Stressors and Coping Mechanisms of Married Female Physicians: A Qualitative review

Eva Marie Starner

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Stressors and Coping Mechanisms of Married Female Physicians:
A Qualitative Review

by

Eva Marie Starner

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

June 2010
Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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DEDICATION

This study is dedicated to the female physicians who so willingly shared their personal and professional journeys with me. They were eager to participate in the hope that the results of this study may make their lives and the lives of other female physicians easier.

Also, I would like to dedicate this study to my three daughters who as professional females struggle daily to navigate their personal and professional lives, and to my up and coming granddaughter, Gabrielle, who is becoming the woman she will become.

Finally, I would like to dedicate this dissertation to women everywhere who leave work and rush home to begin their "second shift" and to the men who love them. May they continue to be innovative and distinctive as they balance their personal and professional lives.
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ABSTRACT OF THE DISSERTATION

Stressors and Coping Mechanisms of Married Female Physicians:
A Qualitative Analysis.

By

Eva Marie Starner

Doctor of Philosophy, Graduate Program in Family Studies
Loma Linda University, June 2010
Dr. Curtis A. Fox, Chairperson

Female physicians live and work in a very complex world fraught with professional demands and personal challenges. Twenty-seven married female physicians were interviewed for this study to assess demands and stressors endemic to them and to determine how they manage them. The breadth of this study looked at the demands and stressors of the female physician from the perspective of her work environment, home and family responsibilities, parenting responsibilities, and self-imposed demands in her perceived roles as a working wife and mother. Two main categories emerged during the development of grounded theory: System Challenge and System Adaptation. Additionally, work demands, home demands, child care demands, self-imposed demands, reaching out and reaching in, emerged as subcategories. This present study has implications for theory, future research, family policy, work-family planning and execution, as well as employee incentives for married female physicians’ lives.
Introduction

Purpose Statement

The challenges of female physicians are unique when compared with those of other professional females (Barnett, Gareis, & Carr, 2005; Carr, Gareis, & Barnett, 2003; Gautum, 2001; Shrier & Shrier, 2005; Straehley & Longo, 2006; Zgheib, Zgheib, & Usta, 2006). The lives of female physicians are often fraught with intense emotion and distress (McMurray et al., 2000). Female physicians have to face life and death issues on a daily basis in their work context (Burke, 2001). Their work environment is often demanding and hostile toward them, and often they have little control over when and how they work (Shrier & Shrier, 2005). Many female physicians spend several hours per day at work, on call and away from their families (Burke, 2001); then on returning home, like many other women in society, they engage in a “second shift” (Hochschild & Machung, 1990) caring for the needs of their families. Because of the unique experience of female physicians, and as their numbers continue to increase in both medicine and medical practice (McMurray et al., 2000), it seems important to understand how they are able to navigate the challenges of balancing work and family life. A failure to cope with these challenges can exact a heavy personal and professional toll, including higher rates of suicide (Frank & Dingle, 1999) and poor emotional and physical outcomes.

Female physicians face unique challenges that may result which may result in devastating consequences such as having a 50% higher rate of suicide than their male colleagues (Frank & Dingle, 1999). Further, female physicians have a rate of suicide that is estimated to be 4 times higher compared to the female population at large (Beautrais,
Fergusson, & Horwood, 2006). In the past, suicide has accounted for 35% of the early deaths of physicians. However, only 3% of male physicians commit suicide, while 6.5% of female physicians are reported to commit suicide (Frank & Dingle, 1999). This rate of suicide for female physicians is much higher than the reported suicide rate for White females over 25 years of age (Beautrais et al., 2006).

Understanding how female physicians cope with their unique stressors is necessary for helping to alleviate some of the challenges and demands that predispose some female physicians to feel distressed and hopeless, leading to outcomes such as higher rates of suicide (Beautrais et al., 2006; Frank, Rothenberg, Brown, & Maiback, 1997; Hawton, Clements, Sakarovitch, Simkin, & Deeks, 2001; McGovern, Angres, Uziel-Miller, & Leon, 1997). The purpose of this present study is to explore empirically the stressors of married female physicians and how they cope with their stressors. The study looked at the challenges, demands, and stressors that these female physicians encountered in their multiple roles, and gathered information from them about how they navigated and balanced their daily lives. This study employed a qualitative methodology, and specifically, a grounded theory, consisting of in-depth interviews with female physicians (and their partners, as much as possible) to derive data in their “own voices” and to develop themes for further explanation.

While there are many anecdotal studies on female physicians from the 2000’s, 1990’s, and even the early 1980’s (Allen, 2005; Arnst, 2008; Baker, 1996; Barnett & Hyde, 2001; Boulis & Long, 2004; Brian, 2001; Maycian & Meyers, 2000; Cohen, 1997; Gautam, 2001; Linney, 1999; Magrane & Lange, 2006; McGovern, 1981; Myers, 1998; Phillips, 2000; Rosenbaum, 2008; Schultz, 2005; Searle, 2000) empirical research is
sparse (Cooney & Uhlenberg, 1989; Gray, 1983) with the most recent studies being conducted in the late 1990’s and early 2000’s (Burke, 2001; Carek, King, Hunter, & Gilbert, 2003; Carr, Friedman, Moskowitz, & Kazis, 1993; Cohen, 1997; McGovern et al., 1997; McMurray et al., 2000; Rout, 1996; Sobecks et al., 1999; Warde, Moonesinghe, Allen, & Gelber, 1999; Schemhammer & Colditz, 2004; Wittink, Barg, & Gallo, 2006).

Female physicians with their unique challenges are a relatively new phenomenon (Allen, 2005; Brian, 2001). Research conducted on physicians in the past has focused primarily on male physicians, although a limited sampling of females has at times been included (Carek et al., 2003; Linney, 1999; Sobecks et al., 1999; Wittink et al., 2006).

The entrance of increasing number of women in the workforce outside the home also could be seen in the medical profession. Over the past four decades this trend has been especially pronounced as the percentage of women earning medical degrees has increased from 8.4% in 1970, to 23% in 1979 (Grant & Eiden, 1981). By early 2000, the number of women has risen to approximately half of US medical school graduates (Magrane & Jolly, 2005). Since 2002, females have made up over half of all medical school applicants (Matthew & Garrison, 2007) and is predicted to be about 30% of practicing physicians by 2010 (American Medical Association, 1995; Allen, 2005; Brian, 200; Magrane & Lange, 2006). Female physicians are making a major impact on how medicine is practiced (Allen, 2005; Brian, 2001; Cohen, 1997; Searle, 2000), including voicing increasing concerns about the physician’s family (Phillips, 2000; Searle, 2000).

There is a present need to understand the history of medicine and the paradigm shift that needs to take place (Searle, 2000) to make medicine more conducive to the life of female physicians. There is a need to understand the married female physicians and
their lives in an effort to prepare them for the challenges that lay ahead of them — being physicians while still being wives and mothers (Allen, 2005; Arnst, 2008; Brian, 2001). However, learning to cope effectively for female physicians may mean adjusting their work environment to make it more friendly and conducive for them and others (Rosenbaum, 2008).

**Background-Gender Roles**

The current order of gender socialization can be traced back to the industrial revolution (Kimmel, 2004; DeVault & Cohen, 2005). Before that time, 80% of families were agrarian, working on farms (Kimmel, 1996). The father, mother, and children were expected to play significant roles to ensure the survival of the home and family (Kimmel, 1996). While the husband worked in the fields, the wife made sure that there was food to eat and that the children were well cared for, and the children helped wherever needed (Kimmel, 1996; Strong et al., 2005).

When families moved from farms into the cities, these roles changed in response to the industrial revolution, the majority of jobs moved into the factories (Kimmel, 1996; Kimmel, 2004; Strong et al., 2005). The males went to work in labor-intensive positions in the factories, while the females stayed at home and continued to provide services for their husbands and children (Strong et al., 2005). However, this unpaid work inside of the home was not as valued as the paid work outside of the home (Ferree, 1991; Strong et al., 2005). The female role became homemaker or housewife, while the male role became breadwinner, providing economic support (Ferree, 1991; Kimmel, 1996; Kimmel, 2004;
Strong et al., 2005). A poem, "The Princess," by Alfred Lord Tennyson, quoted by Kimmel (2004), clearly delineates this position:

Male for the field and female for the hearth:
Male for the sword and for the needle her:
Male with the head and female with the heart:
Male to command and females to obey;
All else, confusion. (p. 120)

Because of industrialization, men no longer spent the amount of time at home helping with housework and childcare; he now spent time in the factories. Areas of family life that suffered with this new arrangement were the male involvement with parenting and housework (Kimmel, 1996). The worlds of the male and female complemented each other, but there was no equality. Notice what women were told by Catherine Beecher and Harriet Beecher Stowe in *The American Women's Home* of 1869, as quoted in Kimmel (2004):

When the family is instituted by marriage, it is man who is head and chief magistrate by the force of his physical power and requirement of the chief responsibility; not less is he so according to the Christian law, by which, when differences arise, the husband has the deciding control, and the wife is too obey. (p. 120)

It was predetermined which roles the males and females should fulfill (Kimmel, 2004; Strong et al., 2005), and any deviation from these roles for both the male and the female was thought to cause "confusion." This same view of male and female roles continues to be evident in society today (Carter, 1994). Females are expected to exhibit the character traits that have been attributed to them for the centuries. These traits include devotion, a gentle spirit, patience, and kindness, all of which uphold the patriarchal view of females serving the needs of the greater male power (Carter, 1994). This patriarchal view typically leaves females in powerless situations at home and at work; consequently,
females are typically relegated to less important positions in society (Carter, 1994; Mason & Goulden, 2002).

Professional females in a gendered society face challenges different to those of men. There has been much debate on the topic of sex and gender with the desire to give specific epistemological origins to the words and the expectations that they denote (Hare-Mustin & Marecek, 1988; Ken, 2007; Kennelly, 2001; Kennelly, 2002; Kimmel, 2004; Phillips, 2000; Pichevin & Hurtig, 2007; West & Fenstenmaker, 1995; West & Zimmerman, 1987; Wolfinger, Mason, & Goulden, 2008). According to societal expectations, the female should be the nurturer, caring for her partner, her children, and any family members that need her (Allen, 2005; Carter, 1994; Cohen, 1997; McMurray et al., 2000; Strong et al., 2005). In a similar vein, the male is given power over the female.

Males in society fight to keep their roles within these social expectations, which give them power and dominance over females (Eagly, 2000; Poortman & van der Lippe, 2009; Schultz, 2005). In some cases, even when a female and a male believe that they have an egalitarian relationship, the family roles revert to those of the traditional gendered society when children enter the family (Brewster & Padavic, 2000; Caniano, Sonnino, & Paolo, 2004; Carter & McGoldrick, 2005; Hochschild & Machung, 1990; Strong et al., 2005). The female cares for the children and home in her role as nurturer, and the male is family breadwinner. This in turn causes the family system to be in a state of equilibrium (Winton, 1995).

Generally, society expects females to be warm, fuzzy, and submissive (Schultz, 2005). Both males and females judge themselves, either positively or negatively, to the extent that these roles are internalized and followed (Eagly, 2000). These expectations
may cause significant stressors and affect the female’s mental health outcomes (Carter, 1994; Coltrane, 2000; Gray, 1983; Pavalko & Smith, 1999; Tsunoda, 2001) and “can also produce ambiguity, confusion, and debates concerning what is the proper place of women and men in society” (Eagly, 2000, p. 452).

Housework is another area that is delegated to females in society. Since males tend to be more powerful in the home, they may choose whether or not to do housework; if he does not want to do it, he does not do it (Poortman & van der Lippe, 2009). More specifically, when things become unbalanced at home, females are held responsible for not handling the responsibilities. This is amplified especially when a female works outside of the home (Eagly, 2000). In addition to performing more of the domestic duties in the home, females often fill positions of lesser significance in society such as teachers, nurses, secretaries, and beauticians (Eagly, 2000).

Conversely, when females become the breadwinner in the home, the male might contribute less to the household than before the wife began to work (Brines, 1994; Kimmel, 1996). As a result, the female remains responsible for caring for the home and children even though her role has shifted to primary breadwinner (Brines, 1994). Society expects females to fulfill the socially acceptable gender roles that have been assigned to them (Eagly, 2000; Poortman & van der Lippe, 2009). Each society assigns individuals specific roles according to their level of economic opportunity, ethnic background, experience, and biological sex (Eagly, 2000).

The American family model perpetuates the traditional view (Mason & Goulden, 2002; Wolfinger et al., 2008) of the male who goes to work, and the female, caring for the children and home, who works typically as a second income for the family. By
holding these low paying and less demanding positions, females typically do not have to worry about traveling for business or working long hours, so they can be available to care for the family (Hochschild & Machung, 1990; Mason & Goulden, 2002; Wolfinger et al., 2008).

When working professional females have greater demands upon their time, they inevitably struggle to juggle their varying roles. Seventy-seven percent of females in professional roles report that they have had role conflict and strain between their home and work (Cooney & Uhlenberg, 1989; Goldberg & Perry-Jenkins, 2004; Gray, 1983). With these competing demands on their time and energy, it is often difficult for professional females to decide which areas receive the most attention, thus causing role conflict and strain (Mason & Goulden, 2002; Sears & Galambos, 1992; Tsunoda, 2001; Wolfinger et al., 2008). Both of the female roles are important because they have spent much time and money working to get to their current positions at work, and have invested an incredible amount of time and energy in building a family (Cooney & Uhlenberg, 1989; Gray, 1983).

Most female physicians want to marry and have children (Brian, 2001; Rosenbaum, 2008). However, their unique challenges continue to include taking responsibility for the well-being of their patients as well as the well-being for their families (Rosenbaum, 2008). Both internal and external forces affect the way the female physician experiences the career of medicine (Shrier & Shrier, 2005). Some of the external challenges that she must meet include (a) gender bias from patients and colleagues, (b) a hostile, inflexible, and competitive work environment, (c) death and dying, and (d) the fact that she is dealing with starting her career while thinking about
starting a family, and the timing of both (McGovern, 1981; Pitt-Catsouphes & Christensen, 2004; Shrier & Shrier, 2005). The female physician has internal forces that challenge her daily also. These include (a) devaluing herself when she does not meet her work and family expectations, (b) not giving herself credit for the work that she does, (c) worrying that if she does better than her male counterpart she will be less valued as a woman, (d) having doubts about her roles at work and home, and (e) attempting to balance at work and at home (Shrier & Shrier, 2005). The female physician may feel she should at all times concede her thoughts, desires, expert abilities, and opinions to her male counterpart in order to prove that she knows her role in life (McGovern, 1981).

**Rationale**

This present study is important and crucial to the profession of medicine and Family Scientists for at least four significant reasons. First, there is a paucity of current empirical literature examining the experiences of female physicians (Carr et al., 2003; End, Mittlboeck, & Piza-Katzer, 2004; Caniano, Sonnino, & Paolo, 2004). Second, while female professionals have common challenges, not all work/family experiences are created equal (Cooney & Uhlenberg, 1989; Gray, 1983). Third, there are ever-increasing numbers of females in the workforce, and this is no less true when applied to female physicians (US Census, 2003). In fact, over 50% of all medical students are now females (Allen, 2005; Brian, 2001; Gibbs, 2009), but only 33% of the practicing physicians are females, which suggests female physicians’ expectations change over time. It is crucial therefore, to uncover who female physicians are and what their needs are both at home
and at work. Fourth, this study helps to influence work-family policy and can provide empirical data, which may influence the best practices for female physicians.
Conceptual Framework

Structural Functionalism

Constructing a conceptual framework that can inform how female physicians cope with their unique challenges necessitates examining already existing theory. There is controversy among the various family researchers who find it difficult to define a theory that encompasses all aspects of the family and its needs (MacDermid, Roy, & Zvonkovic, 2005). According to MacDermid et al., much of the theory available today is conjecture and/or assumptions that are based on previously observed data and is developed from research findings that are limited in their scope and audience. In other words, the theory today that can be used to understand how the family functions and to determine its needs is based on research done many years ago and may not necessarily encompass the challenges of present-day family experience. However, after looking at various theories, it appears that structural functionalism is one that provides a framework with which to understand some of the challenges of the married female physician by exploring the varied functions/roles she performs on a daily basis in her various systems (i.e., home and work) and discovering how she balances “these key roles... affecting the role-related outcomes” (Gareis, Barnett, Ertel, & Berkman, 2009, p. 696).

Structural functionalism is a theoretical framework that can be that can be used to understand how families work and fill their functions or roles in the family and in society (Winton, 1995). Kingsbury and Scanzoni (1993) note that “functionalist assumptions remain central to family sociology and family studies” (p.195). The theory looks at the family as a system and at each individual’s function/role within the system. This theory
examines a society that is formed on order, interdependence, and maintaining balance or equilibrium to keep the systems running smoothly.

According to Strong et al. (2005), one way to understand this theory is to think of a tree. The family is the trunk with its roots deep in the earth. The branches are the individual members and each is connected to the trunk. The members have functions to perform in order to keep the structure (tree) healthy and happy. They may grow leaves or they may grow fruit, whatever is their prescribed function (Strong et al., 2005). This conceptual framework lends itself to a traditional style of family as a unit with specific roles and functions for each member (Kingsbury & Scanzoni, 1993; MacDermid et al., 2005).

The interdependence of the members of the systems means they must have shared values and beliefs. This order encompasses role expectations and gender expectations in an attempt to keep balance and homogeneity within the group. These expectations make this theory especially relevant to female physicians who have gender role expectations, identity role expectations, and career role expectations to keep in balance. Structural functionalism helps to show how female physicians fulfill their various role expectations and how they strive to keep their systems in balance. Structural functionalists do acknowledge change can occur within the system. At these times, the systems must use adaptation due to changes that occur, to help put the system back in order when it is out of alignment (Keel, 2009; Winton, 1995). This adaptation can be viewed as the coping mechanisms that female physicians use to find balance in their daily lives.

Structural functionalism focuses only on the macro level of involvement. Structural functionalism examines large-scale social institutions like society, government,
and the work force. This theory is not focused on the individual as such, but on how the individual can contribute to the whole. There are four basic constructs in structural functionalism. These include (a) family systems, (b) social structures, (c) individual functioning, and (d) equilibrium or balance (Winton, 1995), which will maintain family order. A system is a place where people belong. It could be the family into which they are born, the place at which they work, the family that they create, the place to which they go for religious service, the political party with which they are affiliated, the schools that they have attended, and the place in which they live (Winton, 1995). The female physician’s systems could include where she practices medicine, where her family lives, her church affiliation, and her professional organizations. Whatever the system, the members share normative beliefs and values with each other and the members will do what is expected of them to keep the system working (Winton, 1995).

There are some basic assumptions that will work through all of the systems, whether social, cultural, personal, or behavioral. In each system there will be order and the members will be held together by cooperation, orderliness, and interdependence (Winton, 1995). The female physician functions interdependently with her husband and children, her extended family members, and family of origin; she functions interdependently with her medical school professors and fellow students; she functions interdependently in her work environment with the staff, nurses, colleagues, and hospital administrators; she functions interdependently within her social group, friends, cosmetologist, favorite restaurants, grocery store, and the mall. While she functions within all of these systems, she must strive to maintain balance in all and to fulfill her role expectations in each system. The systems function best when all units within the
system fulfill their expected functions. This maintains the equilibrium (Keel, 2009; Kingsbury & Scanzoni, 1993; Winton, 1995).

The functions are what the members do within the system. The members of the system teach each other the needed functions (MacDermid et al., 2005; Winton, 1995). Female physicians have career and job expectations and requirements. The married female physician has time constraints that keep her from being at home with her family when she would like to be, to fulfill her role expectations, so she has to use adaptation (or coping mechanisms) and allocation (designation) to compensate for her lack of ability to perform her required roles. The female physician teaches or trains her family how to care for the needs of each other while she is away from home. At the same time, she trains her staff how to help take care of the patients in the office or at the hospital in her absence. The members provide support for each other with the members fulfilling the roles according to their skill levels to keep the systems in balance (Keel, 2009; Winton, 1995). The female physician provides support as a function by ensuring that home is taken care of and providing financial support for her family.

