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 235-254). New York, NY: Springer Publications.

Mahoney, A.R. & Knudson-Martin, C. (2009). Gender equality in intimate relationships. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 105-123). New York, NY: Springer Publications.

Mahoney, A.R., & Knudson-Martin, C. (2009). The social context of gendered power. In

C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 105-123). New York, NY: Springer Publications.

Marshall, C., & Rossman, G. (1999). *Designing qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Matta, D.S. (2009). Fathering: Disengaged or responsive? In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 149-169). New York, NY: Springer Publications.

McCue, J. D. (1982). The effects of stress on physicians in their medical practice. *New England Journal of Medicine.* 306:458-463.

McGrath, E., Keita, G., Strickland, B., & Russo, N. (1990). *Women and depression: Risk factors and treatment issues.* Washington, DC: American Psychological Association.

McKay, M. B., Alboszta, M., Bingcang, C. C., Dickson, L., & Kraman, L. (1986). A stressor unique to married female physicians. *American Journal of Psychiatry*. 143(1), 114.

Miles, J.E., Krell, R., & Lin, T.Y. (1975). The doctor's wife: Mental illness and marital pattern. *International Journal of Psychiatry in Medicine, 6*(4), 481-487.

Moghadam, S. & Knudson-Martin, C. (2009). Keeping the peace: Couple relationships in iran. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 255-274). New York, NY: Springer Publications.

Moller, K., Hwang, P., & Wickberg, B. (2008). Couple relationship and transition to parenthood: Does workload at home matter? *Journal of Reproductive & Infant Psychology, 26*(1), 51-68.

Morse, J., & Richards, L. (2002). *Readme first: Users guide to qualitative methods.* Newbury Park, CA: Sage.

Myers, M. F. (1982). The professional woman as patient: a review and an appeal. *Canadian Journal of Psychiatry.* 27:236-240.

Myers, M. F. (1984). Overview: The female physician and her marriage. *American Journal of Psychiatry*. 141, 1386-1391.

Myers, M. F. (1986). Marital distress among resident physicians. *Canadian Medical Association Journal.* 134:1117-1118.

Myers, M. F. (2004). Medical marriages and other intimate relationships. *MJA*. 181(7), 392-394.

Murray, S.L., Rose, P., Holmes, J.G., Derrick, J., Podchaski, E.J., Bellavia, G., & Griffin, D.W. (2005). Putting the partner within reach: A dyadic perspective on felt close relationships. *Journal of personality & Social Psychology, 88*(2): 327-347.

Myers, M. F. (2004). Medical marriages and other intimate relationships. *MJA.* 181(7), 392-394.

Nakonezny, P.A. & Denton, W.H. (2008). Marital relationships: A social exchange theory perspective. *The American Journal of Family Therapy, 36,* 402-412.

Peplau, L.A. (1983). Roles and gender. In H.H.Kelley, E. Berscheid, A. Christensen, J.H. Harvey, T.L. Huston, G. Levinger, E. McClintock, L.A. Peplau, & D.R. Peterson, Close relations (pp. 220-264). New York: Freeman.

Perry-Jenkins, M., & Crouter, A.C. (1990). Men's provider role attitudes: Implications for household work and marital satisfaction. *Journal of Family Issues, 11,* 136-156.

Pleck, J. H. (1985) *Working wives/working husbands.* Beverly Hills, CA: Sage Publications.

Quek, K.M.T. (2009). We-consciousness: Creating equality in collectivist culture. In C. Knudson-Martin & A. Rankin Mahoney (Eds.), *Couples, gender, and power: Creating change in intimate relationships* (pp. 193-214). New York, NY: Springer Publications.

Reid, D.W., Dalton, E.J., Laderoute, K., Doell, F.K., & Nguyen, T. (2007). Therapeutically induced changes in couple identity: The role of we-ness and interpersonal processing in relationship satisfaction. *Genetic, Social, and General Psychology Monographs, 132*(2), 241-284.

Rhoads, J. M. (1977). Overwork. *Journal of the American Medical Association. 237*(24), 2615-2618.