Structural functionalism is an appropriate theory to use to peer into the dynamic world of female physicians. Using the lens of structural functionalism, the researcher plans to show how work/family conflict contributes to unbalance or disequilibrium in the system and how the female physicians must initialize adaptation (or coping) within the system to restore the balance. Structural functionalism can look at the functions and/or roles in the family and not necessarily be concerned with the biological sex even though traditionally the functions have been gendered (Kimmel, 2004; MacDermid et al., 2005; Strong et al., 2005, Winton, 1995). This theory gives the family more choices and helps
them to choose who will fill the various roles in the home and how the family will work out the functionality that is required for the success of the structure (MacDermid et al., 2005).

Female physicians must learn to adapt or cope throughout the system. Work and family stressors typically come when the structure is not functioning due to too many work responsibilities or home responsibilities, and the two become conflicted (MacDermid et al., 2005) or overloaded and disequilibrium occurs (Winton, 1995).

According to Perry-Jenkins, Repetti, and Crouter (2000) in the Journal of Marriage and Family decade review, three areas influence the family and the working relationship of its members. They are (a) the multiple roles that the family members play, (b) the fact that the mother works outside of the home, and (c) the stress that is directly related to the work environment (Kiecolt, 2003).

Since western society was transformed after the Industrial Revolution, what is regarded as housework and paid work and the expectations of both have changed (Allen, Herst, Burck, & Sutton, 2000). With this change comes conflict between work and the home. The expectations of family and work functions or roles are polar opposites and meeting the requirements of either pole means not meeting the requirements of the other (Noor, 2004). More females today hold many roles, which include wife, mother, daughter, employee or employer. Because of these many roles, females experience conflict between work and home (Jonsson, Johansson, Rosengren, Lappas, & Wilhelmsen, 2003; Noor, 2002), upsetting the delicate balance of their family/work systems, and causing them to adapt (cope) in order to return the systems to balance (Keel, 2009; Winton, 1995).
The family is changing in many ways. Notably, there have been significant shifts in roles, rules, and responsibility in the family context (Allen et al., 2000). This seems even more pronounced with physician families. The current theories, even though they provide reasonable explanations, need to be modified so that they may include the way the female physician’s family functions today (MacDermid, 2005). It is important not to throw away the older, proven theories but to incorporate the current perspectives into theories that already exist. However, it is appropriate to examine ways in which existing theories may or may not be helpful in providing clarity to the current observations regarding work and family among female physicians.

This study looked at the married female physician and her demands and adaptations through the structural functionalist lens; it examined how she copes and keeps her systems in equilibrium (MacDermid et al., 2005; Strong et al., 2005; Winton, 1995).
Review of the Literature

Statement of Thesis

Today, females in society today work in a hostile environment that is built upon the male career model that has been in effect since the nineteenth century (Reskin & Bielby, 2005; Wolfinger et al., 2008). This model gives men positions with greater income and more responsible positions outside the home, without the concerns of the family responsibilities (Reskin & Bielby, 2005; Wolfinger et al., 2008). Female physicians are not exempt from the drama that comes from the traditional and gendered roles that are expected of all females in society today (Kimmel, 2004; Winton, 1995). The male career model purports that work comes first, no matter what, and that the home is the females’ work, no matter what (Wolfinger et al., 2008). The field of medicine has also traditionally been built upon a male career model and it expects singularly focused devotion from its physicians whether the physician is male or female (Reskin & Bielby, 2005; Sobecks et al., 1999, Wolfinger et al., 2008). Female physicians are required to work in this career model that is specifically designed for the male who goes to work without family interruptions because his spouse watches over the family (Pitt-Catsouphes & Christensen, 2004; Reskin & Bielby, 2005). The female works and functions in a structure that is based upon the roles that have been set up by a male dominated society (Carter, 1994; Pitt-Catsouphes & Christensen, 2004).

The purpose of this literature review is to examine the previous empirical research that has been published in peer reviewed journals, looking at coping/adaptation, work/family conflict, professional females, and female and male physicians. This study
endeavors to obtain a deeper understanding of how females navigate their role expectations and of the coping/adaptation mechanisms they use for the best possible outcomes.

**Coping/Adaptation**

Coping is an attempt to control or alleviate feelings of stress (Lazarus & Folkman, 1984; Lazarus, 1999). Coping is a process that can (a) reduce the reaction to a stressor, (b) change the meaning of a stressor so that it is no longer conceived as stressful, or (c) remove an individual from the environment that is stressful so that the stress no longer exists (Lazarus, 1999). Thus, according to structural functionalism, coping can put the system back into the state of equilibrium (Winton, 1995).

According to structural functionalists, coping or adaptation is a means used to help reorder when the roles in the various systems become confused or are out of order (Winton, 1995); for example, the case of a female physician who is trying to juggle work and family without success. The three main tenets of structural functionalism are (a) how the family functions in society, (b) what roles are required by each member of the family system as they function within the family and society, and (c) the needs each family member meets for the other members in the family as they fulfill their functions (MacDermid et al., 2005; Strong et al., 2005; Winton, 1995). For example, when a female physician is experiencing work/family conflict because she is being pulled in too many directions, she must use adaptation or coping to change her reaction to the situation, change her view of the situation, or remove herself from the situation so that she can feel in control with all her systems in equilibrium or balance again.
Lazarus (1993) explained the association between appraisals and coping in an attempt to further find meaning for the ways that people cope. According to Folkman, Lazarus, Gruen, and Delongis (1986), when a person is under stress, he or she will appraise the situation “as taxing or exceeding his or her well-being” (p. 572).

There are two types of appraisal used in this process: primary appraisal and secondary appraisal. In the case of primary appraisal the individual has to decide if a current situation affects them in any way, whether positively or negatively. In the case of secondary appraisal the individual determines what, if anything, “can be done to overcome or prevent harm” (Folkman et al., 1986; p. 572) to themselves or anyone else within their systems. The individual will continue to evaluate the situation by noting which coping mechanisms or adaptations may be used to alleviate the current situation (Folkman et al., 1986). Structural functionalism intimates that individuals within the family are constantly appraising the family system to determine any harm that may be occurring in the family and determine what can be done to fix the problem. For example, when the female ER physician discovers that she has to work late due to an emergency that just came in, this causes stress. She can use primary appraisal to see if working late will cause harm to her or her family system. She needs to know if her children are taken care of or if she needs help in caring for them. Once determining that there is potential harm to her family system, she will use secondary appraisal to see who can help her in the situation (perhaps by having someone pick up her children), and then she can make arrangements to alleviate the situation.
Traditional Role Expectations

Empirical research studies have consistently shown that more and more females are working in the labor force with almost half of all workers being female (Gibbs, 2009). Currently, 64% of these working females continue to do the largest portion of the housework, childcare, and the caring for sick relatives (Coltrane, 2000; U. S. Census Bureau, 2003). Research conducted by Poortman and Van Der Lippe (2009) supports the fact that females come home from work and continue to care for the children and home and when there is conflict in the home over who does the household tasks, the male is considered to have more power than the female; therefore, he may choose not to do housework, but the female feels that she is supposed to do the work and eventually gives in and does it.

The traditional role expectations that females fulfill in society today are stereotypes that were first introduced when the females were children (Reid & Bing, 2000). Girls were given dolls to comfort and dress. They were given play kitchens so they could cook and learn to serve (Reid & Bing, 2000). Females are taught at an early age that they should get married, have children, and take care of their home. The female, therefore, plans to marry, and places more importance on marriage and the family than does the male (Meier, Hull, & Ortyl, 2009). Reid and Bing (2000) assert:

Traditional expectations about the manner in which girls and females should behave impose themselves in every arena, both public and private. Beliefs about appropriate responses extend themselves into every social class and into all professions regardless of the level of training. (p. 142)

In all professions and level of training could be applied to female physicians. As a female, she is expected to behave as all females have done before her by following the societal role expectations that have been imposed upon her, while maintaining her
professionalism as a physician (Carter, 1994; Layton, 2004; Reid & Bing, 2000; Wolfinger et al., 2008). Eagly (2000) asserts that for the family to have “smoothly functioning social interaction is to behave consistently with one’s gender role or at least to avoid strongly deviating from the role” (p. 449). When the female physician strays from the sex specific functions in her structural social system, she is considered to cause disequilibrium in the system.

**Professional females and work/family stress.** The fact that there are only so many hours in the day means that if more hours during that day are spent on work, then consequently there are fewer hours per day to spend on family cares (Greenhaus & Parasuraman, 2002). This goes both ways. When too much time is spent in either work or family the other role receives less time and the demands of the neglected role cause stress. This continued demand of both work and family roles puts a strain on the emotional, physiological, and cognitive forces of the individual (Edwards & Rothbard, 2000). The amount of time that an individual spends on work or family roles is based on “early socialization, internalized beliefs, and normative expectations of gender-appropriate role behavior” (Greenhaus & Parasuraman, 2002, p. 116).

Research findings suggest that because females have increased their presence in the workforce and are beginning to hold some of the top level managerial positions once typically held by males, they are experiencing more work/family stress and conflict (Wolfinger et al., 2008). They hold these positions once held by men while they continue navigating societal roles/functions as wife, mother, sister, daughter, cook, maid, nanny, chauffeur, nurturer, and healer (Wolfinger et al., 2008).
Both males and females have stress hormones that rise and fall throughout the day as the need arises, but while the male stress hormone levels drop once they leave work, the female's stress hormones stay at high levels even after they have finished their paid work and head home (Frankenhaeuser et al., 1989), which is why their stress hormones remain high at the end of the day. The female physician is no different. She has the same role expectations as other professional women (Brian, 2001; Rosenbaum, 2008).

Handwerker (1999) asserts males and females fulfill different roles/functions in their lives, and they have stressors that are caused by their gendered life experiences (Wolfinger et al., 2008) as well as their career choices.

The phenomenon of work and family stress among married, female professionals has been explored by several researchers, some with complementary findings and other with contradictory findings. In research conducted by Cooney and Uhlenberg (1989), Gray (1983), and Berger (2000), each took a glimpse into the lives of female professionals, but in different ways. Cooney and Uhlenberg (1989) compared married judges, attorneys, physicians, and teachers to see how they initiated patterns of family life; Gray (1983) studied married physicians, attorneys, and professors to gain insight into their work/family stress; and Berger (2000) gathered insight into the stress and role conflict of married attorneys.

Data used for the Cooney Uhlenberg (1989) study were gathered from the 1980 U.S. Census and were evaluated by the researchers in an attempt to fully understand the phenomenon of married female professionals (U. S. Census, 1980). The inclusion criteria for this study were the age, level of education, and current occupation for the females.
(Cooney & Uhlenberg, 1989). The Cooney and Uhlenberg (1989) study was quantitative and included 839 attorneys, 486 physicians, and 1,120 teachers.

The results from the Cooney and Uhlenberg (1989) study indicated that female attorneys were more likely to divorce than other professional females in the study, and they also are less likely to remarry. The divorce rate of attorneys in this study is more than twice that of physicians, possibly indicating that female physicians are more likely to marry and stay married than are female attorneys (Cooney & Uhlenberg, 1989). One possible explanation for this phenomenon is that physicians typically marry later, usually after residency, and age is a contributing factor to the longevity of the marriage relationship (Cooney & Uhlenberg, 1989). In addition, the findings from this study indicated that highly educated females such as physicians, attorneys, and teachers, typically have higher levels of divorce than the females in the general population (Cooney & Uhlenberg, 1989). Other findings of this study indicated that female attorneys typically married men with less education than themselves, which could be another reason they divorce more often (Cooney & Uhlenberg, 1989). Also, income was important in determining if females married and had children. Attorneys and teachers typically lost income when they decided to begin a family, while physicians’ income remained comparatively unchanged with dual physician families having a much higher income level than married couples in general (Cooney & Uhlenberg, 1989).

The Gray (1983) study was a quantitative study that examined 300 female physicians, attorneys, and teachers from the Philadelphia area. She used a questionnaire to gather data from the females. The results of the survey indicated that 77% of the participants stated the daily strain and conflict between their personal and professional
life was to be expected because they were females and they would continue to strive toward reducing the stress at work and at home (Gray, 1983).

The research done by Cooney and Uhlenberg (1989) and Gray (1983) gives some insight into the professional female in today's society and the work/family stress they endure. Because more females are attending college today, there is a positive correlation between their matriculations through higher education and whether or not they marry, if they have children, and the number of children they have (Rindfuss & St. John, 1983). Additionally, it was noted in these studies that when the female professional did marry, she married later in life and had fewer children and typically encountered some infertility issues (Cooney & Uhlenberg, 1989; Rindfuss, Morgan, & Swicegood, 1988).

A later study by Berger (2000) reported complementary findings to the Cooney and Uhlenberg (1989) study in relation to attorneys. Berger examined the stress, burnout, and role conflict among female attorneys. The findings from this study revealed that female attorneys experience stress and role conflict at a higher rate than other professional females, which could also be an indicator of why they divorce more often (Berger, 2000; Cooney & Uhlenberg, 1989). In addition, those who participated in the study stipulated to any future female attorneys who wanted to get married or to have children, that they should change their career paths before attempting to fulfill the traditional societal roles of caring and nurturing that are expected of them (Berger, 2000).

The experience of professional females and work family stress was also explored by Mason and Goulden (2002). Mason and Goulden (2002) were interested in female Ph.D’s and if they would follow the traditional roles/functions that have been given to females in regards to family formation and specifically to having children, and if it would
cause stress between work and family. The researchers wanted to see if female Ph.D.'s were likely to get married and have children before, during, or after attaining to higher levels of education, and if they experienced work/family stress (Mason & Goulden, 2002; Wolfinger et al., 2008).

For professional females to attain high positions in business, academia, and other professional fields, it was discovered that they typically delayed getting married and having children well into their thirties and for some of them, even into their forties (Mason & Goulden, 2002; Wolfinger et al., 2008). This research can help prepare young doctoral students and other professional females who may be thinking about family formation to understand the reality of their decisions. The study by Mason and Goulden (2002) indicated that 56% of the female Ph.D.'s married and had children within 5 years of getting their degree, and another 44% of female Ph.D.'s married and had children within the first 12 years after receiving their degree. However, having children for the female Ph.D. limited the possibility of her ever attaining tenure (Wolfinger et al., 2008).

**Professional females and role conflict and well-being.** Educated females in social systems today are expecting to be more equal in the job and career choices with the male in society. According to Hoffnung (2004), “they want it all:” a non-traditional career, a fulfilling family life, and happiness (p. 711). Noor (2002) conducted research in how the role conflicts affected the outcomes for the professional females. The role/function conflict significantly impacted whether the female was satisfied with her career choice and whether she experienced dysfunction, disequilibrium, and stress because of her career choice (Noor, 2002). The females who choose not to function in the
structure that was provided for them by society may choose not to marry or have children (Hoffnung, 2004).

Several other researchers have taken a look at females who work in an effort to determine which specific areas cause conflict for females (Barzilai-Pesach, Sheiner, Potashnik, & Shoham-Vardi, 2006; Maycian & Meyer, 2000; Goldberg & Perry-Jenkins, 2004; Hakansson et al., 2005; Handwerker 1999; Jonsson et al., 2003). This phenomenon, as explored by Goldberg and Perry-Jenkins (2004), examined how females’ stress level is predicted using the division of household chores and child-care tasks. Goldberg and Perry-Jenkins determined that when the females’ expectations were not met in regard to division of child-care tasks, the female’s well-being was affected negatively and this introduced distress, dysfunction and/or disequilibrium into the social and family system (Winton, 1995). This, in turn, causes the professional female to experience role conflict. Once children are introduced into the marriage relationship, the majority of both spouses, 67% females and 84% men, believe that the females should stay home and care for the children (Hoffnung, 2004). The female became distressed more frequently by child-care division of labor than work-conflict or division of household chores (Goldberg & Perry-Jenkins, 2004). According to Goldberg and Perry-Jenkins, females who work are more interested in the care of their children than their outside work and their housework, and when their children are not being taken care of, they experience distress and become unbalanced.

Studies by Barzilai-Pesach et al. (2006) and Thompson, Murphy, O’Hara, and Wallymahmed (1997) took a look at professional working females to see how role stress affected their conception and pregnancy. The study by Barzilai-Pesach et al. (2006)
provided data in the area of females, role conflict, and well-being that included the area of conception. The study determined females with more role conflict had a more difficult time conceiving. An earlier study by Thompson et al. (1997) wanted to know if pregnant females experienced role conflict and stress in the same ways that females with children did. The outcome of the study indicated that females who worked in the first trimester of pregnancy had more severe role conflicts than nonworking pregnant females. Additionally, working females in the last trimester of pregnancy had more role conflict than their nonworking pregnant counterparts (Thompson et al., 1997).

Jonsson et al. (2003) considered females who work and the stress they endure. Their longitudinal study looked at 1413 females over an 18-year period. The purpose was to determine how role conflict affected distress or disease. The sample of females in the first study sample indicated that role conflict was severe in all cases across the board, regardless of age (Jonsson et al., 2003).

Noor (2004) attempted to understand females’ stress levels in relation to work-family conflict and family-role salience, and provided findings that complemented the Hoffnung (2004) and Thompson et al. (1997) data. Noor studied 147 employed, married females who had children, and determined that the well-being of the working female was affected by stress-strained relationships and work-family conflicts caused by the stress of their working outside of her expected roles.

Coping skills for professional females. This section of the literature review looks at professional females and how they cope with various stressors. The professional females who were most successful in research studies were those who had been able to appraise the stressful situation and had developed effective coping or adaptation
strategies. As the females were functioning within their social system, they tried to stay where they were put as wives and mothers, but they often had a desire to do more. The question now becomes, how is the professional female who is stepping outside her gender box and causing disequilibrium able to bring back equilibrium to the system?

Gray (1983) considered married professional females and the coping strategies they used. The research study examined the lives of female attorneys, physicians, and professors. The participants noted that the most important element that helped them navigate through their busy schedules was their spouse’s support (Gray, 1983).

There were several strategies employed that the researcher discovered to be most effective for these female professionals coping on a daily basis with the various roles/functions they had to fulfill (Gray, 1983). The professional females used secondary appraisal to cope with getting their household chores completed by getting other members of their households and other family members to help do chores. The successful professional females also used family members to help resolve conflict that arose in the home, thus freeing their time. The professional females also understood their personal limitations and learned how to reduce their tasks by doing only those things that were necessary, prioritizing important tasks on a daily basis. Handwerker (1999) noted another way the professional females coped was by being respectful in their words and actions, as well as treating all members with equality, value, and love.

Another study, conducted at the University of Alabama by Gerald (1998), asked women tasked with caring for children and for aging parents at the same time which coping skills they had developed for their own use. Data were collected from 113 females who worked outside of the home in professional capacities and who provided care for
their children and aging members in their family. The outcome of this study indicated that females, who are in the care-giving role, have less stress when they have the support of their spouses and other family members for help in child care, chores around the house, and alleviating some of the burden of providing care.

A later inquiry by Tsunoda (2001) discussed coping skills for the professional working mother. She explained the process of female professionals and their personal and professional goals living a life that is divided. All females, no matter the culture, according to Tsunoda, struggle to balance and navigate through a myriad of roles and expectations imposed by others as well as themselves. Being divided does not give the impression of wholeness for the female professional, but in reality balancing the sides, the personal and professional, has become the way of life. Tsunoda asserts that most females separate the two. They have accepted the fact that they are many things to many people and may do their best to understand what is expected of them and to communicate what they can and cannot do.

Through her years of experience as a wife, mother, grandmother, and professional business women Tsunoda (2001) came up with coping skills that she recommends for the married female professional. Her suggestion is that the female professional should follow her own instincts and do what is best for her family and not let society tell her how to run her household. She also encouraged female professionals to not only care for others but to be sure that their own personal needs are being met. Tsunoda used specific language to help the female professional understand the lessons of life so that she can live more fully and stay balanced. According to Tsunoda, the female professional should begin by taking the initiative at work and at home. She should ensure open
communication with all with whom she comes in contact; she should love her job no
matter what it is; she should let her children make their own way in life; she should laugh
at herself and with herself, and not take herself too seriously; and she should remember
who she is and where she came from. Tsunoda thinks it is important for the married
professional female to remember and understand when coping with the role/functions in
her daily life that having achievements is good, but living without the love and support of
your family is a life not worth living.

**Male Physicians**

There is a wide body of research available on male physicians. Some of these
studies had large samples and others small (McMurray et al., 2000; Sobecks et al., 1999;
Warde et al., 1999). Early research on physicians has investigated mainly White male
physicians but more recent studies beginning in the latter 1990’s and early 2000’s
included small numbers of female physicians. There are very specific ideologies that
surround male physicians. This section will look at the professional and personal
characteristics of male physicians and their family formation.

The characteristics of 752 male physicians were explored by Sobecks et al. (1999)
and her team of researchers. The average age of the male physician in this survey was 37
and 92% of male participants were White Protestants. The most prevalent specialty for
the male physicians was internal medicine at 21% and surgery was a close second at
18%. The least favored specialties for the male physicians were pediatrics and psychiatry,
both tied at 6%. This study focuses on younger physicians who graduated between 1980
and 1999. Fifty-seven percent worked in private practice, either solo or in a group. Working in academia was the most popular place of practice with 23% of the sample. T

Sobecks et al. (1999) looked at family formation and personal life of male physicians. Male physicians worked an average of 57 hours per week and made between $100,000 and $200,000 annually. Forty-four percent of their spouses didn’t work and 21% of the male physicians indicated that they were the “primary or equal” caregivers for their children. In this study the physicians indicated that 7% of the time they had limited their professional practice for family needs and 51% said they often felt conflicted between work and home.

Warde et al. (1999) studied a sample of male physicians as well. Approximately 264 male physicians responded to a mailed questionnaire. The average age of the male physician in this survey was 45. The most prevalent specialty for the physicians was surgical specialties at 23% and family practice was a close second at 22%. The least favored specialty for the male physicians was psychiatry at 3%. Seventy-two percent worked in private practice, either solo or in a group.

The physicians’ spouses’ occupation was most often a homemaker, at 52%. Eighty-five percent of male physicians indicated that their spouses were the primary caregivers for their children. Twenty-three percent said they felt very conflicted between work and home.

A study by McMurray et al. (2000) reported complementary findings to the study by Sobecks et al. (1999). The Physician Work Life Study was designed to observe physicians (McMurray et al., 2000). For this study, there were a total of 1,582 male physician respondents. McMurray et al. attempted to add depth to the study of physicians.
The average age for the male physicians in the McMurray et al. (2000) study was 49 years old, which was a little older than Sobecks’ et al. (1999) sample. The ethnicity of the physicians was mostly white. Regarding family formation of physicians’ families, it was reported that most male physicians marry (McMurray et al., 2000). The male physicians had an average of 2.5 children, which is comparable with Sobecks et al. finding of 2.4 children. Table 1 below compares the studies of Sobecks et al., McMurray et al., and Ward et al. (Table 1).

**Female Physicians**

Females professionals in general have more stress in their personal and professional lives due to their navigating multiple roles/functions and attempting to care for their families while being professionals at work (Berger, 2000; Cooney & Uhlenberg, 1989; Gray, 1983; Eagly, 2000; Gerald, 1998; Handwerker, 1999; Hoffnung, 2004; Maly et al., 2005; Mason & Goulden, 2002; Noor, 2002; Noor, 2004; Reid & Bing, 2000; Wolfinger et al., 2008). It is a challenge that is attempted most days and is accomplished some days. How do female physicians compare with male physicians? Both are physicians who have families and who work outside of the home. However, female physicians hold a position that has long been considered to be the ultimate in a choice of professions, while still being the primary care giver for her family. This section examines female physicians – who they are and what the body of literature says about them.

According to McMurray et al. (2000), female physicians have experienced discrimination in one of the oldest professions. They have to do more than the male physician on a daily basis. Female physicians see more female patients and often get the
Table 1

*Comparison of Male Physicians in the Sobeck et al., McMurray et al., and Warde et al. studies.*

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<tr>
<td>Physicians in study</td>
<td>752</td>
<td>264</td>
<td>1585</td>
</tr>
<tr>
<td>Average age</td>
<td>37</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>White – 92%</td>
<td>Unavailable</td>
<td>White – 68%</td>
</tr>
<tr>
<td>Top specialty</td>
<td>Internal Medicine</td>
<td>Surgical specialties</td>
<td>Family Practice</td>
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<tr>
<td>Lest specialty</td>
<td>Pediatrics &amp; Psychiatry</td>
<td>Psychiatry</td>
<td>Pediatrics</td>
</tr>
<tr>
<td>Practice type</td>
<td>Private – 57%</td>
<td>Private – 72%</td>
<td>Private – 75%</td>
</tr>
<tr>
<td>Average hrs week</td>
<td>57</td>
<td>41-60</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Yrly Income</td>
<td>$100,000 to 200,000</td>
<td>$100,000 to 200,000</td>
<td>Unavailable</td>
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<tr>
<td>Primary/Equal Caregiver of children</td>
<td>21%</td>
<td>13%</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Spouse at home</td>
<td>47%</td>
<td>52%</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Number of Children</td>
<td>2.4</td>
<td>2</td>
<td>2.5</td>
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more complex and demanding patients. Female physicians often feel pressured in the amount of time that they can spend with the patient because they are regulated by external forces which require them to see as many patients per day as they can.

There is a new phenomenon occurring in the field of medicine. The field of medicine is becoming for-profit managed care and physicians are being judged according to the amount of income they can bring into the organization, so the more patients they see, the more money they bring, and they more valued they are to the organization (McMurray et al., 1999). Female physicians consistently make less money due to the amount of time they spend with their patients because they spend more time on preventative care and health counseling.

The medical societies in general are beginning to see how important female physicians are and are beginning to seek out their opinion in the field (Cohen, 1997). Previously, females have been limited in their careers in medicine due to their sex, but that is changing (Phillips, 2000). The medical school doors are open to females, but the challenge is to provide the policies and planning that are necessary to make them successful (Cohen, 2000). It was thought that females could not handle the rougher sides of medicine, like surgery. Females were considered better suited to be nurses and to take of the sick, but not to do the actual work of a physician. Female physicians often experience guilt about neglecting their role/function expectations (Phillips, 2000).

Puddester (2004), a physician, wanted to identify the stressors that plague him and his female colleagues. His review of current literature indicated that physicians, especially female physicians, have a difficult time with their personal and professional lives. He indicated female physicians are expected to be good parents and good doctors
and they are expected to think and act like a male but still be a female. Puddester asserts that the most intense stressors for female physicians are (a) guilt over leaving their children, (b) remorse over not being able to spend quality time with them, and (c) not being a parent full time.

Sobecks et al. (1999) studied family formation among female physicians and noticed that 44% of female physicians marry male physicians and additionally, 92% of female physicians indicated that they were the primary or equal caregiver for their children. Female physicians indicated that they often change their work schedules to accommodate child care needs. Twenty-five percent of female physicians indicated that they had limited their professional practice for family needs and 58% said that they often felt conflict between work and home. This study added to the body of literature showing how female physicians form family and live their professional lives.

Another study, *The Physician Work Life Study* (McMurray et al., 2000), was very similar to the Sobecks et al. (1999) study. In this study there were a total of 826 female respondents. The researcher in this study attempted to add depth to the study of female physicians while helping to understand the personal and professional lives of female physicians. Seventy-five percent of the female physicians in this study were married and had 1.7 children (McMurray et al., 2000). Female physicians overwhelmingly choose pediatrics as a specialty, with 55% of female physicians being pediatricians. In regard to the work habits of female physicians, McMurray reported that 44% of female physicians are in a group practice while 12% choose academia. This study also found that female physicians work on a part time basis 22% of the time.
A survey conducted by Warde et al. (1999) surveyed 306 female physicians. The average age of the physicians was under 45. This study indicated that female physicians were likely to choose family practice as their specialty. Additionally, as shown in the previous studies, the top specialty for female physicians was pediatrics, at 24% (McMurray et al., 2000; Sobecks et al., 1999; Warde et al., 1999). Most of these physicians were split between working in a private practice and being an HMO staff physician. The median salary for female physicians was topped out at $100,000.

Warde et al. (1999) were also interested in family formation of the physicians. They wanted to know whom the physician married; if the spouse worked, how many hours a week; who takes care of the home; and who takes care of any children. This study showed that 36% of female physicians married another physician. In the arena of housework, female physicians shared some or one half of the responsibilities with her spouse 94% of the time. In addition, female physicians paid for outside help with household tasks 73% of the time. Previous literature on women professionals (Gray, 1983; Cooney & Uhlenberg, 1989) indicated that female physicians have more conflict with role expectations. Wardes et al. study indicated that 48% of female physicians say they have an extremely difficult time with balancing and navigating the multiple roles in their personal and professional life.

**Female physicians and stress.** This section of the literature review focuses on female physicians and the stressors that they have to navigate on a daily basis in their personal and professional lives. The stressors of female physicians are unique when compared with other female professionals (Gautum, 2001; Shrier & Shrier, 2005; Straehley & Longo, 2006). Female physicians come face to face with death on a daily
basis in their work environment (Burke, 2001). Their work environment can be demanding and hostile, and typically they have little control over when and how they work (Frank, Rothenberg, Brown, & Maibec, 1997; Frank, McMurray, Linzer, & Elon, 1999).

Brian (2001), a female physician, felt conflicted because of the role/function expectations put upon her as a female and as a physician. She did research with other female physicians, attempting to discover their causes of stress. The results of her study indicated the reasons female physicians experience stress. First, she has no control in her work environment. Her environment is run for and by males, and as such, she feels harassed both sexually and racially. Second, she found that many female physicians are dissatisfied with the career they have chosen, due in part to the reasons previously mentioned and in part because of the inequities that are associated with financial compensation and time requirements. Third, Brian stated the socialized gender expectations for the female and her having to fill multiple roles at home and at work cause her much stress. Her advice to females who want to be physicians is to work part time at it or go into another line of work.

A mother and daughter research team, Shrier and Shrier (2005) conducted a research study to explore the phenomenon of female physicians. From their study of 428 female physicians, these researchers uncovered several stressors that female physicians experience in their daily personal and professional lives that affect how they practice medicine and take care of family.

The stressors that were most prevalent for female physicians in this study included having too many work requirements and expectations. Being a physician
requires many hours per day spent on patient care, writing notes, and staying current in
the medical field (Shrier & Shrier, 2005). The work environment also places stress on
female physicians when they do not have control over how things are run. The last thing
to pile stress on top of female physicians is home, to which she rushes off to do her
second shift (Hochschild & Machung, 1999; Shrier & Shrier, 2005). In general, however,
Shrier and Shrier found that female physicians reported they would choose medicine
again, they would choose the same specialty, and they would like their daughters to be
physicians.

Myers (1998) mentioned some stressors that he found to be specific to female
physicians. The biggest stressors that Myers found were related to child care and
household tasks, in addition to constant interruptions at home by their patients. Meyers
sees female physicians as being under more stress and having more need for intervention
than male physicians (Myers, 1998).

A literature review done by Burke (2001) indicated that there are several factors
that may cause stress in the physician’s personal and professional life. The concern of
this study was whether the stressors that the physician faced could cause them to do harm
to themselves or to someone else (Burke, 2001; Frank & Dingle, 1999). The study
uncovered several stressors that affected the physician on a daily basis including financial
concerns, problem patients, work/family conflicts, work overload, being on call, life and
death situations, and being fatigued (Burke, 2001). There were many concerns that
female physicians encountered on a daily basis, which her male counterpart did not.
Because of this, she was more likely to develop a high level of stress and related
conditions like depression or anxiety, which could lead to suicide (Beautrais, 2006, Burke, 2001; Frank & Dingle; Miller & McGowen, 2000).

According to Frank and Dingle (1999) the younger the female physician, the more stressful the work environment. The cause for this phenomenon could be explained by the fact that the younger physician had less experience, thereby having less control over the situations at work. She reported feeling more harassed by the older physicians, and more distressed. Frank and Dingle continued by stating that female physicians committed suicide twice as often as male physicians.

Miller and McGowen (2000) examined current literature on the rate of suicide among physicians, especially female physicians. Miller and McGowen reported that female physicians tend to neglect their own psychological needs in an effort to fulfill the various needs of the others in their lives. Female physicians may criticize themselves more harshly and expect to be perfect. Female physicians are expected to show proficiency and to be capable in their work while showing empathy for the patients and being connected to their concerns. It is difficult for female physicians to handle the intense concerns of their patients and to remain psychologically healthy, according to this study. It was shown that 50% more female physicians committed suicide than the male physician (Beautrais, 2006; Frank & Dingle, 1999; Miller & McGowen, 2000). Those female physicians who did commit suicide did not have children, were not partnered, and were Protestant but were not highly religious. Overwhelmingly, of those who committed suicide female physician’s specialty was psychiatry (Frank & Dingle, 1999).

**Female physicians and coping skills.** This literature review has examined the stressors and coping skills of female professionals, and the stressors of female physicians.
This section will look at female physicians and the coping skills they use on a daily basis to help navigate and balance the roles/functions that they fill.

The number of females entering the medical field is causing a paradigm shift in the way medicine is practiced (Searle, 2000). Female physicians are becoming more and more a part of the medical landscape. As a female physician herself, Searle sees the need for a change in the medical profession to include consideration for the specific needs of female physicians and a change in the mindset of the medical establishment, giving female physicians the respect they deserve for the job that they do (Searle, 2000).

Linney (1999) has written a guide specifically for female physicians, giving them guidelines on things they can do to help cope with their multiple roles/functions. She says that female physicians need to set boundaries on their personal and professional time. They should not get discouraged when they make an error, but to learn from it and do it differently the next time. She wants female physicians to tell themselves that death happens and they cannot always prevent it. Linney states that the married female physician should cherish her spouse and the time she spends with him. She should take care of her own personal needs and see her own doctor on a regular basis. Because the female physician’s job is so intense, sometimes they do not take the time to do the basic things in life that may help them to be healthy and happy.

Gautam (2001), as a physician herself, saw female physicians dealing with stressors in the home and in the work environment on a daily basis and decided to look at both venues and make suggestions on ways that female physicians can cope as they fill their multiple roles on a daily basis. For the work environment, Gautam suggests that female physicians need to take control of their work hours, take breaks every day, and be
sure to take days off. They need to set boundaries at work and learn to say no. They also need to manage their time better while at work by organizing and prioritizing their daily duties.

Gautam (2001) also states that female physicians should not only think about their own needs but should lobby and support any programs that would help female physicians in general to be more productive and have a better work experience. Gautam (2001) indicated that for female physicians to be truly successful, they need to learn to cope in both the work and home environment; they need to find the balance that will help to keep both areas running smoothly.

Gautam (2001) suggests that before the female physician rushes home to begin her next set of tasks, that she stop, take a deep breath, and relax for a few minutes. Also, she should leave work at work; do not bring it home. Gautam, as a physician, realizes the societal expectations placed upon females and she tells female physicians not to stress over housework, let some things go and spend more time playing with their children and spouse.

Gautam (2001) concludes by indicating that female physicians need to make personal time for them to take care of themselves and meet their own needs. They should also take the time to make friends and go out and have fun with them whenever possible. According to Gautam, female physicians should control their spending, exercise, and not feel guilty because they cannot do it all.
Conclusion

Many of the studies on female physicians used for this literature review were dated at least 10 years ago. The current empirical research is very limited. Females make up over half of all medical school classes today, but they are considered to be doctors who are expected to provide pink medicine, good for treating female problems or caring for children, thus fulfilling the societal roles expected of females. But female physicians may and should fill any role that they choose.

The purpose of this literature review was to look at (a) coping in general, (b) the stressors families and professional females have and the methods they use to cope with their stressors, (c) the ways male and female physicians formulate family and work, (d) female physicians’ stressors, and (e) the ways female physicians have coped with navigating, personally and professionally.

We saw how Lazarus & Folkman (1984) defined coping with primary and secondary appraisals. We noticed that structural functionalists refer to coping as adaptation (Winton, 1995). Reid & Bing, 2000 told us that female fill traditional gender roles and even when females have roles of great importance in society, they are still expected to be wives and mothers at home.

Greenhaus & Parasuraman (2002) and Wolfinger et al. (2008) showed us that most females who work outside of the home have some level of work and family conflict and stress due to the amount of the limits on the amount of time spent in each day. Further studies by Gray (1983) and Cooney and Uhlenberg (1989) indicated that females who work in male roles have more stress and a more difficult time with family formation.
Hoffnung (2004) and Noor (2004) conducted studies on female role conflict and well being. They indicated that females over want a high level position as well as a well run family but it is not always possible to have both, and often times the professional female has to choose to do one or the other.

Gray (1983), Gerald (1998), Tsunoda gave tips on how professional females can best cope with there varied and divided life roles. Gray told females to get support from their families and also pay for help if possible. Gerald said that professional females should get more support from their spouses to ensure the works gets done around the home. And lastly, Tsunoda told professional females to not be regulated by societal expectations but to do those things that would help them to find balance in their own families.

McMurray et al., Sobecks et al., (1999), and Warde et al. (2000) took a look at male and female physicians and noted the differences. Some of the findings included: male physicians make more money than their female colleagues. Female physicians spend more time on housework and childcare than their male colleagues and male physicians’ wives most often do not work outside of the home and female physicians’ husbands most often do.

Lastly, Gautam (2001), Shrier and Shrier (2005) and others indicated that female physicians have higher levels of stress compared to the female population in general and to their male colleagues. This stress is caused by the many roles they are expected to hold, specially the care of the home and children coupled with their work requirements and patient expectations.
Methodology

This chapter of the research study will explain the methods that were used to collect and analyze data. This study of how female physicians navigate the stressors of their personal and professional lives and their coping strategies uses a grounded theory approach. The grounded theory approach of Charmaz (2006) was used to access the lived experiences of female physicians. Data were analyzed to develop a theoretical model of the coping strategies that female physicians use to navigate through the various roles and demands that they experience on a daily basis.

When trying to understand and discover meaning, it is best to use a qualitative method according to Holstein and Gubrium (1995). Grounded theory emphasizes that the meaning of the data will come out of the data as the researcher negotiates and interacts with the data. A qualitative research design has been shown be effectual in separating the data into categories, thus helping to delineate the research participant’s experiences, and giving a better appreciation to the themes that arise from the data (Charmaz, 2006). By using a grounded theory-based research approach, the data have a better chance of giving explanations of the abstract concepts including the feelings and emotions that arise from the individual interviews, and helping the experience to be valid (Charmaz, 2006). The validity of the research data is measured by how well the researchers took the stories of the participants and made a narrative that compels others to read.

There is much discussion on the type of research to use for families (Holstein & Gubrium, 1995; MacDermid et al., 2005). Quantitative methods have been widely accepted because of the reliability and validity of the empirical research process (Denzin
& Lincoln, 2003). However, with qualitative research methods, the researcher is able to look deeper into how and why families do what they do (Holstein & Gubrium, 1995), which can help discover the values, beliefs, and feelings of the participants. These are important in the study of families, helping them to find meaning. These data give insight that can be used to understand the specific coping methods that have been successful for female physicians in this current study.

Questions for this study were developed in an attempt to gain knowledge regarding the lived experience of those interviewed for the study. There are two main questions that this research study wanted to answer: (a) What are the stressors and demands of the married female physician? (b) What sources of support do female physicians see as being salient in coping with the stressors and demands of their personal and professional life? The grounded theory that was developed from the data revealed the answers to these questions and should be amenable to substantiation from other research studies (Charmaz, 2006) in the future that look at female physicians and their coping mechanisms and support systems, although this study cannot be generalized to all married female physicians.

For this current study, a one-on-one, in-depth interview was conducted, using a semi-structured questionnaire. According to Holstein and Gubrium (1995) interviews are the best method to use for data gathering in both research and popular methods. There were eight categories of demographic questions that were used to gather general as well as specific research data.