Ricer, R. E. (1983). Marital satisfaction among military and civilian family practice residents. *Journal of Family Practice.* 17:303-307.

Risman, B.J. (1998). *Gender vertigo: American families in transition.* New Haven, CT: Yale University Press.

Risman, B.J. (2009). From doing to undoing: Gender as we know it. *Gender & Society, 23*(1), 81-84.

Robertson, R. (1986). How can we as physicians care for our own families? *Journal of Family Practice.* 23(2), 165-166.

Rosen, H. (1996). Meaning-making narratives: Foundations for constructivist and social constructionist psychotherapies. In H. Rosen & K.T. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists* (pp. 3-51). San Francisco: Jossey-Bass.

Rosow, I. & Rose, K. D. (1972). Divorce among doctors. *Journal of Marriage and the Family. 34*(4), 587-598.

Rusovick, R. & Knudson-Martin, C. (2009). Gender discourse in relationship stories of young american couples. In C. Knudson-Martin & A. Rankin Mahoney (Eds.*), Couples, gender, and power: Creating change in intimate relationships* (pp. 275-294). New York, NY: Springer Publications.

Schroen, A. T., Brownstein, M. R., & Sheldon, G. F. (2003).Comparison of Private Versus Academic Practice for General Surgeons: A Guide for Medical Students and Residents. *Journal of American College of Surgeons, 197(6),* 1000-1011.

Schwartz, P. (1994). *Love between equals: How peer marriage really works*. New York: The Free Press.

Segraves, K., Segraves, R. T., Woods, S. M. (1987). When the physician's marriage is in trouble. *Medical Aspects of Human Sexuality.* June 1987, 148-160.

Sexton, C.S. & Perlman, D.S. (1989). Couples' career orientation, gender role orientation, and perceived equity as determinants of marital power. *Journal of Marriage and the Family, 51*, 933-941.

Siegel, D.J. (2007). *The Mindful Brain: Reflection and Attunement in the Cultivation of Well-Being.* New York, NY: Guilford.

Sobecks N. W., Justice, A. C., Hinze, S., Chirayath, H. T., Lasek, R. J., Chren, M. M., Aucott, J., Juknialis, B., Fortinsky, R., Youngner, S., & Landefeld, C. S. (1999). When doctors marry doctors: A survey exploring the professional and family lives of young physicians. *Annals of Internal Medicine.* 130(4):312-319.

Sotile, W. M., & Sotile, M. O. (2004). Physicians' wives evaluate their marriages, their husbands, and life in medicine: Results of the AMA-Alliance Medical Marriage Survey. *Bulletin of the Menninger Clinic*. 68(1), 39-59.

Spendlove, D. C., Reed, B. D., & Whitman, N. (1990). Marital adjustment among housestaff and new attorneys. *Academic Medicine.* 65(9), 599-603.

Stamm, M., & Buddeberg-Fisher, B. (2011). How do physicians and their partners coordinate their careers and private lives? *Swiss Medical Weekly,* 141, 1-7.

Starner, E. M. (2010). Stressors and coping mechanisms of married female physicians: A qualitative review. *Dissertations and Theses,* Loma Linda University.

Steil, J. (1997). *Marital equality: Its relationship to the well-being of husbands and wives*. Newbury Park, CA: Sage.

Straehley, C. J., & Longo, P. (2006). Family issues affecting women in medicine, particularly women surgeons. *American Journal of Surgery* 192, 695-698.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*, 2nd ed. Thousand Oaks, CA: Sage Publications.

Stone, P. (2010). *Opting out: Why women really quit careers and head home*. Berkeley: University of California Press.

Strong, B., Devault, C., & Cohen, T. (2011). *The marriage and family experience: Intimate relationships in a changing society.* Belmont, CA: Wadsworth Cengage Learning.

Sullivan, O. (2006). *Changing gender relationships, changing families: Tracing the pace of change over time.* Boulder, CO: Rowman & Littlefield.

Talbott, G. D., Angres, D. H., Gallegos, K. V., Bettinardi-Angres, K., & Collins, J. (1991). The model medical marriage. *Journal of M*

Taylor, A. D. (1983). Special problems of physicians' children. *Physician's Management. 24*(1) 117-27.

Tichenor, V.J. (1999). Status and income as gendered resources: The case of marital power. *Journal of Marriage and the Family, 61*, 638-650.

Tichenor, V. J. (2005). *Earning more and getting less: Why successful wives can't buy equality*. New Brunswick, NJ: Rutgers University Press.

Vaillant, G. E., Sobowale, N. C. McArthur, C. (1972) Some psychologic vulnerabilities of physicians. *New England Journal of Medicine*, Vol. 287(8), Aug 1972. pp. 372-375.

Vincent, M. O. (1969). Dr. and Mrs.: Their mental health. *Canadian Psychiatric Journal. 14*(5), 509-515.

Vincent, M. O. (1985). A well doctor's family: The struggle for intimacy. *M M Journal. 35*(2), 111-115.

Warde, C. M., Moonesinghe, K., Allen, W., & Gelberg, L. (1999). Marital and parental satisfaction of married physicians with children. *Journal of General Internal Medicine*. (3):157-65.

Walker, A.J. (2009). A feminist critique of family studies. . In S.A.Lloyd, A.L. Few, &

K.R. Allen (Eds.), *Handbook of Feminist Family Studies* (pp. 18-27). Los Angeles, CA: Sage.

Whisman, M.A., & Jacobson, N.S. (1989). Depression, marital satisfaction, and marital and relationality measures of sex roles. *Journal of Marital and Family Therapy, 15*, 177-186.

Whisman, M.A., & Jacobson, N.S. (1990). Power, marital satisfaction, and response to marital therapy. *Journal of Family Psychology, 4*(2), 202-212.

West, C. & Zimmerman, D.H. (1987). Doing gender. *Gender and Society, 1*, 125-151.

Woodward, C. A. (2005). When a physician marries a physician: Effect of physician-physician marriages on professional activities. *Canadian Family Physician.* 51:850-851.

Yandoli, A. H. (1989). Stress and medical marriages. *Stress Medicine.* 5(4), 213-219.

Ziegler (1992). Dealing with stress in the physician's marriage. *Pennsylvania Medicine.* June, 38-41.

Zimmerman, T.S. (2000). Marital equality and satisfaction in stay-at-home mother and stay-at-home father families. *Contemporary Family Therapy, 22*(3), 337-354.

Zimmerman, T.S., Haddock, S.A., Ziemba, S., & Rust, A. (2001). Family organizational labor: Who is calling the plays. In T.S. Zimmerman (Ed.). *Balancing family and work: Special considerations in feminist therapy?* (pp.65-90). New York: Haworth Press.

Zinke, A. B. (2012). Dual Physician Couples: An Exploration of Family Stressors and Coping. *Dissertations and Theses,* Loma Linda University.

Zvonkovic, A., Greaves, K., Schmeige, C., & Hall, L. (1996). The marital construction of gender through work and family decisions. *Journal of Marriage and the Family, 58,* 91-100.

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRES

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. Gross annual income last year (individual, not combined).....

9. Years in current marriage .....

10. Years in current relationship .....

11. Number of children.....

12. Number of children living at home .....

13. Children's gender and age:

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

14. How many hours per week do you typically spend on:
    Paid work .....
    Housework .....
    Childcare .....
    Leisure.....
    Being with spouse .....
    Being with children.....
    Being with both spouse and child(ren) .....

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

Medical Doctors and Their Families: Spouse Questionnaire

Please answer the following questions:

1. Gender o Male (1) o Female (2)
2. Age.....
3. Race/ethnicity you most closely identify with:
   o Caucasian (1) o Black/African American (2) o Hispanic/Latino American (3)
   o Asian American (4) o Other .....
4. Religious organization/denomination that you most closely identify with:
   .....
5. Occupation .....
6. Highest level of education completed: o Less than High School (1)
   o High School Degree (2) o Some College (3) o College Degree (4)
   o Masters Degree (5) o Doctorate Degree (6)
   oOther.....
7. Gross annual income last year (individual, not combined).....
8. Years in current marriage .....
9. Years in current relationship .....
10. Number of children.....
11. Number of children living at home .....