This present research study was conducted as part of a larger research study being conducted at Loma Linda University’s School of Science and Technology in the
Department of Counseling and Family Sciences on physician families. A research group was started by two professors who wanted to get students involved in the research process. These two professors, along with 9 students, 2 males and 7 females, conducted research on various aspects of the physician family, including (a) dual physician couples, (b) dual career couples, (c) female physicians, (d) immigrant physicians, (e) physicians and mental health, (f) physicians and spirituality, (g) minority physicians, and (h) gender/power issues.

The methodology used in this present study on married female physicians was qualitative analysis. The first event of the study utilized qualitative analysis as the method used to collect and analyze data. This present study is the result of that event. A future direction of this study is to utilize a quantitative method of data collection and analysis. This event will be started approximately one year after all of the qualitative data has been collected and analyzed. In addition, the group plans to edit a publishable work containing all of the papers written based on the qualitative analysis.

As a member of the research group I was given extensive training in qualitative data collection, interviewing techniques, and the qualitative analysis process. I participated in the IRB process of getting approval for the research study and spent time working together preparing the interview instrument. The questions and categories for the current research instrument were developed in the group, using a trial and error method. The researcher felt competent to conduct the current research study due to the extensive training given in the research group (See Appendix B).
Participants

The data for this present study were drawn from participants recruited from various hospitals in the southern California area, including Loma Linda University Medical Center, the Loma Linda University East Campus hospital, the Loma Linda University Behavioral Health Center, the Loma Linda University Heart and Surgery Hospital, and the Loma Linda Veteran’s Administration hospital, as well as snowball sampling. Additionally, through the use of snowball sampling, private practice physicians in Washington, D.C. and Huntsville, Alabama were recruited as participants for this study. Respondents were recruited by using flyers, posters, personal phone calls, and snowball sampling methods. Snowball sampling involves getting names of other physicians who would be interested in being part of the study, from the current participants of the study.

The flyer was prepared by the group and distributed among area hospitals. The flyer included the background for the study, what data were going to be collected, the faculty sponsors for the study, and a phone number that the physician could call if they wanted to participate. Flyers were posted in the break room of the hospitals listed above and on the announcement board at the medical school offices. In addition, flyers were posted in the Faulty Medical Offices of Loma Linda University, in the physician break room and in Loma Linda University Medical Center.

Screening Procedures

Emailed flyers were sent to physicians. They were directed to call and interviews were set up. The respondents who called were screened as to their eligibility for the study
according to the inclusion criteria in the approved IRB documents. Other physicians were called directly from the master list of physician names that were compiled from names collected from various locations including, but not limited to local hospital registries, area phone books, and Internet sources. These physicians were given information regarding the study and were asked to participate. The entire process, along with its procedures and risks, were explained to the physicians before the interviews were held, to avoid any future concerns.

**IRB Approval/Informed Consent**

As stated previously, the IRB approval was applied for and received. According to the IRB protocol, the researcher for this current had the participants sign an informed consent before the interview began. The form (see Appendix C) explained to the participants the risks and benefits of their participation in the study (Collogan, Tuma, Dolan-Sewell, Borja, & Fleischman, 2004). The participants were given information as to where they could go for psychological treatment if they felt that participation in the study caused them any emotional distress. They were referred to the Loma Linda University Marital and Family Therapy Clinic on Hospitality Lane in San Bernardino, California, the Psychology Department of Loma Linda University in Loma Linda, California, the Counseling Departments at Washington Adventist University, and the Psychology Department at Oakwood University.

It was verified that the participants were able to provide informed consent for this study by asking them (Allmark, 2002; Flick, 2006). The participants were informed that their participation was strictly voluntary and that at any time that they felt uncomfortable
they could stop the interview process (Allmark, 2002). The researcher also did not use any type of coercive methods to elicit information from the participants, but allowed the participants to answer in any way they felt comfortable. The researcher attempted to avoid causing any harm or discomfort for the participants (Flick, 2006).

**Inclusion Criteria**

There are three basic inclusion criteria for this study. First, the physician is currently married for a minimum of 2 years; second, the physician has been out of residency for a minimum of 1 year, and third, the physician is a female. There was no age limit for the physician; however, she had to have been practicing full time, part time or sometime. Ethnicity, specialty, and location of practice were not criteria for inclusion. However, the majority of the subjects for this study were from the southern California general area because that was most convenient for the researcher.

There were 27 respondents for this present study. Because this research study developed grounded theory, the data were collected until it was determined that theoretical saturation had occurred (Strauss & Corbin, 1998). There was no specific number of respondents required for this study, given the methodology used. The researcher stopped data collection when it appeared that no new information was being added to the already developing theoretical perspective as the initial analysis took place (Flick, 2006).
Grounded Theory

Grounded theory was developed as the researcher became involved with data collection and data analysis. Codes and categories were developed from the data. Each step of the data analysis brought the researcher closer to developing grounded theory. There are three main proponents of grounded theory; they are concepts, categories and propositions. The concepts are the units of analysis that are basic to the development of grounded theory; they come directly from the data during the initial coding. Strauss and Corbin (1990) state the following:

Theories can’t be built with actual incidents or activities as observed or reported; that is, from “raw data.” The incidents, events, happenings are taken as, or analyzed as, potential indicators of phenomena, which are thereby given conceptual labels. If a respondent says to the researcher, “Each day I spread my activities over the morning, resting between shaving and bathing,” then the researcher might label this phenomenon as “pacing.” As the researcher encounters other incidents, and when after comparison to the first, they appear to resemble the same phenomena, then these, too, can be labeled as “pacing.” Only by comparing incidents and naming like phenomena with the same term can the theorist accumulate the basic units for theory. (p. 7)

Strauss and Corbin (1990) describe the second proponent of grounded theory, categories, below:

Categories are higher in level and more abstract than the concepts they represent. They are generated through the same analytic process of making comparisons to highlight similarities and differences that is used to produce lower level concepts. Categories are the “cornerstones” of developing theory. They provide the means by which the theory can be integrated. We can show how the grouping of concepts form categories by continuing with the example presented above. In addition to the concept of “pacing” the analyst might generate the concepts of “self-medicating,” “resting,” and “watching one’s diet.” While coding, the analyst may note that, although these concepts are different in form, they seem to represent activities directed toward a similar process: keeping an illness under control. They could be grouped under a more abstract heading, the category: “Self Strategies for Controlling Illness.” (p. 7)
The third proponent of grounded theory is propositions or theory building. A proposition is according to www.dictionary.com are “a statement in which something is affirmed or denied, so that it can, therefore, be significantly characterized as either true or false.” Therefore, the purpose of grounded theory is to understand the meaning of data, and the process of developing grounded theory enables the researcher to discover truth. Grounded theory is not tested against previous theory, but as Strauss and Corbin (1990) assert:

(Grounded theory is)...inductively derived from the study of the phenomenon it represents. That is, discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory should stand in reciprocal relationship with each other. One does not begin with a theory, then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (p. 23)

Therefore, the researcher comes to the data collection and analysis with an open mind, ready to accept the findings as they present themselves, without any preconceived notions.

The researcher, therefore, kept asking what relevant contribution these findings were making in the area of work/family conflict. The researcher took a glimpse into the personal experiences of female physicians, the roles and relationship systems with which they were involved, and the social systems that sought their time, all in an attempt to describe these roles, functions, and relationships in contrast to other professional females and female physicians. The data helped the researcher to look into the effect that various dilemmas have on married female physicians’ well-being.

Concept mapping (Flick, 2006) was used to develop the graphical display of the concepts and their interactions to help develop the grounded theory. The key concepts helped the researcher to gain access to the processes that were relevant to female
physicians. Triangulation was used by the researcher to further clarify the combinations of the various viewpoints, to obtain as many varied aspects as probable. Investigator triangulation was used when the researcher met with the professors and group members to discuss the meaning of the emerging data and to verify concepts and categories. Investigator triangulation was used to inform when there was specific researcher bias; this helped minimize as much as possible. Once completed, the grounded theory met certain criteria, including (a) being a close fit to the data, (b) being useful to the population and the research, (c) being conceptually dense, (d) showing endurance over time, and (e) having the power to be able to shed light on the experiences of female physicians and their coping strategies.

**Interview Procedures**

After the initial screening, a day, time, and location were set for the interview. The researcher gave the interviewee a number at which she could be reached in case there was a problem or a need to reschedule. The researcher called each participant before the day of her interview to remind her of the time and location. On the day of the interview, the researcher met the participant at the agreed upon location and at the agreed upon time. The room was secured so that privacy and confidentiality as much as possible depending on the location of the interview. Interviews were collected in the family home, the LLU research building, the community, and any other place that the participants chose and the interviewer approved for confidentiality purposes. The researcher made a concerted effort to ensure that the environment was suitable for the interview for both the respondent and the researcher. The interview was recorded with the use of a digital recorder, and in fact
two recorders were used at each interview to ensure safe and reliable recording in case
the batteries died, and then transcribed in accordance with IRB approved protocol.

**Collecting Data**

The researcher realized from the training that she was also a research instrument
(Babbie, 2007; Flick, 2006; Strauss & Corbin, 1998) and how she conducted the
interviews would affect the outcome of the study. For this study of female physicians, the
primary interviewer was female. The two male interviewers in the group each
interviewed one female physician. When developing grounded theory, the sex of the
researcher as well as the personal biases of the researcher played a big part in how the
research questions are perceived and answered (Babbie, 2007; Flick, 2006; Strauss &
Corbin, 1998). Agar (1980) says that the researcher is a professional but still a stranger,
thereby making it important for the researcher to put the respondent at ease in the very
beginning of the interview. This is done much easier, female-to-female or male-to-male,
as the case may be. Female-to-female interviews elicited a more relaxed and amiable
atmosphere, which in itself elicited more responsive and intimate answers to the
questions from the participants of this study (Agar, 1980).

Much effort was put into helping female physicians not to feel threatened when
answering intimate questions about themselves from another female (Agar, 1980; Flick,
2006). However, if female physicians were interviewed by a male it was believed that
they would be less likely to fully reveal the intimacies that they may feel are important
and respond less truthfully about issues of gender discrimination or sexual harassment or
even the coping mechanisms that they use (Babbie, 2007; Flick, 2006). Flick (2006)
asserts that it is easier for a female to interview a female and a male to interview a male because some of the barriers to gathering information will be eliminated, such as the ability to disclose personal information, mutual interests, clarity of statements, and a spirit of cooperation.

The interviews were recorded on an Olympus WS-321M Digital Voice Recorder. This recorder has the capability to download directly into the computer. Once the interviews were downloaded on the computer the files were identified by the appropriate code. The files were then put on data CD’s to give to the transcriber, listed only by code. The interviews were then erased from the digital recorder. The completed Informed Consents were kept separately from the actual interviews.

Confidentiality

The researcher maintained the confidentiality of the participants (Babbie, 2007; Charmaz, 2006; Flick, 2006; Strauss & Corbin, 1998). The researcher made sure that the participants felt comfortable about giving out private information. Confidentiality was noted and addressed continually throughout the interview process and in the data management after the interview process (Flick, 2006). The participant’s identity was protected throughout the process, beginning with the recruitment and continuing through to the publication of the research data by using pseudo names instead of their real names (Flick, 2006). The researcher informed the participants that the documentation that arises from the research data would be kept in strictest confidence.
For identification purposes, each interview was assigned a code number. The code number was made up of the interviewer's initials and the number of the interview for the interviewer. A separate file was kept for all demographic information.

Once completed, the interviews were transcribed. A hard copy and an electronic copy were archived in a locked file cabinet by interviewer initials and interview number. All identifying information that occurred during the interview process was eliminated during the transcription process. The transcriber was given the completed interview on a data CD. The transcriber returned the completed transcribed interview on a data flash drive. All interviews that were sent out for transcribing were either certified mailed or hand delivered. They were returned the same way.

**Interview Questions**

To create grounded theory conventionally, the interview questions were semi-structured, giving the participants an opportunity to indicate what was meaningful for them and not limiting them to respond in a way to illicit specific answers to questions. The questions themselves were both narrow and broad, giving the participants an opportunity to be focused at some points and flexible at other points as they answered the questions (See Appendix A). The participants were given a demographic questionnaire (See Appendix D) with questions to determine the gender, age, nationality, country of origin, religious affiliation, medical specialty, number of years married, number of children, number of hours spent on child care each week, number of hours spent on housework each week, and time spent with their spouse.
The questions of the interview were developed to help participants think about and express thoughts and information that might not be readily remembered. It had been suggested by previous research that using semi-structured interview questions in a qualitative designed research study enabled the interviewer to gather more clear-cut answers that relate specifically to the research questions (Flick, 2006). By using this semi-structured interview, the researcher was able to collect more in-depth knowledge (Charmaz, 2006). See Appendix A for a complete list of interview questions.

**Qualitative Analysis**

Qualitative analysis is a way to interpret data without using a numerical examination. It makes observations about the data for the purpose of determining underlying meanings and patterns of relationships (Babbie, 2007). The purpose of qualitative analysis is to acquire knowledge of how and why, or to discover the meaning of something before it is put into practice to make a difference in the lives of others. For example, the data that was discovered helped find the meaning of female physicians’ personal and professional lives, and then educators may be able to use the data to aid as they educate them. The grounded theory was developed from the data gathered from female physicians, “in their own voices” through in-depth interviews (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Analytic tools were used by the researcher to assist with making comparisons and asking questions (Strauss & Corbin, 1998). Some tools used were (a) case analysis, (b) cross case analysis, (c) semiotics, (d) narrative analysis, (e) conversation analysis, and (f) variable analysis (Babbie, 2007). These analytic tools increased the sensitivity of the
research, helped the user recognize bias, and helped the user to overcome analytic blocks by asking questions (Strauss & Corbin, 1998) like who, when, what, where, and how. These tools helped the researcher get past not knowing, generated new ideas and ways of looking at the data, and gave stimuli for thinking (Strauss & Corbin, 1998). Theoretical memo writing was used for this study throughout the analysis process. The process of writing notes and memos helped the researcher and associates to discover patterns and deeper meaning of the actual interview data. For example, some conversation was not recorded during the interviews. Because that could make a difference in the interpretation of the data, the researcher wrote them in a memo and attached them to the transcribed interviews. The coding analysis process began with three main stages: initial coding of concepts, focused coding on categories, and theoretical coding of propositions.

**Initial Coding**

The first step in the analysis, initial coding, was used as an opening or beginning for the researcher to help check her own preconceptions (Strauss & Corbin, 1998). In the initial coding the interviewer looked at the data and then asked broad questions from each section of the interview (Charmaz, 2006). This initial classification and labeling of concepts thus developed the codes suggested by the researchers’ examination and questioning of the data. This coding was the logical starting point to begin qualitative data analysis. The outcome of this coding was the identification of numerous concepts relevant to the subject under study (Babbie, 2007; Strauss & Corbin, 1998). After studying these concepts about how female physicians find meaning, the researcher was
able to move on to the next stage of analysis, focused coding, to look at what themes and categories were arising.

**Focused Coding**

Stage two of developing grounded theory was focused coding. Comparisons were made of the groupings of similar or different concepts to discover properties and dimensions that were possible when they were not first evident to the researcher (Strauss & Corbin, 1998). This process involved using the groupings that emerged in initial coding and making sub-groups or themes that gave the explicit groupings of properties and dimensions (Charmaz, 2006). Focused coding identified the central categories in the study. Focused coding used the results from initial coding and encompassed a regrouping of the initial coding data.

**Theoretical Coding**

Stage three of developing grounded theory was theoretical coding. This coding process was used to validate the theory. It was a process that verified the theoretical categories that emerged during the initial and focused coding process and developed theory that was an accurate embodiment of the meaning informed by the interview process (Strauss and Corbin, 1998). Theoretical coding also helped to ferret out the main code in the study – the one code to which all of the other data points. The patterns of relationships could then be understood with this far-reaching and in-depth examination. This body of interviews helped to build grounded theory about the stressors and coping strategies of female physicians.
**Internal Validity**

In qualitative research, just as in quantitative research, it is important to ensure that there is internal validity. However, in qualitative research, this is not the focus of the study. Internal validity was not determined in this qualitative study in the same way that it would have been in a quantitative research study. Flick (2006) tells the researcher that “trustworthiness and credibility replace reliability and validity” in qualitative research (p. 376). By pursuing truthfulness in the qualitative research, the researcher replaced the principles of validity and reliability with the principles of truth and inclusion of the facts or in other words are the findings reasonable (Flick, 2006). This was a way to ensure that the grounded theory could be considered as valid and reliable. In the present study, the researcher attained truthfulness by presenting only the actual words the female physicians used, and by being honest in the reporting of the data, and not inferring meaning.

**External Validity**

External validity in a qualitative study was attained by the researcher in rightly interpreting the data and having the interpretations drawn directly from the source material. The researcher found meaning in the data. It can be noted that as coding was done, no inferences were made as in quantitative analysis but the actual words of the respondents were developed to be used as theory (Flick, 2006). This qualitative study did not reproduce previous knowledge, but presented the research data as it was discovered: truthfully and with honesty.
Reliability

In the case of qualitative research, reliability is the ability to substantiate the research findings through other research studies (Flick, 2006). Even though qualitative research does not begin with a hypothesis, it does look at the previous literature. The analysis of the data reflected previous findings on this same group. With standardized field notes, the reliability of the data was achieved. In addition, by having the interviewers trained before, during, and after the interviews, the reliability of the data that were collected (Flick, 2006) was also increased.

Contributions and Limitations

The results of this study may contribute to the field of family studies and family science in a myriad of ways. It builds empirical data for the growing area of the study of stress and coping. This current study examines and describes the lived experiences of married female physicians and their personal and professional lives. Previous research studies gave a limited view of the impact of being a physician has on marriage, parenting, and the family life of the female physician.

Conclusion

With more than 50% of medical school classes currently being made up of females, there is a need to get a better understanding of the stressors in the lives of female physicians and to come up with a way to make their lives less hectic. Married female physicians are becoming more the norm than the exception, and it is time for the administrators of medical schools and hospitals to realize the valuable resources that they
have in female physicians, and to realize that they are also wives and mothers. They are not married to medicine and they work hard to balance the work that they love with their family, whom they love even more.

This present study will use the article dissertation approach, with the article giving the results of the study. The article that follows will present the issues, theoretical constructs, and results of this study. The article will focus on (a) background of work and family issues, (b) married professional working females, (c) societal gender expectations, (d) systems in which the females are involved, (e) physicians as professionals, and (f) system challenges and system adaptations of married female physicians as compared with other female professionals in the current body of literature.
Stressors and Coping Strategies of Married Female Physicians:
A Qualitative Analysis

by
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Female physicians live and work in a very complex world fraught with professional demands and personal challenges. Twenty-seven married female physicians were interviewed for this study to assess demands and stressors endemic to them and to determine how they manage them. The breadth of this study looked at the demands and stressors of the female physician from the perspective of her work environment, home and family responsibilities, parenting responsibilities, and self-imposed demands in her perceived roles as a working wife and mother. Two main categories emerged during the development of grounded theory: System Challenge and System Adaptation. Additionally, work demands, home demands, child care demands, self-imposed demands, reaching out and reaching in, emerged as subcategories. This present study has implications for theory, future research, family policy, work-family planning and execution, as well as employee incentives for married female physicians’ lives.
Introduction

In the 1970’s, females were expected to marry and become good wives and mothers. The average age at which females married was 21, and the wife depended on her husband for financial and emotional support. The wife voted like her husband, supported her husband in his religious beliefs, and needed his permission to have medical procedures done (Gibbs, 2009). The wife often worked at less demanding jobs like nursing, retail sales, and customer service, made less money, and often did not attend college as did males, because that is how life was then (Gibbs, 2009). But things have changed. In the 21st century, females marry later, with the average age of 26 being the norm. Females now make up over 57% of students in college, receive 60% of master’s degrees, over 50% of doctoral and medical degrees, and 49% of law degrees, (Gibbs, 2009). Forty percent of females are now the principal breadwinner in their family (Gibbs, 2009). Family life has changed, and often females have control over the economic well-being of the family. Societal expectations of gender roles are changing (Gibbs, 2009).