12. Child's gender and age:

	Gender (male or female)	Age
First child		
Second child		
Third child		
Fourth child		
Fifth child		
Sixth child		

13. How many hours per week do you typically spend on:
    Paid work .....
    Housework .....
    Childcare .....
    Leisure.....
    Being with spouse .....
    Being with children.....
    Being with both spouse and child(ren) .....

14. Do you have a housekeeper? o Yes (1) o No (2)
    If yes, for how many hours per week.....

APPENDIX B

CONSENT FORM

LOMA LINDA UNIVERSITY

School of Science and Technology

Medical Doctors and Their Families: A Qualitative Inquiry

Loma Linda University Department of Counseling and Family Science

Consent Form

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

Purpose

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

Voluntary

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

Confidentiality

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

Referral

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

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

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

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

_____ _____

Name of Participant Date

_____ _____

Signature of Participant Date

APPENDIX C

INTERVIEW GUIDE

Interview Questions for
Medical Doctors and their Families: Qualitative Study
Revised 9/23/08

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

1. How did it come about in your life that you chose to become a physician?
    a. Probe: How did your childhood and family experiences affect your desire to become a physician?
    b. Probe: How did you choose your particular specialty?

2. What is it like being a physician for you? (shape who you are/what you should be)
    a. Probe: How rewarding or satisfying is your professional life?
    b. Probe: What are some aspects of being a physician that are challenging to you?
    c. Probe: What makes your work meaningful to you?
    d. Probe: How does being a physician help shape your identity/sense of self?

3. What core values or ethics guide you personally as a physician?
    a. Probe: What motivates you and guides you in your profession?
    b. Probe: How do you relate to the core-values/ethics of your profession?

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

1. Please tell me about the story of your relationship.
    a. Probe: How did you two meet?
    b. Probe: What attracted you to each other?
    c. Probe: What stage of your medical training or career were you in when your relationship began? What was it like to begin a relationship during that time? (ASK ONLY IF APPLICABLE)

2. How has your relationship evolved or changed during each stage of your medical training and career?
    a. Probes: During medical school, residency training, early practice, established practice, retirement? (ASK ONLY IF APPLICABLE)

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

1. How would you describe your current relationship?
    a. Probe: What aspects of your relationship do you find most satisfying?
    b. Probes: 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 most challenging or how might you wish it to be different?

2. What aspects of being in a physician marriage 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. Probe: 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 manage work and family?
    a. Probe: How are housework (and childcare) responsibilities divided? Why is it that way?
    b. Probe: How do you manage the responsibilities or the conflict associated with paid work and family work?
    c.

5. As a medical doctor, how do you manage the professional demands of your job and that of your spouse?
    a. Probe: How do you manage when there is a conflict between your job and your spouse's job?
    b. Probe: What are your thoughts about how your spouse feels about how their needs are being met? Probe further for professional and personal needs
    c. Probe: Would you say that one person's professional responsibilities precedence over the others'? Why is that?

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

D. Spirituality (in professional and personal lives)

1. Would you please tell me about your spiritual and religious life?
   Probe: How has your spiritual and religious life changed over time?

2. How do you maintain your relationship and stay connected with God (or Higher Power)?
    a. Probe: What specific practices help you stay close to God?

3. How does your spirituality affect your relationship with your spouse?

4. (TAKE OUT?) How does your spirituality affect your relationship(s) with your child(ren)?

5. *(to the physician)* How does your spirituality affect your work as a physician?

6. *(to the physician)* How have your work experiences affected your spirituality?

a. Probe: During what professional moments, whether moral dilemmas or inspirational events, have you experienced spiritual growth or difficulties?

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

E. <u>Stress</u> *(questions for the physician only)*

1. What are your thoughts about the demands of your professional life?
    a. Probes: What are the demands? How stressful are the demands?

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

3. How do you cope with stress?
    a. Probes: What works best? What does not work as well?

4. What kinds of support are available to you in managing the stressors in your life?
    a. What is most helpful about their support? Least helpful?
5. How does stress affect your relationships?
    a. Probes: With your spouse? With your children? With colleagues? With patients? With friends or extended family?