Work and family and stress are important issues that have occupied the attention of scholars (Carr, Gareis, & Barnett, 2003; Nonnemaker, 2000; Noor, 2002; Noor, 2004). With the influx of females into the work place and the beginning of the women’s movement, females are staying in school longer and becoming professionals. However, many females in the work place are still trying to maintain family life that is similar to what it was before females entered the market place in force. This trend is not lost among female professionals and particularly female physicians. This qualitative study seeks to
look at married female physicians and the impact that being a physician has on her personal and professional life.

**Problem Statement**

Currently, females make up over half of all medical school classes and one third of all practicing physicians (Allen, 2005; Magrane & Lange, 2006; Brian, 2001; Searle, 2000). Previous research studies conducted on physician families usually made the assumption that the physician was Caucasian and male (McMurray et al., 2000; Sobecks et al., 1999). This is just one of the aspects in which the history of medicine presents interesting paradigm shifts; the field may benefit by many other changes. Even though more females are enrolling in medical school today, they still have not attained the levels of advancement in medicine that male physicians have (Laine & Turner, 2004). This lack of success may be due to the impact of family responsibilities as well as the often hostile work environment and the lack of control over the work place (Carr, Gareis, & Barnett, 2003; Nonnemaker, 2000). Because of their larger numbers, however, practicing female physicians are making a major impact on how medicine is practiced, including concerns about who cares for female physicians' family (Searle, 2000).

**Background**

The current system of gender socialization can be traced back to the industrial revolution (Kimmel, 2004; Strong, DeVault, & Cohen, 2005). Before that time, 80% of families were agrarian, working on farms (Kimmel, 1996). The father, mother, and children were expected to play a significant role to ensure the survival of the home and
family (Kimmel, 1996). While the husband worked in the fields, the wife made sure that there was food to eat and that the children were well cared for (Kimmel, 1996; Strong et al., 2005).

When families moved from the farms into the cities, these roles changed. During the industrial revolution, the majority of jobs moved into the factories (Kimmel, 1996; Kimmel, 2004; Strong et al., 2005). The males went to work in labor-intensive positions in the factories, while the females stayed at home to provide services for her husband and children (Strong et al., 2005). However, this unpaid work inside the home was not as valued as the paid work outside the home (Ferree, 1991; Strong et al., 2005). The female role became homemaker or housewife, while the male role became breadwinner, providing economic support (Ferree, 1991; Kimmel, 1996; Strong et al., 2005). Because of industrialization, men no longer spent the amount of time at home doing housework and caring for the children (Kimmel, 1996). The worlds of the male and female became separate but unequal. The roles of female physicians violate the preconceived social norms of the female as the primary caregiver, and the male as the primary breadwinner in the family. According to the theoretical thought of the marriage gradient, (Bernard, 1982) males tend to marry down and females tend to marry up. But the female physician has flipped the gender roles and she is often the primary breadwinner. She creates dissonance in the marriage gradient because of her higher education, prestige and income.

It was predetermined by society which roles males and the females should fulfill (Kimmel, 2004; Strong et al., 2005), and any deviation from these roles for both males and females was thought to cause confusion. Females were expected to exhibit the character traits that have been attributed to them for decades. These traits include
devotion, a gentle spirit, patience, and kindness, all of which uphold the patriarchal view of females serving the needs of the greater male power (Carter, 1994). This patriarchal view typically leaves females in powerless situations at home and at work; consequently, females are typically relegated to less important positions in society (Carter, 1994; Mason & Goulden, 2002).

For males and females to fulfill their social roles, they feel they should exhibit the behaviors that are expected of their gender roles (Eagly, 2000). Both males and females judge themselves, either positively or negatively, to the extent that these roles are internalized and followed (Eagly, 2000). These expectations may cause significant stressors, affect the female’s mental health outcomes, (Carter, 1994; Coltrane, 2000; Gray, 1983; Pavalko & Smith, 1999; Tsunoda, 2001) and “can also produce ambiguity, confusion, and debates concerning what is the proper place of women and men in society” (Eagly, 2000, p. 452).

Rationale

The present study is important and crucial to the profession of medicine for four significant reasons. First, there is a paucity of current empirical literature examining the experiences of female physicians (Carr et al., 2003; End, Mittlboeck, & Piza-Katzer, 2004; Caniano, Sonnino, & Paolo, 2004). Second, while female professionals have common challenges, not all work/family experiences are created equal (Cooney & Uhlenberg, 1989; Gray, 1983). Third, there are an ever increasing number of females in the workforce and this is no less true when applied to female physicians (US Census, 2003). In fact, over 50% of all medical students are now female (Allen, 2005; Brian,
2001; Gibbs, 2009), but only 33% of the practicing physicians are female, which suggests female physicians' expectations change over time. It is crucial therefore, to uncover who female physicians are and what their needs are, both at home and at work. Fourth, this study helps to influence work-family policy for females and can provide empirical data which may influence the best practices for female physicians in theory formation, practice, and family life.

**Conceptual Framework**

Constructing a conceptual framework that can inform how female physicians cope with their unique challenges necessitates examining already existing theory, still, there is controversy among the various family researchers who find it difficult to define a theory that encompasses all aspects of the family and its needs (MacDermid, Roy, & Zvonkovic, 2005). According to MacDermid et al., much of the theory available today is conjecture and/or assumptions that are based on previously observed data and is developed from research findings that are limited in their scope and audience. In other words, the theory that can be used today to understand how the family functions and to pinpoint its needs is based on research done many years ago and may not necessarily encompass the challenges that face the changing nature of today's family. After looking at various theories, this researcher believes that structural functionalism comes the closest to explaining some of the challenges of the married female physician by looking at the varied functions/roles she performs on a daily basis in her various systems (i.e., home and work) and how she balances “these key roles... affecting the role-related outcomes” (Gareis, Barnett, Ertel, & Berkman, 2009, p. 696).
Structural Functionalism is a family studies theory that can be used to understand how families work and fulfill their functions or roles in the family and in society (Winton, 1995). Kingsbury & Scanzoni (1993) note that “functionalist assumptions remain central to family sociology and family studies” (p. 195). This theory looks at the family as a system and each individual’s function/role within the system. This theory examines a society that is formed on order and interdependence, while maintaining balance or equilibrium, keeping the systems running smoothly. Structural functionalism looks at large-scale social institutions like society, government, and the work force. This theory is not focused on the individual as such, but on how the individual can contribute to the whole.

The interdependence of the members of the systems means they must have shared values and beliefs. This order encompasses role expectations and gender expectations in an attempt to keep balance and homogeneity within the group. These expectations make this theory especially relevant to female physicians who need to have gender role expectations, identity role expectations, and career role expectations stay in balance. Structural functionalism helps to show how female physicians fulfill their various role expectations and how they strive to keep their systems in balance. Structural functionalists do acknowledge change can occur within the system. At these times the systems must use adaptation to help put the system back in order when it is out of alignment (Keel, 2009; Winton, 1995). This adaptation can be viewed as the coping mechanisms that female physicians use to find balance in their daily lives.
Literature Review

Females in society today work in a hostile environment that is built upon the male career model that has been in effect since the nineteenth century (Reskin & Bielby, 2005; Wolfinger et al., 2008). This model gives men positions with greater income and more responsible positions outside the home, without the concerns of the family responsibilities (Reskin & Bielby, 2005; Wolfinger et al., 2008). The male career model purports that work comes first, no matter what, and that the home is the females’ work, no matter what (Wolfinger et al., 2008). The field of medicine expects singularly focused devotion from its physicians whether the physician is male or female (Reskin & Bielby, 2005; Sobecks et al., 1999, Wolfinger et al., 2008). Female physicians work and function in a structure that is based upon the roles that have been set up by a male dominated society (Carter, 1994; Pitt-Catsouphes & Christensen, 2004).

The purpose of this literature review is to examine the previous quantitative and qualitative research that has been published in peer reviewed journals looking at coping/adaptation, work/family conflict, professional females, and female physicians. This study would like to obtain a deeper understanding of how females navigate their role expectations and the coping/adaptation mechanisms that help them find meaning.

Coping/Adaptation

Coping is an attempt to control or alleviate feelings of stress (Lazarus & Folkman, 1984; Lazarus, 1999). Coping is a process that can reduce the reaction to a stressor, change the meaning of a stressor so that it is no longer perceived as stressful, or remove an individual from the environment that is stressful so that the stress no longer exists.
(Lazarus, 1999), thus, according to structural functionalism, putting the system back into the state of equilibrium (Winton, 1995).

According to structural functionalists, coping or adaptation is a means used to help reorder the system when the roles in the various systems have become confused or are out of order (Winton, 1995); for example, the case of a female physician who is trying to juggle work and family without success. When a female physician experiences work/family conflict because she is being pulled in too many directions, she must use adaptation or coping to change her reaction to the situation, change her view of the situation, or remove herself from the situation so that she can feel in control with all her systems in equilibrium or balance again.

Much research describes ways that people have learned to cope. Lazarus and Folkman (1984) give a definition of coping as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taking or exceeding the resources of the person” (p.141, italics supplied). This definition of coping agrees with structural functionalism adaptation. Adaptation is a process whereby individuals in the various systems have to constantly reassess both cognitively and behaviorally what is happening to determine if there is anything out of balance. This explanation of coping can describe the female physician and the ways that she has to manage the specific roles that she navigates on a daily basis.

Lazarus (1993) explained the association between appraisals and coping in an attempt to further find meaning for the ways that people cope. According to Folkman, Lazarus, Gruen, and Delongis (1986), when a person is under stress they will appraise the situation “as taxing or exceeding his or her well-being” (p. 572). Two types of appraisal
are used in this process; primary appraisal and secondary appraisal. In the case of primary appraisal, the individual has to decide if a current situation affects them in any way, whether positively or negatively. In the case of secondary appraisal, the individual determines what, if anything, “can be done to overcome or prevent harm” (Folkman et al., 1986; p. 572) to themselves or anyone else within their systems. The individual will continue to evaluate the situation by noting which coping mechanisms or adaptations can be used to alleviate the current situation (Folkman et al., 1986). For example, when the female ER physician discovers that she has to work late due to an emergency that just came in, this causes stress. Now she can use primary appraisal to see if working late will cause harm to her or her family system. She needs to know if her children are taken care of or if she needs help in caring for them, thus creating harm for the medical family system. Once determining that there is harm, she will use secondary appraisal to see who can help her in the situation, (perhaps by having someone pick up her children) and then she can make arrangements to alleviate the situation.

**Professional Females and Work/Family Stress**

The fact that there are only so many hours in the day means that if more hours during that day are spent on work, then consequently there are fewer hours available to spend on family matters (Greenhaus & Parasuraman, 2002). This goes both ways. Thusly, when too much time is spent in either work or family the other role receives less time and the demands of the neglected role causes stress. This continued demand of both work and family roles puts a strain on the emotional, physiological, and cognitive forces of the individual (Edwards & Rothbard, 2000). The amount of time that an individual spends on
work or family roles is based on “early socialization, internalized beliefs, and normative expectations of gender-appropriate role behavior” (Greenhaus & Parasuraman, 2002, p. 116).

Both males and females have stress hormones that rise and fall throughout the day as the need arises, but while the male’s stress hormone levels drop once they leave work, the female’s stress hormones stay at high levels even after she has finished her paid work and heads home for her unpaid work (Frankenhaeuser, et al., 1989). This finding correlates with research done by Hochschild and Machung (1990), which indicates that when females leave their paid work, they have to go home to work their “second shift,” which is the unpaid job of caring for their family. This is why their stress hormones remain high at the end of the day. Female physicians are no different. They have the same role expectations as other professional women (Brian, 2001; Rosenbaum, 2008).

**Coping skills for professional females.** Gray (1983) considered married professional females who worked in positions that were typically held by males and the strategies they used to cope. This research study examined the lives of female attorneys, physicians, and professors (Gray, 1983). The participants noted that the most important element that helped them navigate through their busy schedules was their spouse’s support (Gray, 1983; Maly, Umezawa, Leake, & Silliman, 2005).

Gray (1983) discovered several strategies that were used by professional female to be most effective for these female professionals in coping on a daily basis with the various roles/functions that they had to fulfill (Gray, 1983). The professional females used secondary appraisal to cope with getting their household chores completed by getting other members of her household and other family members to help do chores. The
successful professional female also used family members to help resolve conflict that arose in the home, freeing her time. The professional female understood her personal limitations and learned how to reduce her tasks by doing only those things that were necessary, and prioritizing important tasks on a daily basis.

**Female Physicians**

Female professionals in general have more stress in their personal and professional lives due to their navigating multiple roles/functions and attempting to care for their families while being a professional at work (Berger, 2000; Cooney & Uhlenberg, 1989; Gray, 1983; Eagly, 2000; Gerald, 1998; Handwerker, 1999; Hoffnung, 2004; Maly et al., 2005; Mason & Goulden, 2002; Noor, 2002; Noor, 2004; Reid & Bing, 2000; Wolfinger et al, 2008). It is a challenge that is attempted most days and is accomplished some days. The next section will look at female physicians, who they are, and what the body of literature says about them.

Female physicians have experienced discrimination in one of the oldest professions (McMurray et al., 2000). Female physicians have to do more than the male physicians on a daily basis. Female physicians see more female patients, who are more complex and demanding (McMurray et al., 2000). Female physicians often feel pressured in the amount of time that they can spend with the patient due to regulation by job requirements (McMurray et al., 2000). Female physicians consistently make less than male physicians in the same specialty, with an average difference of $22,000 per year (McMurray et al., 2000). Another area of major difference between male and female physicians is the control over the work environment. Female physicians have
significantly less control over the environment than male physicians, even after considering where they practice, their specialty, whether they are over or under 40, and how many hours per week they work (McMurray et al., 2000).

**Female physicians and stress.** The stressors of female physicians are unique when compared with other female professionals (Gautum, 2001; Shrier & Shrier, 2005; Straehley & Longo, 2006). Female physicians come face to face with death on a daily basis in their work environment (Burke, 2001). Their work environment can be demanding and hostile, and typically they have little control over when and how they work (Frank, Rothenberg, Brown, & Maiback, 1997; Frank, McMurray, Linzer, & Elon, 1999).

Michael Myers (1998) mentioned some stressors that he found to be specific to female physicians. The biggest stressors that Myers (1998) found had to do with child care and household tasks. Myers sees female physicians as being under more stress and having more need for intervention than the male physician (Myers, 1998).

A meta-analysis conducted by Burke (2001) indicated that there are several factors that may cause stress in the physician’s personal and professional life. The concern of this study was whether the stressors physicians faced could cause them to do harm to themselves or to someone else (Burke, 2001; Frank & Dingle, 1999). The study uncovered several stressors that affected the physician on a daily basis, including (a) financial concerns, (b) problem patients, (c) work/family conflicts, (d) work overload, (e) being on call, (f) life and death situations, and (g) being fatigued (Burke, 2001). Female physicians were found to be more likely to develop high level of stress and related
conditions like depression or anxiety, which could lead to suicide (Beautrais, Fergusson, & Horwood, 2006, Burke, 2001; Frank & Dingle, 1999; Miller & McGowen, 2000).

**Female physicians and coping skills.** Because so many females are entering the medical field, they are causing a paradigm shift in the way medicine is practiced (Searle, 2000). Female physicians are becoming more and more a part of the medical landscape. As a female physician herself, Searle sees the need for a change in the medical profession to include the specific needs of female physicians and a change in the mindset of the medical establishment, giving female physicians the respect they deserve for the job that they do (Searle, 2001).

Gautam (2001), a physician, saw female physicians dealing with stressors in the home and in the work environment on a daily basis and decided to look at both venues and make suggestions on ways that female physicians can cope as they fulfill their multiple roles on a daily basis. For the work environment, Gautam (2001) suggests that female physicians need to take control of their work hours and take breaks every day, and be sure to take days off. They need to set boundaries at work and learn to say no. They also need to manage their time better while at work by organizing and prioritizing their daily duties.

Gautam (2001) also states that female physicians should not only think about their own needs but should lobby and support any programs that would help female physicians in general to be more productive and have a better work experience. Finally, Gautam (2001) indicated that for female physicians to be truly successful, they need to learn to cope in both the work and home environment, and to find the balance that will help to keep both areas running smoothly.
Methodology

Participants

There were 27 married female physicians who participated in this study. They were recruited from various hospitals in the southern California area, including Loma Linda University Medical Center, the Loma Linda University East Campus hospital, the Loma Linda University Behavioral Health Center, the Loma Linda University Heart and Surgery Hospital, and the Loma Linda Veteran’s Administration hospital. Additionally, through the use of snowball sampling, private practice physicians in Washington, D.C., and in Huntsville, Alabama, were also recruited. Snowball sampling is a process by which future participants for the study are garnered from the current participants of the study.

Inclusion Criteria

There are three basic inclusion criteria for this study. First, the physician had to have been married for a minimum of 2 years; second, the physician had to have been out of residency for a minimum of 1 year; and third, the physician had to be a female. There was no age limit for the physician; however, she must still be practicing either full time, part time, or sometimes. Ethnicity, specialty, and location of practice were not criteria for inclusion. However, the majority of the subjects for this study were from the southern California area, because that was most convenient for the researcher.

The number of female respondents for this research study was 27. Because this research study developed grounded theory, the data was collected until it was determined
that theoretical saturation had occurred (Strauss & Corbin, 1998). There was no specific number of respondents required for this study, but the researcher stopped data collection when it appeared that no new information was being added to the already developing theoretical perspective as the initial coding took place (Flick, 2006).

**Qualitative Analysis**

Qualitative analysis is a way to interpret data without using a numerical examination, and makes observations about the data for the purpose of determining underlying meanings and patterns of relationships (Babbie, 2007). The purpose of qualitative analysis is to acquire knowledge of how and why, or to discover the meaning of something before it is put into practice to make a difference in the lives of others. For example, in this study, the data that was discovered may help find the meaning for female physicians’ personal and professional lives. This data analysis was then built into grounded theory (Charmaz, 2006). The grounded theory was developed from the data gathered from female physicians, “in their own voices” through in-depth interviews (Charmaz, 2006).

Analytic tools were used by the researcher to assist her with making comparisons and asking questions (Strauss & Corbin, 1998). Some tools used were case analysis, cross case analysis, semiotics, narrative analysis, conversation analysis, and variable analysis (Flick, 2006). These analytic tools increased the sensitivity of the research, helped the user recognize bias, and helped the user overcome analytic blocks by asking questions (Strauss & Corbin, 1998) like who, when, what, where, and how. Theoretical memo writing was also used for this study throughout the analysis process. Also, investigator
triangulation was used to minimize bias, and member checks were conducted with female physicians. The coding analysis process encompassed three main stages: initial coding, focused coding, and theoretical coding.

**Initial Coding**

The first step in the analysis, initial coding, was used as an opening or beginning for the researcher to help check her own preconceptions (Strauss & Corbin, 1998). In initial coding the interviewer looked at the data and then asked broad questions from each section of the interview (Charmaz, 2006). This initial classification and labeling of concepts developed the codes suggested by the researchers’ examination and questioning of the data. The outcome of coding was the identification of numerous concepts relevant to the study of female physicians (Babbie, 2007; Strauss & Corbin, 1998).

**Focused Coding**

Stage two of developing grounded theory was focused coding. Comparisons were made of groupings of similar or different concepts to discover properties and dimensions that were possible when they are not first evident to the researcher (Strauss & Corbin, 1998). This process involved using the concepts that emerged in initial coding and making categories and sub categories that gave the explicit groupings of properties and dimensions (Charmaz, 2006). Focused coding also identified the central categories in the study.
Theoretical Coding

Stage three of developing grounded theory was theoretical coding. This coding process was used to validate the theory. It was a process that verified the developed theory was an accurate testament of the meaning informed by the interview process (Strauss & Corbin, 1998). This coding helped to ferret out the main categories in the study – the main categories to which all of the data points. The patterns of relationships could then be understood with this far-reaching and in-depth examination of the interviews that helped to build grounded theory of the stressors and coping strategies married female physicians.

Results

The quantitative questions yielded many interesting statistics. The ages ranged from 29 to 64 years. Fifty-two percent of the physicians were under 40 and 48% of the physicians were over 40. There was one set of mother/daughter family physicians who participated in the study. The ethnic breakdown for the physicians was 26% Caucasian, 46% Black (which included Caribbean, African, and African American), 11% Asian, 11% East Indian, and 6% Hispanic.

The top four specialties for the female physicians were Family Practice 16%, Obstetrics/Gynecology 16%, Psychiatry 16%, and Pediatrics 16%. The least practiced specialties were Gastroenterology 3%, Ophthalmology 3%, and Radiology 3%. Thirty-five percent of the female physicians were married to other physicians; 35% were married to business professionals. The remaining 30% were married to a teacher, peace officer, lawyer, and professional chef. Seventy percent of the female physicians had two
or fewer children, while 30% had three or more children. The majority of the physicians, 70%, spent less than 30 hours per week on child care, and 30% spent more than 30 hours per week on childcare. The study indicated that 30% of the female physicians worked less than 30 hours per week, while the remaining 70% worked more than 30 hours per week. When it came to doing housework, 44% indicated that they spent 6 hours or less on housework per week, while 56% indicated that they spent up to 20 hours per week on household chores. Fifty-six percent of the physicians paid for a house keeper, and 44% did not. Female physicians worked less than 30 hrs per week and 30% worked more than 30 hrs per week. The settings of their practices were university or academic setting, 28%; private practice, 28%; community hospital or clinic, 40%; and remotely from their home, 4%.

As the qualitative data were analyzed, it became evident that two broad categories described the experiences of married female physicians: system challenges the high level of demands faced on a daily basis and system adaptation the coping strategies used to alleviate challenges. The six subcategories that emerged from the data were (a) work demands, (b) family demands, (c) child care needs, (d) self imposed demands, and (e) reaching out and (f) reaching in coping techniques.

Balancing work and family is important for female physicians to have the best of both worlds and for them to enjoy spending time at work and enjoy spending time with their families. The data indicate the work demands for the married female physician are many and varied, depending on her specialty and work schedule. The physicians, in their own words, told how female physicians who work in certain specialtities like surgery or obstetrics can expect to work more hours and have a more demanding schedule with
more interruptions of family life than their male counterparts. In addition, several married female physicians have chosen to work part time rather than full time so that they can better manage the demands of both work and home.

In response to the question: “What are your thoughts about the demands of your professional life?” a common complaint of married female physicians was the issue of balance. Female physicians found that balancing the demands of work and home is quite challenging, regardless of their specialty or their work schedule, due to the high demands of each. Keisha put it this way: “Being able to balance work and family is a challenge. I love the profession but if I spend too much time with my work I will be losing precious time with my family.” Kathy stated,

As far as the joys of it, and the demands of it, I’m not so sure that I would have chosen this career path because it pulls away from really what I would like to do most, which is raising my children.

Other physicians saw the issue of balance as something that was discussed from the beginning of medical school as to why women should not become doctors in the first place. Susan said, “That is why they originally discouraged women from becoming doctors because they would have to take care of the home and how can they be a doctor and a wife and mother.” Debbie sees the problem this way: “Being a female physician and a mother is like putting a square peg into a round hole; it doesn’t fit.”

**Finding System Balance at Work**

Balancing their work roles is one of the major challenges according to the married female physician. They have to meet the work requirements and the patient expectations. According to the physicians, time is a much sought-after commodity. Cindy indicated, “It
is difficult to balance the patient expectations with the work requirements when I am expected to see a certain number of patients every day.” Female physicians see many patients during their shift. They can begin work early in the morning and work until late in the evening, when they finally get to leave and go home. There are few breaks for the female physician and she often hopes that she has not missed a serious condition because of her limited time with each patient. Julie put it this way:

My patients are generally started from early in the morning and I generally see 23 to 35 patients per day in 15 minutes intervals and if I go over with one patient, then I am behind schedule the rest of the day and the patients get mad.

Jennifer, an internal medicine physician commented on the time constraints of being a female physician:

They (the job) make it hard for us by having these deadlines and we are behind all the time because the amount of time they allow for each patient is not enough time to really treat them the way you are supposed to and this causes me a lot of stress.

Tina, a family practice physician, stated this about time constraints:

Time restraints are stressful. You are allowed a certain amount of time to see the patient and chances are there are more patients than time available in any given day. You never have a light work load. I have many women patients and women like to talk and I often go over the allotted time per patient.

Nicole, a family physician in private practice, indicates that:

Unfortunately, the working part is very stressful because it is a full time job and I only work part time and unfortunately it is my job of being a physician. My job is very stressful and I get anxious driving to work when I think about my job because I spend a lot of time with my patients and then I get behind and it is stressful trying to keep up because I am 40 minutes late because I spent an extra 15 minutes with a patient that needed it and I want to be on time, but it is more important for me to spend the time with the patient who needs it.
Often female physicians take her patients home with her at night, not literally, but in her mind, worrying if she did the right thing for the patient and if she provided appropriate care because of the time constraints. Lorine, a physician who sees patients in a community hospital noted:

From the time I get there (at work) in the morning I am seeing patients; I hardly ever get to sit. I am going from room to room to see the patients and I don't only have to see the patients but I have to talk to them as well as document everything that they told me. It is never ending. And then my pager is going off every 5 minutes and I am expected to return patients' and colleagues phone calls. And while all of this is going on I'm thinking "I really don't have time to sit around and second guess myself but there are times when I have a particularly difficult patient and I will come home and lay awake at night thinking about the patient and what I could have done differently and what I can do the next day when I approach the patient. Many times I lay awake planning a strategy and working it out in my head how things will work out, and then I can sleep.

Another work system challenge that many of the physicians commented on was the life and death responsibility of being a physician. For many of them the thought of their patients' mortality was constantly on their minds, even after they left for home. Louise confided, "I always have it in the back of my mind that I have to get it right or there will be a lawsuit." Another physician, Joy, intimated:

There is the risk of not knowing who will walk through that door and if they will sue you. But the risk is always out there so it is very stressful because I don't want to hurt anybody. You could kill somebody accidentally.

Cathy wanted the researcher to know, "As far as work wise I always think that my work could cause somebody's death." And she continues, "You practice as careful medicine as you can so that you don't miss anything."
Kathy, an OB/GYN, noted that, "Physicians are perceived as having the answer to everything and I think work is stressful because you are perceived as having the knowledge that you do not necessarily have." Alyssa informed the researcher:

You have to try and not make errors which can lead to serious consequences. So that's the intensity here. You have patients that are sick and some of them are near dying, and you really don't want them to die on your watch.

Marilyn, a physician in a community hospital, had this to say about death:

I've just had two patients die right before I went on maternity leave and that was very stressful. I had just been to the hospital to see them and then they died. And then we had a 2-year-old and her mother die in a car accident and that was hard, and I don't know how you deal with those kinds of deaths.

Evelyn was quite emphatic that the biggest work system challenge was getting her patients to follow the care she prescribes for them that could save their life:

It is difficult to get patients to follow through on the advice I give them. You see patients coming in today for a particular problem; you prescribe a treatment, and then you see them coming back in 3 months with the same problem. They didn't do what you told them to do 3 months ago, so now they are back with the same problem.

Female physicians face stressors that other professional females do not because they have very intense system challenges placed on them, both at work and at home.

**Finding System Balance at Home**

When asked, "What other demands or expectations do you experience apart from your job?" The next levels of stressors that demanded attention from female physicians were the stressors at home and with the family. Married female physician not only had stressors from work, but stressors at home. The home demands are broken down into
concepts of housework and family responsibilities. Female physicians, like other professional females, continue to have the greater responsibility of housework and family needs. Joy stated, “I do have to divide my time between home and work you know, so I can’t compare myself to my male colleague who doesn’t have to come home and do laundry or cook.” Female physicians not only come home to do laundry and cook, they have to formulate their lives in such a way that they have to limit their opportunities in medicine.

For example, Hannah gave up an academic position because it took up too much of her home time and she believed that “family comes first.” Michelle tells us that, “Things invade your family time. You have to control your hours and juggle your professional life and private life so you can have family time.” Jennifer tells about leaving her academic career for her family:

I had to give up working at the University, the job that I liked a lot. It just wasn’t working for us because of the type of job and the stressors. I have had to make job decisions that have been limiting to my professional opportunities. I could be teaching at the university and have more prestige on my job, but I had to make choices of what we want and what is best for my family. It was a non-issue because family comes first.

Louise wanted to encourage other female physicians to choose the specialty that would best fit their lifestyle:

Depending on the type of family life that you want to have, female physicians are a little bit more limited in the specialty types that they choose. That doesn’t mean that a female can’t be an excellent surgeon, anesthesiologist or whatever you would like to be. However, I have seen situations in which marriages have failed. I wouldn’t necessarily say because the woman took this role, but that plays a part in it. I think a female can do whatever she wants to do, but it depends on the family structure that you want to have.
Finding balance at home can be difficult for the female physician because by the time she gets home she is so fatigued that her work no longer has the quality that she so desperately seeks. Keisha tells us that:

There are some days when I am really tired but when I get home I have to start cleaning up and cooking and putting things in order and getting the children ready for the next day. Some days I am just tired and frustrated and I don’t want to do it. That whole emotional thing that’s pulled out of you at work really can be fatiguing and then you come home and now your husband wants to tell you about his day or whatever, or he says, “I think we should redo the backyard, what do you think?” I can’t think at that point. When I’m asked to make another decision after I’ve used up my decisional mind for the day, I can’t.

Because female physicians have to make decisions all day about patient care and hospital needs, when she comes home she does not want to make decisions, but she has to provide the basic care that is expected of her as a wife and mother.

Phyllis said:

Eventually you have to make the decision about what is the position of everything in the hierarchy so there is balance and then there’s the hierarchy. Family comes first and work comes second. There can be balance and there have to be sacrifices on both ends. But as long as you know what position in the hierarchy each thing is, the choices are easier.

Finding Balance with Children

In addition to the stressors of patient care and family another subcategory that arose from the data was children. Children are a big stressor for the married female physician. Like other professional females, she feels responsible to be the primary caregiver for her children. According to research by Puddester (2004), one of the biggest stressors for female physicians is guilt over leaving her children and the remorse that she feels because she cannot be a full time parent. Ginger declared, “Once you have a child
your whole focus changes. Medicine is not as important and providing care for your kid becomes most important.” In Sobecks’ et al. (1999) study, 92% of female physicians believed that they were the primary care giver for their children. Evelyn, an internist, noted: “I see myself as a mother, I see myself as a physician, and a wife. I hold all three of them as very important jobs. But I had to choose when my kids were little.” Keisha stated:

That’s my legacy, my children are my legacy, and if you as a parent you cannot say I did a good job with the most important job that I had to do, even more important than medicine is my parenting. And if you have offspring that are not successful it reflects on you, it should reflect on you. This present study showed that female physicians continue to be responsible for the majority of the care for her children. She not only does the majority of the physical labor, but she also does the mental labor, thinking about what has to be done for the children. She is planning who is going to pick up the child, and what is for dinner, and how she is going to manage the environment at home. Sarah confided: “I get stressed out when my kids don’t eat well. How do I put a nutritious meal on the table is a major stress for me.” Evelyn told us that:

In terms of childcare, I do most of it. My child is in daycare 40 hours per week and I pick him up from daycare. Starting in the morning I’m usually the one to get him up, feed him breakfast, change his clothes, and get him into his clothes for the day. He goes with me in the morning and I drop him off at day care. Then I pick him up, bring him home, give him his dinner, give him his bath, read to him and put him to bed. If I have to work on the weekend, I have to get a babysitter to watch him, depending on my husband’s schedule.

For married female physicians, thoughts take up more of their daily routine than the actual work. Because of this, female physicians will stretch themselves to the farthest limitations to provide the appropriate care for their children. Julie affirmed that: “When
my child is sick, 99% of the time, it is me staying home. I just have to reschedule my patients.” Beverly, a family medicine physician, says:

We try to keep this (child care) balance but every day there are decisions that make you feel stressed. This week he woke up with a fever and the day before I had to leave work early because he fell at school and had a nose bleed. I don’t want to keep missing work, so what do I do? I gave him Tylenol, gave him a bath, no fever. He’s telling mommy I feel fine. What do I do? Do I take him to school or stay home? I thought ok, I’m going to take him to school and they can call me and tell me if he gets sick. I’m a bad mommy, bad mommy.

Often, a female physician feels that she is a “bad mommy” because she cannot always stay home with her children when they are sick; this causes her stress. Because of this stress, she learns to use coping or adaptation to alleviate that stress and to provide the care for her child in other ways, thus finding balance in the system.

**Self Imposed Demands**

In this study, it was discovered that even though female physicians work long hours and have a continuous emotional drain as do the male physicians, they are still expected to fulfill the roles that females have filled in the home for generations, that of nurturer and care provider. Tarah, a psychiatrist says, “The sense that providing in the home, making sure that there is food, the home is clean; his (husband’s) shirts are laundered and ironed are the duties of the wife.” Some of these demands are imposed by society and others are imposed by the physicians themselves. Linda stated:

My mother was the one who took care of the home, did the meals, and took care of the clothing... That is engrained in my background so I still feel like I should do these things.

Michelle informed that:
What I do comes from my background because my mother was the same way. I was shaped based on this mentality that you have to push yourself, no excuses allowed, beating the odds and whatever I do, I have to do it well, be it parenting, being a physician, or being a home maker.

Even though female physicians work hard outside the home, they often feel that they must work hard inside the home as well. They feel like they are bad mommies if they leave their sick child to go take care of their sick patients. They feel guilty if they “don’t cook every night” for their children. They feel guilty if they don’t “attend all the parent teacher meetings and go on field trips” at school. Phyllis, a radiologist, states:

I was always feeling guilty because I was running from home to work and I felt I wasn’t doing either well, or as well as I could so I don’t think I was as great as I could have been.

Not being able to do everything well is hard for female physicians because they believe it is their job to do it all. Sarah, an OB/GYN physician confessed, “I’m the type that tries to do everything myself and therein lies part of the problem because I think I should do it all myself and not ask for help.” Hannah often feels guilty because she really likes her work and she puts it above her family:

I am a workaholic type and I am somewhat obsessive compulsive and my work can consume me. It makes me a good physician but it doesn’t work for marriage and it doesn’t work for raising kids. It is hard for me to put my husband and kids above my work.

Again, this mentality comes from the societal expectations that the female is responsible for the care of the home and the children, as noted in the literature review.
System Adaptation/Coping Strategies – Reaching In

When asked, “How do you cope with stress,” the physicians responded that an important coping strategy used was looking to God for strength. Cindy, a rehab physician, stated, “Spirituality helps me.” The looking to God for strength was an important theme in the data. Christina, a partner at an HMO noted:

I see where I attribute everything that I have achieved and everything that I enjoy as a blessing from God. I am able to sit and listen to my patients, have empathy with their problems, and offer them the support that they need because of my relationship with God and Him helping me when I don’t know what else to do.

And Debbie proffered, “Everything that I do when I go to work is serving God. He helps to get me through the difficult situations at work and at home.”

Not only was having a relationship with God important to help the physicians cope, but also prayer and meditation was a way of inward seeking. Olivia, an ER physician, put it this way:

I pray. I take a moment. I pray a lot. I bring that same intensity that you have professionally at home and my consultant in both places is God in the form of prayer. I think it is not even really a prayer but more of just a discussion. Sometimes it is like okay God, what do I do? I’m arguing with God and asking what I am supposed do in a situation and the answer will come to me.

Through inward seeking of God, and through meditation, female physicians were able to feel that they had some control of the chaos that is their life. Other ways of reaching in to cope was getting enough rest, eating right, exercising, reading a good book, setting boundaries on their time, and spending time alone.

System Adaptation/Coping Strategies – Reaching Out

When asked, “What kinds of support are available to you in managing the
Stressors’ in your life?” the physicians also used reaching out to cope. Female physicians were quite innovative in the ways that they reached out for help as they used appraisal to try to find ways to alleviate or prevent harm from occurring in their families due to stress and other demands on themselves. A physician in a busy practice built an apartment on the back of her office so she could bring her children to work and not have to worry about them when they were sick or she did not have day care. She and her staff would care for the children throughout the day. Billie, who specializes in geriatrics, travels out of state to work, and she has babysitters on call who travel with her family and care for the children while she sees her patients.

The most reliable outside source of support, according to the physicians, were their spouse and family. Ginger purported, “One of the most important things is taking time off to be with my husband and children. That family first deal helps to keep me in balance,” also, “having good friends and family helps. I think now technology is so great; our families are thousands of miles apart, but through the phones they are just a call away.” Lorine likes the fact that:

Sometimes my days can be a little extended even though I’m part time. He (husband) helps with the children, he helps the housework, like I said, there are no defined rules, so if something is not done he steps in and does it. He supports me. He enables me to do any of the peripheral things that have to be done with my job.

In the area of support, Caren stated, “You have got to have support and it really does take a village. We are both physicians and you have got to have a village to get things done.” Female physicians also paid for help with the housework and childcare.

Another way the female physician seeks outward support to keep balance is by talking things through with her friends and other physicians. Nicole confessed:
My husband doesn’t like to talk to me about medical stuff. He is tired from the kids at school and the kids at home; so on my way home, I call my mother, who is a physician, and talk with her and tell about my day before I get home. This saves my husband from having to listen.

Many physicians stated that having “girl’s night out” was important for them because, as Hannah said, “this is a time when we have fellowship, and we sit and talk and laugh.” Support groups like “Women in Medicine” are good, but Olivia states, “The problem is that women in medicine, especially mothers, are very busy and they don’t have time to get together professionally.” At other times female physicians would collaborate with other female physicians so that they could cover family needs. For example, Beverly stated:

When I had to be there (at work) based on scheduled times it was very stressful and then there are meeting times, and you can’t say, “schedule that meeting for 12:30 because my kid is reciting a poem at 11.” When I had to be there based on their scheduled times it was very stressful because the guys didn’t understand if I wanted to be at my child’s ballet recital that night, but I could talk to another female physician and say my daughter has a ballet recital on this night and I am scheduled to work, can you help me out? And she would say sure. Then when she needed time off or her kid was sick, she could trade schedules with me.

Seeking and receiving outside help was an important factor in helping the female

**Grounded Theory**

From this data a grounded theory was established to explain the stressors and coping strategies of female physicians. There were five areas of analysis that were used to build the grounded theory. The analysis began with the research design, continued with the data collection and data ordering, then data analysis, and finally, comparing the previous literature. As these analyses were conducted, the quality of the research study
was probed, using a criterion that has been established to understand research. This criterion includes reliability, internal validity, construct validity, and external validity. These areas of analysis are not typical of qualitative research, but the terms are used to help the quantitative reader better understand the rigor of the data being analyzed. The reliability of the study relates to how the data was collected and analyzed and if another study can use the same methods and get similar results. The internal validity of the study indicates the truth finding and whether the analysis of the data actually presents the true meaning of what the respondents had to say. Construct validity is the actual construction of the research study and a determination of whether the specific protocols outlined were followed. Finally, external validity refers to the researcher’s ability to appropriate the theory developed to a broader, previously established theory.

**Sampling.** During this phase of grounded theory development, the researcher used in-depth interviews in an attempt to find the meaning of the married female physicians’ lives. According to Glaser and Strauss (1967):

> In theoretical sampling, no one kind of data on a category or technique for data collection is necessarily appropriate. Different kinds of data give the analyst different views or vantage points from which to understand a category and to develop its properties; these different views we have called ‘slices of data.’ While the (researcher) may use one technique of data collection primarily theoretical sampling for saturation of a category allows multifaceted investigations, in which there are no limits to the techniques of data collection, the way they are or the types of data acquired. (p. 65)

Therefore, the in-depth interviews were an appropriate way to gather data for this qualitative study. This data helped the researcher to understand the how’s and why’s and the meanings of the relationships of the data.