F. <u>Female Physicians</u> *(ask both male and female physicians 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 in your professional life?
    a. Probes: In the workplace? In marital life? In experiences of parenting?

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

G. <u>Parenting</u>

1. How did you make 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?

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

a. Probe: What values and priorities guide you in balancing these demands and needs?
b. Probe: What expectations do you place on yourself?
c. Probe: What does it mean to be a good parent? How do you achieve that?
d. Probe: What does it mean to be a good spouse? How do you achieve that?
e. Probe: How positively do you feel about your ability to meet these expectations from yourself and from others?

5. What is your relationship like with your children?
    a. Probes: Is it enjoyable? How do you spend time together? What do you do? How do you communicate with each other?

6. How is discipline handled with your children?
    a. Probes: Who handles it and how do you do it?
7. What aspects of being a physician parent affect your parenting or your relationship with your children?
    a. Probe: What are some of the benefits to your family of your being (your spouse's being) a physician?

8. What do you think is your child(ren)'s view of your professional life as a physician?

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

H. <u>Dual Physician Marriages</u>

1. What are some of the benefits or advantages to being in a marriage of two physicians?

2. What are some challenges particular to being in a dual-physician marriage?
    a. How have you two handled these challenges?

3. What advice would you offer to others in dual-physician marriages?

APPENDIX D

DEMOGRAPHICS

	Physician (n=33)	Spouse (n=16)
Sex		
Female	63.6% (21)	68.8% (11)
Male	36.4% (12)	31.3% (5)
Race		
Asian/Pacific Islander	**9.1% (3)** f 9.1% (3), m (0)	**6.3% (1)** f (0), m 6.3% (1)
Black/African American	**51.5% (17)** f 27.3% (9), m 24.3% (8)	**50.0% (8)** f 37.5% (6), m 12.5% (2)
East Indian	**6.1% (2)** f 6.1% (2), m (0)	0
Hispanic/Latino	**6.1% (2)** f 6.1% (2), m (0)	**12.5% (2)** f 6.3% (1), m 6.3% (1)
White/Caucasian	**27.3% (9)** f 15.2% (5), m 12.1% (4)	**31.3% (5)** f 25.0% (4), m 6.3% (1)
Age		
28-38	**42.4% (14)** f 33.3% (11), m 9.1% (3)	**37.7% (6)** f 12.5% (2), m 25.0% (4)
40-49	**24.2% (8)** f 18.2% (6), m 6.1% (2)	**31.4% (5)** f 25.0% (4), m 6.3% (1)
50-66	**30.1% (10)** f 12.1% (4), m 18.2% (6)	**31.5% (5)** f 31.5% (5), m (0)
67+	**3.0% (1)** f (0), m 3.0% (1)	0
Religion		
Baptist	**3.0% (1)** f 3.0% (1), m (0)	0
Catholic	**6.1% (2)** f 6.1% (2), m (0)	**7.1% (1)** f 7.1% (1), m (0)
Christian	**3.0% (1)** f 3.0% (1), m (0)	**7.1% (1)** f 7.1% (1), m (0)
Hindu	**3.0% (1)** f 3.0% (1), m (0)	**7.1% (1)** f (0), m 7.1% (1)
Lutheran	**3.0% (1)** f 3.0% (1), m (0)	0
Seventh-Day Adventist	**75.8% (25)** f 42.4% (14), m 33.3% (11)	**78.6% (11)** f 50.0% (8), m 18.8% (3)
None/Does not apply	**6.1% (2)** f 3.0% (1), m 3.0% (1)	0
Missing	0	2
Marital Status		
First Marriage	**93.1% (27)** f 54.5% (18), m 27.3% (9)	**90.9% (10)** f 23.1% (6), m 25.0% (4)
Second Marriage	**6.9% (2)** f 3.0% (1), m 3.0% (1)	**9.1% (1)** f 9.1% (1), m (0)