**Coding.** The analysis began with questioning the data to get an understanding of who, what, why, and when. These answers led to a better understanding of the meaning
of female physicians' stressors and demands and the coping strategies they used to adapt to these demands and stressors (see Figure 1).

The grounded theory developed from the data of this study indicated that female physicians who have stressors and demands at work, at home, with their children, and self-imposed demands use two basic coping strategies, either outward seeking or inward seeking (see Figure 2).
Develop Grounded Theory
Female Physician Reaching In and Reaching Out Coping Strategies

Data Analysis
Initial Coding, Focused Coding, and Theoretical Coding

Data Collection, Sampling, In-depth Interviews

Figure 1: Process of Data Collection and Data Analysis to Develop Grounded Theory
Figure 2: Stressors and Coping Strategies of Married Female Physicians

**Reaching out**
- Help from Spouse
- Help from family members
- Girls “night out”
- Talk to other female physicians
- Delegate housework
- Delegate child care
- Pay for outside help
- Take children to work with them

**Reaching In**
- Prayer
- Meditation
- Going to church
- Seeking guidance from God
- Bible Study
- Setting boundaries at work and at home
- Proper nutrition and rest
- Learn to let go and choose battles
Discussion

Although there have been a significant body of work looking at physicians, the focus has been on the profession and with samples that consisted of White males, mostly. There is an obvious paucity of work, relatively, that focuses on female physicians. This present study analyzed interviews of married female physician, and, as such, was able to illuminate a still obscure literature to date. The study was able to take an in-depth look into the experiences of 27 married female physicians, and was able to show what life is really like for them as they navigate the stressors and demands endemic to them on a daily basis.

Although the literature suggests that professional females still provide most of the care for their home and family, I was surprised that female physicians, who have broken the societal molds in many ways, are still steeped in traditional gender expectations (Carter & McGoldrick, 2005). Even though you would expect the female physician to order her roles differently, no matter how egalitarian the couple may seem, once children enter the picture, the family roles revert to the traditional ones of the male breadwinner and the female caregiver. Given the number of years that female have been in the medical profession, one would have thought that they would have a greater impact system, but they are describing gendered situations the same way they did 10 years ago (McMurry et al., 1999; Sobecks et al., 1999; Warde et al., 2000).

Simply put, there are many unique aspects of married female physicians and much has to do with the challenges and demands associated with work. For example, the intrusive schedule, the time expectations, the patient expectations, the concern whether they make a mistake that can cause a person’s death, etc. Indeed past research has show
adaptation in the family life to accommodate professional females and I would have expected to find more accommodations given their profession. This present study highlighted the serious demands of work, home, child care, and self imposed expectations.

The individual experiences of female physicians are unique in that their personal characteristics, needs and ability to adapt are important in their coping. The current study adds to the limited number of empirical studies that have been conducted on female physicians and informs on the impact of marriage and family living on their profession, and on life in general. There is no one way for female physicians to make meaning of their life situation, meaning both family and work.

This present study is not intended to be a complete description of married female physicians and her demands and stressors, but it is offered as an exploratory point of view to give insight into specific experiences of these female physicians.

The results of this present study shed light on female physicians at work and at home. It was discovered that female physicians have intense stressors placed on them at work mostly due to time management issues and work expectations. She also has stressors at home that demand her attention, from house work, and other demands and expectations from family members. Time management both at work and home are an issue that is addressed everyday and realized some days. Married female physicians are also wives who have to learn to make decisions in a marital context, but when they are at work, they typically are the “captain of the ship” as one physician put it, and everyone looks to them for guidance. At home, she sometimes forgets that marriage requires more negotiation, than orders. The work-family dynamics of female physicians are different
than other professional females. She has flipped the gendered script and she and her husband fill roles and shoulder responsibilities that are not what society expects.

The female physician has often an "intense personality", as one physician describes it, which causes her to strive be the best she can be at work while still seeking to be the best wife and mother at home. Often, she feels that she is neglecting home and family because she is not as available to her family as she would like. However, female physicians have learned how to adapt to their environment. They have discovered that part time work is best when you have children at home. They have discovered that family support, especially that of the spouse, is essential. They have discovered that once children enter the picture, it is important to have another person available who can provide care for their children. Female physicians have developed ways to self soothe that helps them get through the challenges they face on a daily basis in their personal and professional lives as the reach inside of themselves and out to others.

Many female physicians in this sample reported that they have to negotiate an optimal schedule that allowed for maximal performance in the domains of work and the home. One thing she can do is trade shifts with another physician. Trading shifts can be difficult though, because single female physicians do not see the need to help out and male physicians do not like giving up their shifts to help female physicians, because they both do the same job.

The body of literature on female physicians indicated that the female physician continued to be responsible for home and family even with the intense challenges of her job (Gautum, 2001; Shrier & Shrier, 2005; Sobecks et al. 1999; Warde et al., 2000), the results from this current study confirms previous studies on female physicians. Even
though they are in highly professional families and she is so absorbed in her work, but she doesn’t organize her domestic affairs differently, but still essentially practiced under the patriarchal system of gender still struggling to balance work and home.

Although the literature showed that female physicians’ husbands didn’t feel responsible for the care of the home and family (Linney, 1999; Myers, 1998), it was interesting to note in this present study that even when the female physician was the primary breadwinner, contributing more to the family finances than the spouse, he didn’t feel responsible for the care of the family and home. Additionally, male physicians married to female physicians, who understand the intensity of the physician work place, didn’t take responsibility for home and children, but expected his physician wife to do so. The researcher did expect that the male physician, married to the female physician, would be more involved with the completion of house hold tasks and the care of the family.

This present study heard from female physicians that they had to limit the amount of time they took post partum because the male physicians they worked with would get angry if they took too much time to be with their new infant. Olivia said that after she had her children she would be back to work as soon as she was released by her doctor because she felt that she had to prove to the male physicians that she was equal to them and could fulfill her responsibilities and not expect them to do her job. This is one way that female physicians choose to use system adaptation to help keep her systems in order.

The previous research conducted on female professionals and female physicians indicate that having time to do everything she needs to in a day is often as challenging (Greenhaus & Parasuauraman, 1999; Wolfinger et al., 2008) as well as for the female
physician (Gautam, 2001; McMurray et al., 2000; Shrier & Shrier, 2005; Straehley & Longo, 2006).

The data collected for this present study agree with the previous research on professional females and female physicians. It also contributes to the broader area of work-family balance (Greenhouse & Parasuraman, 2002; Frone, 2003; Grzywacz & Marks, 2000), by examining how female physicians collaborate with work and home systems to balance and minimize conflict. From the breadth of research data collected during this present study, it can be concluded that female physicians work in an environment that causes emotional, psychological, and physical drain on their natural body forces. They do not just go to work – they live their work; they give 100% of themselves at work and at home. They are required to give everything they have to each patient so that at the end of their shift they are drained and can barely make it home. However, unlike the male who comes home after his long work day and has his stress levels drop back to normal, the married female physician begins her second shift when coming home, thus sustaining her levels of stress (Frankenhaeuser et al., 1989). Instead of being able to come home and just sit with the TV remote and fall asleep in a recliner, she has to rush through the door and hear her family asking, “What’s for dinner?” “Can you help with my homework?” “Can you read me a story?” “Honey, do you want to remodel the back yard?” as were some of the responses of female physicians in this present study.

The female physician is constantly trying to balance the domains of work and home, and often feels stressed. For example as Evelyn tells us, “Unfortunately the working part is very stressful because it is a full time job and I only work part time and
unfortunately it is my job of being a physician.” She also has the responsibility of providing child care and performing household tasks after saving lives all day (Myers, 1998). Female physicians continue to have financial concerns, problem patients, work overload, life and death situations, and fatigue (Burke, 2001).

Myers (1998) stated that the biggest stressors for female physicians are child care and household tasks. This current study found that home and family demands and child care demands were constant stressors for the female physician who attempts to balance their spheres on a daily basis. Burke (2001) indicated that problem patients, life and death issues, and fatigue caused stress for the female physician. This present study also found these stressors to be existent in the lives of female physicians. For example, when Julie has a patient that dies, she goes home at night and tries to determine if she could have done anything differently before she can finally sleep. Olivia worries about tomorrow and wonders who she is going to get to care for children the following day because her husband is out of town at a meeting.

The female physicians of today are getting more ingenious, however. They are finding ways to care for their family while they care for their patients while keeping their systems in balance. They are willing to pay for help and they are not afraid to ask for help when needed. This new breed of female physicians is working hard to make medicine work for them. They are no longer married to medicine, as the old adage says, but now they are concerned with having a life outside of work. Michelle told what a professor she had in medical school told her. The professor pulled all of the female medical students aside and gave them some very good advice. She informed them that they didn’t need to
“darn socks,” “patch pants,” or “clean toilets” because they were going to make plenty of money and they could pay someone to do those things.

In summary, the literature says that we are essentially gendered creatures (Kimmel, 2004). One would think that given the female physicians position and work, for her it would be different, but gender is a very pervasive influence in how people function. The major findings of this current study came up with some plausible alternatives to the current view of gender. There is a strong call for role reversal for the married female physicians’ family.

In the real world patriarchy abounds and females are expected to work at a lesser job than her husband and to care for her home and family. According to the marriage gradient, the male typically marries down. He marries a female with less education, less money, less prestige, and fewer demands from her job. However, in the female physician’s world, she typically has more prestige, makes more money, has more demands placed upon her time, and has more education than her husband causing a backward gradient with the wife on top and a schism in the family system. With the wife on top, the entire system has to adapt. The husband will gain a new role of working around his wife and her schedule changing the patriarchal system of family management.

According to structural functionalism there are roles, rules, and relationships in society. In the case of married female physicians, there needs to be a gender role reversal. Some roles must be played in a family for the family systems to function and if the one member doesn’t fill their expected roles, like female physicians, then someone needs to pick up the slack and it should be the spouse of the female physician or if both spouses
are physicians, then the members will need to find other ways for the system to adapt possibly by paying for help.

Resource theory states that there is only so much resource, in this case time, to go around. Female physicians are faced with a choice as to how they will spend their resource of time. They can choose to spend it at work with patients or at home with family. Overwhelmingly female physicians in this study chose family life over work as a way of adapting their system to keep balance and order.

**Future Directions**

Future directions in the study of female physicians can continue to explore the six subcategories of work stress, family stress, child care demands, self imposed demands, reaching in and reaching out coping strategies to determine where the female physician continues to place most of her energies.

Family was a major priority for the female physician in this current study and it would be interesting to see if this continues to be the trend with married female physicians. Future studies could examine if female physicians have found ways to simultaneously satisfy both her desire to be a physician and her desire to be a wife and mother. Finally, future directions could explore the impact medicine has on the life of the female physician when her spouse becomes more involved with domestic and child care duties in the home.
Summary of Goals and Benefits of the Study

The goal of this study was to add up-to-date empirical data to the current body of literature that is available on the phenomenon of the married female physician. The goal was also to find what meaning female physicians gave to their lives and their work. The researcher wanted to explore the stressors that are involved in female physicians' lives, as well as the methods that they used to adapt to their environments so that they could keep their systems running in balance.

Using the structural functionalism framework, this current study was able to confirm the challenges that put the systems of home and work out of balance – for example, time constraints, child care demands, and self-imposed personal demands. This present study also discovered that female physicians used coping/adaptation and primary and secondary appraisal to determine what, if anything, they could do to put their systems back into balance. Female physicians used inward coping mechanisms like prayer, meditation, and worship to help them cope, but they also used outward methods of coping; for example, getting help from their spouse, family members, paid workers, friends, and coworkers to alleviate some of the stressors and to enable their systems to stay in balance.

The benefits of this present study are that it provides insight into female physicians' lives. It corroborates the body of literature on female physicians' work and family life and provides theory as to why female physicians practice medicine the way they do.

This current study may aid female physicians to understand the necessity of balancing work and family. This study also can inform female physicians about the
opportunities and possibilities of working part time, some time, full time, and even participating in job sharing. This present study can help the female who is trying to decide on a specialty to choose a specialty that requires fewer working hours (i.e., dermatology, rehabilitation, pathology, radiology, pediatrics, and ophthalmology), or at least plan to work part time once she has children. This current study also informs in the area of becoming parents, the number of children to have if she chooses the “mommy track,” and the events that need to occur in the life of the female physician before children come.

**Implications to the Area of Family Science, Theory Development, and Future Studies**

This study developed grounded theory from the qualitative data that was collected during the interviews. This grounded theory of system challenges and system adaptation can be used to further study physician families. As noted earlier, there is much debate as to which methodology works best with families and which framework is most indicated in family relationships. This current study used the conceptual framework of structural functionalism to help provide a valid explanation as to how female physicians balance their personal and professional lives. Even though this theory is considered to be out date, it deals with the roles, rules, and responsibilities of female physicians’ show ways that they can adapt their systems to maintain order during times of challenge and disequilibrium.
Strengths and Limitations of the Study

The present research study advanced the empirical understanding of the married female physician and added to the limited body of knowledge. The strengths of this study included the in-depth interviews of the female physicians, and allowing the researcher to discover the meaning that is important to the female physician by reaching saturation with 27 participants. The participants' diversity was a strength for this present quantitative study. Seventy-five percent of the respondents were ethnic minorities, giving a more diverse look into the lives of married female physicians. Most of the previous research on female physicians has had a large population of White participants. Another strength of this study was the extensive training that the researcher received prior to the beginning of the current study, and the congruence in coding, as all team members came together on a regular basis to collaborate and gain insight into the data. The principal supporters of the research group met together regularly with the group members to ensure proper handling of the data and processing.

This present study was not without some important limitations. The limitations of the current study include the fact that 75% of the respondents considered themselves Christian. The system adaptation of inward looking coping mechanisms may have been replaced by other things like alcohol, drugs, or smoking if the sample had fewer Christians. In hindsight, other questions could have been added to the study that would have elicited more depth of experience from the respondents. Finally, the geographic location was a limitation since 93% of the respondents were from the southern California area. If they were from another part of the country, their system adaptation could have been different.
This qualitative research study only skims the surface of how female physicians find meaning in their personal and professional lives in the 21st century. Further studies are indicated to more fully understand the processes that are involved with female physicians as they strive to find meaning. The researcher will continue to look through the interview material in an effort to fully understand the meaning that is associated with married female physicians. It is important to note that the procedures described in this present study represent only one study with one group of 27 physicians, mainly from southern California and mainly Christian. There is so much more data to be collected and because of the sample size and because this is a qualitative study, the results cannot be generalized to other female physicians around the United States or in other countries. This data does open the door to developing further research studies that will look more deeply into the topic, using qualitative, quantitative, and mixed method approaches in an effort to understand the shift of the paradigm in medicine that now includes females as physicians.

**Conclusion**

The current study was able to open a window on the lives of married female physicians and gives the world a look at them, their work lives, their married lives, their lives as parents, and their lives as females. It showed them in their truest selves, as wives and mothers, and as physicians. They are not different from other women. There struggles qualitatively different from other females, except that their work roles are extraordinarily demanding. They want to be good parents and have their children to grow up happy, healthy, and successful. They want to live life to the fullest. They want
to enjoy their lives and they want to take care of others while they do it. The females in this present study are strong and powerful. They were intense and devoted. They appeared to be loving and lovable.

With more than 50% of medical school classes being made up of females, there is a need to obtain a better understanding of the life of a female physician and to discover a way to make her life less hectic. One female physician stated, “You need twice as many female physicians as male physicians because it takes two females to do the work of one male physician because they work part time.” Married female physicians are becoming more the norm than the exception and it is time for the administrators of medical schools and hospitals to realize the valuable resources that they have in female physicians, but to also realize that they are also wives and mothers; they are not married to medicine, and they are trying to balance the work that they love with their family whom they love even more.
References


Appendix A

Physician Interview Guide
Interview Questions for
Medical Doctors and their Families: Qualitative Study
9/22/09

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. Tell me about your expectations for marriage.

2. How would you describe your current relationship?
   a. Probe: What aspects of your relationship do you find most satisfying?
   b. Probe: Get a sense of how the following are experienced
      i. intimacy (physical, emotional, sexual)
ii. communication
iii. time together
iv. closeness
v. sense of partnership
c. Probe: What aspects of your relationship do you perceive to be most challenging or how might you wish it to be different?
d. *How do you create time to nurture your relationship?

3. What aspects of being in a physician marriage most impact your marital life?

4. How does being married to your spouse affect your work life?
   a. Probe: How does your spouse support your career goals?
   b. Probe: How does your spouse support you with the demands of your profession?
   c. Probe: *(to the physician)* What are some areas in which physicians have expressed a need for more spousal support?

5. 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?

6. 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?
   d. *Probe: How do you perceive support from your partner?

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

**D. Immigrant Couples** (Immigrant Physicians only)

1. It is common for both spouses to work outside of the home. How does this fit with your cultural upbringing (being from the Caribbean)?

2. Has this issue of both spouses working outside the home been a source of conflict in your marriage?
   a. If so how?
3. From time to time, conflicts between career and family arise for dual career couples.
   a. Do you feel that your cultural heritage has helped or harmed the way you negotiate these conflicts? How so?

**E.—Spirituality** (in professional and personal lives)

1. Please describe your view of God.
   a. Probe: If you don’t believe in God, how do you make sense of life?
   b. Probe: Do you have a particular worldview? What makes life meaningful to you?

2. What is your experience of God being aware or not aware of you and your thoughts and feelings?
   a. Probe: What lets you know he is aware or not aware of you?
   b. Probe: How do you experience His awareness of you?

3. Can you describe a difficult experience and what thoughts or emotions you were or were not able to share with God?
   a. Probe: Describe what it’s like trying to articulate your feelings/thoughts to God?
   b. Probe: What might be holding you back from sharing certain things with God? (i.e. guilt, shame?)

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

5. How do you know whether or not you are willing to be influenced by God?
   a. Probe: How do you feel when you are aware of God wanting you to do something you may not want to do?

6. What is your experience of being able or not able to influence God?
   a. Probe: What is it like feeling like you can or cannot alter God’s actions?

7. What is your experience of being able or not able to influence God?
   a. Probe: What is it like feeling like you can or cannot alter God’s actions?

8. Sometimes what one believes about God may not match one’s experience of God. Can you describe what that’s like for you?
   a. Probe: What is it like for you when you don’t experience what you believe to be true about God?
   b. Probe: For example, when something bad happens, I might not feel God cares. Or it may be hard to feel God loves me even when I believe God loves everyone. What’s it like not experiencing what you believe?
Sections F, G, and H contain questions for the physicians only:

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

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

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

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

4. What kinds of support are available to you in managing the stressors in your life?
   a. What is most helpful about their support? Least helpful?

5. How does stress affect your relationships?

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

1. What are your thoughts regarding the demands of your spouse’s profession?

2. What are the demands of your own profession?

3. As a couple, how have you been able to cope with the varying demands of each partner’s profession?
   Probe: What works best?
   Probe: What does not work as well?

G.---Physicians and Gender

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

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

****For those couples with children, only: -----------------------------------------------
H.--Parenting

1. How did you make the decision (or how are you making the decision whether or not) to become parents? (If have no children move to section H)

2. How does having children impact your professional life?
   a. Probe: When in your professional training or career did you begin your family?
   b. Probes: Do you feel this was the ideal timing? What would the ideal timing be, if there is any?

3. What does quality time as a family look like?

4. How are you able to arrange for quality time as a family?

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

6. What is your relationship like with your children?

7. How is parenting handled with your children?
   a. Probe: How do you discipline?
   b. Probe: Who does most of the discipline of the children?

8. What aspects of being a physician parent affect your parenting or your relationship with your children?
   a. Probe: What are some of the benefits to your family of your being (your spouse’s being) a physician?