	Female Physician (n=21)	Male Physician (n=12)
Specialty		
Anesthesiology	0	8.33% (1)
Cardiology	0	16.67% (2)
Community/Public Health	4.76% (1)	0
Emergency Medicine	9.52% (2)	0
Family Practice	19.05% (4)	0
Family/Preventive/Public Health	0	8.33% (1)
Gastroenterology	4.76% (1)	0
General Surgery	0	8.33% (1)
Internal Medicine	9.52% (2)	0
Internal Medicine/Pediatrics	4.76% (1)	8.33% (1)
Obstetrics/Gynecology	14.29% (3)	0
Ophthalmology	4.76% (1)	0
Orthopedic Surgery	0	8.33% (1)
Pediatrics	4.76% (1)	0
Podiatry	4.76% (1)	0
Preventive Medicine	0	8.33% (1)
Preventive/Rehabilitative Medicine	4.76% (1)	0
Psychiatry	14.29% (3)	25.00% (3)
Radiology	0	8.33% (1)
Current Place of Work		
Community Clinic	14.76% (1)	0
Community Hospital	9.52% (2)	8.33% (1)
County	4.76% (1)	0
Large Group Practice	4.76% (1)	0
Multispecialty Group/Hospital	4.76% (1)	0
Outpatient Clinic	4.76% (1)	0
Private Practice	19.05% (4)	25.00% (3)
Public Health Department	0	8.33% (1)
State Hospital	4.76% (1)	0
University	4.76% (1)	0
University Hospital	14.29% (3)	33.33% (4)
VA Hospital	14.29% (3)	0
Missing	9.52% (2)	25.00% (3)

	Female Spouse (n=11)	Male Spouse (n=5)
Highest Level of Education Completed		
Some College	9.1% (1)	0
College Degree	54.5% (6)	20.0% (1)
Master's Degree	27.3% (3)	80.0% (4)
Doctorate Degree	9.1% (1)	0
Occupation		
Artist	9.1% (1)	0
Registered Nurse	36.4% (4)	0
Teacher	0	20.0% (1)
Business Manager	9.1% (1)	20.0% (1)
Physical Therapist	9.1% (1)	0
Stay at Home Mom	18.2% (2)	0
Com. Real Estate/Finance/Investments	0	20.0% (1)
Medical Administrator	9.1% (1)	0
Physician Family Practice	9.1% (1)	0
Graduate Student	0	20.0% (1)
Software	0	20.0% (1)

	Male Physician, Female Spouse								
	1	2	3	4	5	6	7	8	9
Hours Per Week Spent:									
Being with spouse	30,2	20,5	2,80	6,10	5,5	2,14	15,25	168,168	40,40
Being with children	M,0	M,35	4,130	6,30	6,168	3,20	4,68	0,M	1,2
With both spouse and children	M,0	20,15	20,75	6,10	M,14	2,21	20,20	M,M	2,2
On Leisure	4,2	20,15	86,160	4,8	17,6	8,14	8,4	15,14	10,10
On Childcare	M,0	10,20	0,0	0,30	4,0	2,14	M,M	0,M	0,0
On Housework	1,1	2,40	3,56	2,8	8,30	1,26	8,16	M,16	2,12
Do you have a Housekeeper?	No	Yes	Yes	No	No	M	Yes	No	No
How many hrs per week?		2	4				2		

	Female Physician, Male Spouse					Unknown (F/F)	
	10	11	12	13	14	15	16
Hours Per Week Spent:							
Being with spouse	5,45	40,10	M,25	10,54	40,10	20,100	2,2
Being with children	50,40	75,75	M,25	24,54	0,0	74,30	20,12
With both spouse and children	20,40	75,55	25,25	16,54	40,0	20,10	8,14
On Leisure	4,0	20,20	M,6	10,8	8,10	60,30	6,2
On Childcare	50,10	20,20	20,25	0,24	0,0	167,0	45,16
On Housework	14,4	M,20	15,10	20,4	5,5	21,6	15,2
Do you have a Housekeeper?	Yes	No	No	Yes	No	Yes	Yes
How many hrs per week?	1.5			24		6	2