9. How do you think your child(ren) view(s) your professional life as a physician?

10. If you had a choice to do your life over again, would you choose the same profession, why or why not?
    a. Probe: For family life
For those couples in dual-physician marriages, only

I. Dual Physician Marriages
   1. What are some benefits or advantages of being in a dual-physician marriage?
   2. What are some challenges particular to being in a dual-physician marriage?
   3. How have you handled these challenges?
   4. What advice would you offer to others in dual-physician marriages?
Appendix B

How to Conduct Qualitative Interviews
Conducting Qualitative Interviews

- It is important to build rapport with the interviewee. Use the first few minutes of the interview to get to know the participant.
- Keep the interview objectives in mind as you conduct the interview, that way you are aware if the important issues are covered even if all the questions are not asked.
- Questions should not be read. Try to commit the flow of questions to memory that way the interview is more conversational.
  - Questions should be open ended, clear, short, simple, conversational, and should not be double barrel
- Questions should follow a ‘question journey’ with the least intrusive questions being asked first, followed by questions that are more intrusive, then ending with questions that give power back to the interviewee. You may choose to ask about successes and things that have worked.
- The interview environment:
  - Avoid tables (can be seen as barriers)
  - Mimic non-verbal without making fun of
  - Use appropriate eye contact
  - Private environment
  - Give the interviewee the option of where to meet (their home may not be the best option)
- Transcription of interviews should occur shortly after interviews.
- Have two recording devices – just incase...
- Make observational notes following the interview.
- If consent is not given to record, make the interviewee aware that you may have to pause to take notes during the interview process.
- Meetings with the research team should be held after interviews are completed to ensure that everyone is on the same page and to evaluate level of saturation. This may show that some questions need to be changed.
- When interviewing couples:
  - Not the dominant speaker
  - Normalize
  - If difficult questions are avoided, try to ask again at some point during the interview (rephrase it). If the question is avoided again, don’t continue to ask it.
- Focus groups can be used to validate the experiences of individuals.
Suggestions for current study:
- Interview key informant first then interview couple
- Use group validation process
- If saturation is achieved for one area, focus on other areas where saturation has not been achieved.
Appendix C

Informed Consent Form
Medical Doctors and Their Families: A Qualitative Inquiry
Loma Linda University Department of Counseling and Family Science

Consent Form

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

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

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

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

Referral
Due to the nature of the interview questions, you may experience emotional discomfort or new awareness of interpersonal issues. If you should choose, 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 D

Physician and Spouse

Demographic Forms
Medical Doctors and Their Families: Physician Questionnaire

Please answer the following questions:

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

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<tr>
<th>Birth Order</th>
<th>Gender (male/female)</th>
<th>Age</th>
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<td>Third child</td>
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17. How many hours per week do you typically spend on:
   Paid work......  Housework............  Childcare............
   Leisure........  Being with spouse.....  Being with child(ren)....
   Being with both spouse and child(ren)................

18. Do you have a housekeeper? Yes No If yes, for how many hours per week?........
Medical Doctors and Their Families: Spouse Questionnaire

Please answer the following questions:

1. Gender: Male    Female
2. Age:.................
3. Place of Birth: Other  If other, how long have you been in the US?............
4. Race/ethnicity you most closely identify with:
   Caucasian    Black/African American    Hispanic/Latino American
   Asian American    Other ..........................
5. Religious organization/denomination that you most closely identify with: ..................
6. What part has God played in your experience in the US?..........................
7. Occupation ..........................
8. Highest level of education completed:    Less than High School
   High School Degree    Some College    College Degree
   Masters Degree    Doctorate Degree    Other..........
9. Marital Status: First Marriage   Second Marriage
Other...........................................................
10. Years in current marriage.................................
11. Years in current relationship............................
12. Number of children........................................
13. Number of children living at home........................
14. Children's gender and age:

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<tr>
<th>Birth Order</th>
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<td>Third child</td>
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<td>Fourth child</td>
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</table>
15. How many hours per week do you typically spend on:
   Paid work.................................  Housework...........................
   Childcare.................................  Leisure.............................
   Being with spouse.......................  Being with
   child(ren)..................=
   Being with both spouse and child(ren) ..............
16. Do you have a housekeeper?  Yes    No
   If yes, for how many hours per week.............
Appendix E

Results

Stressors of Married Female Physicians

Work Demands, Home Demands, Child Care Demands, Self Imposed Demands
Work Demands

"As far as the joys of it, and the demands of it, I'm not so sure that I would have chosen this career path because it pulls away from really what I would like to do most which is raising my kids."

"From the time I get there (at work) in the morning I am seeing patients, I hardly ever get to sit. I am going from room to room to see the patients and I don't only have to see the patients but I have to talk to them as well as document everything that they told me. It is never ending. And then my pager is going off every 5 minutes and I am expected to return patients' and colleagues phone calls. And while all of this is going on I'm thinking I really don't have time to sit around and second guess myself but there are times when I have a particularly difficult patient and I will come home and lay awake at night thinking about the patient and what I could have done differently and what I can do the next day when I approach the patient. Many times I lay awake planning a strategy and working it out in my head how things will work out, and then I can sleep."

"They (work) make it hard for us by having these deadlines and we are behind all the time because the amount of time they allow for each patient is not enough time to really treat them the way you are supposed to and this causes me a lot of stress."
"I sure hope I didn't miss anything."

"Time restraints are stressful. You are allowed a certain amount of time to see the patient and chances are there are more patients than time available in any given day. You never have a light work load. I have many women patients and women like to talk and I often go over the allotted time per patient."

"Unfortunately the working part is very stressful because it is a full time job and I only work part time and unfortunately it is my job of being a physician. My job is very stressful and I get anxious driving to work when I think about my job because I spend a lot of time with my patients and then I get behind and it is stressful trying to keep up because I am 40 minutes late because I spent an extra 15 minutes with a patient that needed it and I want to be on time, but it is more important for me to spend the time with the patient who needs it."

"I've just had two patients die right before I went on maternity leave and that was very stressful. I had just been to the hospital to see them and then they died. And then we had a 2 year old and her mother die after a car accident and that was hard, and I don't know how you deal with those kinds of deaths. You try to help everyone get through it and you have to help yourself."

"You have to try and not make errors which can lead to serious consequences. So that's the intensity here. You have patients that are sick and some of them are near dying, and you really don't want them to die on your watch."
"We live in a very litigious society, and also there are so many demands made by patients and demands made by your colleagues and those above you. Medicine is not what it used to be. You have to be so careful that your I’s are doted and your T’s are crossed because if someone dies or if anything goes wrong with the patient care, they will come after you."

"I need to be fair with each of my patients and be honest with them about their prognosis."

"There are times when a patient may have a physical condition that limits their ability to work but doesn’t prevent them from doing all types of work. Sometimes it is tempting to be a pleaser and just say yes when they come asking you to sign them up for disability. It takes tact to tell the patient that they are not permanently disabled and that you will not sign their paper and that they should try to find another type of work. This can be hard especially when the patient is insistent, but you have to be fair with the patient."

"It is difficult to get patients to follow through on the advice I give them. You see patients coming in today for a particular problem you prescribe a treatment, and then you see them coming back in 3 months with the same problem. They didn’t do what you told them to do 3 months ago, so now they are back with the same problem. Now what can you do because the problem has probably exacerbated since you last saw them."

"(As a pediatrician) your challenges are going to be parents because they are the ones who give the care to your patients. You meet parents with all different personalities when dealing with their children. Some (parents) are the overly demanding type and you can’t do enough for their children. Others are the overly protective type and they think they have to bring their kids in for every scratch and sniffle. Then there are the parents who have an agenda and there is nothing you can do to change it. So you are not only dealing with illnesses but you also have to deal with social issues, psychological issues and people with various belief systems and from different backgrounds."

**Home/Family Demands**

"I do have to divide my time you know so if I compare myself to my male colleague he doesn’t have to come home and do laundry and my husband although he says, ‘oh don’t worry I’ll cook a couple times a week or I’ll do the laundry’ it’s just not going to happen."

"I don’t call my mother and sisters often enough which is true and my sisters complain you know and that kind of a thing but they are all adults and they know that when I get a chance I will give them a call."

"I had to give up working at the University, the job that I like a lot. It just wasn’t working for us because of the type of job and the stressors. I have had to make job
decisions that have been limiting. I could be teaching at the university and have more prestige on my job, but I had to make choices of what we want and what is best for my family. It was a non issue because family comes first.”

“Recently we’ve had health issues. I recently had a miscarriage; my husband had a pain in the leg that we didn’t know what the diagnosis was. So health, just recently had been a stress for us as well which we were not expecting that to be a stressor at this age.”

“Depending on the type of family life that you want to have, female physicians are a little bit more limited in the specialty types that they choose. That doesn’t mean that a female can’t be an excellent surgeon, anesthesiologist or whatever you would like to be. However, I have seen situations in which marriages have failed. I wouldn’t necessarily say because the woman took this role, but that plays a part in it. I think a female can do whatever she wants to do, but it depends on the family structure that you want to have.”

“Things invade your family time. You have to control your hours and juggle your professional life and private life so you can have family time.”

“There are some days when I am really tired but when I get home I have to start cleaning up and cooking and putting things in order and getting the kids ready for the next day. Some days I am just tired and frustrated and I don’t want to do anything, but I have to do it anyway.”

“Eventually you have to make the decision about what is the position of everything in the hierarchy so there is balance and then there’s the hierarchy. Family comes first and work comes second. There can be balance and there have to be sacrifices on both ends. But as long as you know what position in the hierarchy each thing is the choices are easier.”

“My culture is very different from my husbands and there are family expectations on his side that I don’t have and it can be hard me at times to fit into the cultural demands of his family. Women are looked so down upon in the culture. My mother-in-law would be considered a very different woman with very strong views and so not all families are like that. My mother-in-law has a very strong sense of culture and when my husband and I were first married I was young and naïve and I thought if I said no to her she would get upset and the entire family would be upset with me for disturbing the peace and so I went along with them. But going along meant keeping silent, and adjusting myself, my personality, my culture, my whatever, my ideas in order to fit hers, the way she wanted to run the family. So it was not easy. Many times my husband was caught in the middle.”

“Female physicians get married later and have kids later and I think it’s hard. Just because you are working does not exempt you from all the other obligations of being a mom, cooking nutritious meals for your family, cleaning, making sure there are clean clothes for them. So a lot of female physicians that I know just stay at home as moms and they are not practicing.”
“My mother was sick and in a nursing home and my brother also was handicapped and I had to be there. I had to be there. I couldn’t tell them I didn’t want to be there or I didn’t have the time to be there, I had to be there with them and so I guess I didn’t feel my stress when we were together, but they could feel my stress of being there.”

“My husband is going to be 50 in a few days and I asked him what he wanted. He said, ‘A kind wife, and kind, good kids.’”

“He (my husband) is a workaholic and also likes to make money. He has made decisions that cost us more money than I think we should have to spend. I have worked part time since our sons were born. My theory is I didn’t ask for these things and so I don’t think I have to work harder to pay for it. I hope I never have to work full time. Like 40 hours a week.”

“My husband washes dishes and the clothes. I hate housework and he doesn’t like the way I do it so he does it himself: I used to iron his shirts but I hate ironing so I used to send his shirts to someone else to iron. I asked for a housekeeper to help around the house and my husband said, no. I don’t like to clean the house. My husband would be happy if I was one of those women who cater to their husbands. He would be happy if I didn’t do anything in the house as long as I catered to him. I know that’s the way he is as long as I could be like that. That’s just not me catering to a man and worshiping the ground he walks on.”

“That whole emotional thing that’s pulled out of you really can be fatiguing and then when you come home and now your husband wants to tell you about the day or whatever or he says, ‘I think we should redo the backyard, what do you think?’ I can’t think at that point. When I’m asked to make another decision after I’ve used up my decisional mind for the day, I can’t. Plus I have the responsibility of getting the dinner together and deciding what we are going to have for dinner and that just adds to it. Especially now with a child in the mix, I’m not able to do everything.”

“I see myself as a mother, I see myself as a physician, and a wife. I hold all three of them as very important jobs. But I had to choose when my kids were little. I had to juggle. After my daughter was born then I worked part time, then I had to make the decision as to what was best for me and her and my family. As far as what to do I think all women have to do that if they want to be mothers.”

“You have to decide how to manage work and family. I think a woman has to sacrifice some of her profession. She can’t be a surgeon who spends 80 hours per week working if she is going to watch over family; you have to curtail the amount of hours you work. I need to balance. So I determined that I would say, no, to everything. I’ve got to. I had to sculpture my life so that I had balance. I had time for myself, time for my husband, time for my children, and my profession. And even if it’s curtailing some of my profession, I have to be there for the important parts of my life.”
“I remember working ten hours in the emergency room, coming home, cooking the meal and doing the dishes while he (my husband) read the newspaper and watched TV.”

Child Care Demands

“Once you have a child your whole focus changes. Medicine is not as important and providing care for your kid becomes most important.”

“That’s my legacy, my children are my legacy, and if you as a parent cannot say I did a good job with the most important job that I had to do, even more important than medicine is my parenting. And if you have offspring that are not successful it reflects on you, it should reflect on you.”

“(You have to) try to figure out how to juggle. How you are going to make sure that your daughter who is going to preschool gets up on time and you get to work on time and make sure your son, the babysitter comes? And then if they are sick that puts more stress on you.”

“I have to get my daughter up and now that I have to get her ready and she dilly dallies around. It’s like we’re going to be late, get in the car! She’s a challenging person who will push you every single day. And I have to leave work at a certain time in order to pick up my daughter from school so I have to finish things up before I can leave. I’d probably have to quit if I had more than one (child) basically.”

“When someone would get sick and we didn’t want to send them to the babysitter and get everyone else sick, usually it would be me to stay home because I work part time.”

“I have taken the heaviest load with regards to practical work, but my husband helps. But I’ve done much more than him. He would never understand those early Sunday mornings when we so called ‘shared them’ (the children) and he didn’t understand that I needed him to take the kids out of my room so that I could sleep. I see that I am the one who would identify when and if there was a problem (with the children) and bring it to his attention and we would discuss it.”

“I get stressed out when my kids don’t eat well. How do I put a nutritious meal on the table is a major stress for me because usually when I come home I am exhausted, so and I am not really much of a cook and I don’t particularly enjoy it so we would really have something simple like rice and fish or tofu, but you can’t have that every night! I get really stressed about meals. Then there is breakfast, you know we have to make breakfast, pack their lunches, you know. If I come home and their lunch is not eaten then I get upset, and I feel bad and say, ‘man she didn’t eat healthy today’ so I try to cook a healthy dinner. It is a major stressor for me.”
“In terms of childcare, I do most of it. My child is in daycare 40 hours per week and I pick him up from daycare. Starting in the morning I’m usually the one to get him up, feed him breakfast, change his clothes, and get him into his clothes for the day. He goes with me in the morning and I drop him off at day care. Then I pick him up, bring him home, give him his dinner, give him his bath, read to him and put him to bed. If I have to work on the weekend, I have to get a babysitter to watch him.”

“I do most of the childcare. I have to work days because that is when child care is available.”

“When my child is sick, 99% of the time, it is me staying home. I just have to reschedule my patients.”

“I am the one that has to be there. I am the one who has to keep a cell phone all the time in case there is a problem with the kids. I need to be available at all time.”

“Childcare is the biggest stress, you know. The feeling that you need to be there all the time and just the demands of childhood: discipline, had a good day in school, had a bad day in school, what to do about it. Stress!”

“We try to keep this balance but everyday there are decisions that you feel in stress. This week he woke up with a fever and the day before I had to leave work early because he fell at school and had a nose bleed. I don’t want to keep missing work, so what do I do? I gave him Tylenol, gave him a bath, no fever. He’s telling mommy I feel fine. What do I do? Do I take him to school or stay home? I thought ok, I’m going to take him to school and they can call me and tell me if he gets sick. I’m a bad mommy, bad mommy.”

“My first year in residency, my son would call me daddy which caused me to cry. Daddy was the one who did everything for him. I had a hectic schedule and I had to go into the hospital for 4 am surgery and when I left my son was sleeping and when I came home at night my son was sleeping because I came home at very late hours. Sometimes the only opportunity that I had to see my son was when I would give him his breakfast and he would say, ‘thank you daddy.’ ”

**Self Imposed Demands**

“I feel I need to be supportive of my husband in the sense that providing in the home, making sure that there’s food and the home is clean, and making sure his clothes are laundered and shirts are ironed and all these things are part of what I see are the duties of the wife, because of my background growing up and seeing these roles of the wife. My mother was the one who took care of the home, did the meals, and took care of the clothing. They (the wife) took care of things. That is engrained in my background so I still feel like I should do these things.”
“I was always feeling guilty because I was running from home to work and I felt I wasn’t doing either well, or as well as I could so I don’t think I was as great as I could have been.”

“When the kid were babies I didn’t really have that much guilt, dilemma or burden should I be at work when both of the kids were babies and they didn’t know I am not there, of course I am working. But as the kids are older I feel a lot more burden and I don’t think it’s because anyone is putting I on me, I think I am putting it on myself.”

“What I do came from my background because my mother was the same way. I was shaped based on this mentality that you have to push yourself, no excuses allowed, beating the odds and whatever I do, I have to do it well be it parenting, being a physician or being a home maker.”

“My desire is to have a little better balance. By balance I mean being able to be a good wife, mother, and doctor, all of that. This has been a struggle for me lately since my son was born. I think I am a Type A personality and I try to do it all myself and there lies part of the problem because I think I can do it all myself and I won’t ask for help.”

“We always joke ‘welcome to the world of guilt’ once you have kids. You feel guilty for leaving them in daycare and going to work. I would feel even more guilt when I was training and I would have to go in on the weekend.”

“You take it. We take it. I called people I work with and told them I’m coming to work on a guilt trip, I’m a good doctor, but I’m a bad mommy. We joke about it if today you are a good doctor/bad mommy or you could be a good mommy/bad doctor. And you feel bad when you can’t make it to work because you need to stay home with your kids. I think being a physician is good and bad for being a parent.”

“The woman (female physician) definitely has a lot of guilt if she is leaving her child in daycare for all those hours of the week, in the care of others basically. When you are leaving him you don’t know what habits he is picking up and that causes guilt. I don’t know if male physicians feel this way but the female physicians there is almost a yearning to be able to spend time with the child.”

“I love to work and I love what I do tremendously. Because I am a workaholic type and I am somewhat obsessive compulsive my work can consume me. It makes me a good physician but it doesn’t work for marriage and it doesn’t work for raising kids. It is hard on me to put my husband and kids above my work.”
Appendix F

Results

Coping Strategies of Married Female Physicians

Reaching Out/Reaching In
Reaching In

If anything we prayed more. It was more drawing us to God. (I) actually look to God for help. I pray, I haven’t faulted God for things that happen. I should say, I ask for his support. I don’t think I have, I am fortunate enough and I should be thankful to God that nothing serious has happened. I’m sure that there will be instances that happen when will have to look to God.

I think what keeps me going in terms of job and my life is an over arching sense of moral justice.

Every Sabbath I went to church and I clung to the alter while I was praying and praying. I have whispered a prayer for help in a situation that I didn’t know what to do and God has helped me because you never know what is going to happen in an emergency situation.

I pray and read my Bible a lot.

I make sure I pray every day.

A lot of prayer, time to myself on occasion to reflect and think. Personally and professionally I have to set goals for myself. Some things I have to give up.

In the middle of the night I play out a scenario in my mind, what strategy and what way I should go and it helps me put things in perspective. When I go back to work my thoughts help me put the problems back into perspective.

I will do a silent prayer if I meet a difficult patient, just me personally, needing to seek out my own peace or wisdom, or understanding, or whatever.

I guess I try to forgive and move on.

Reading a lot of books, I like to read.

I read books that tell you things to do, but I forget to do them. Every so often I decide okay I am going to take deep breathes between every patient or I’m going to go up the stairs between every patient.

I like reading. I like hanging out at Barnes and Nobles.

If I am anxious I won’t be listening to 92.3, it will be 91.5, or a more calming type. It helps you calm down.
I've tried different medications for anxiety. There's Prozac, there Paxil, and Zoloft. I took Zoloft once and I have to say it seemed to make me feel calmer. Every so often I think I should back to Zoloft. When I would take these medicines I would do it in a different name and go to a Wal-mart to have them filled and I got tired of that subterfuge.

I try to relax, or I try to work through, work faster, work more efficiently, or prioritize, really when I am overwhelmed, I pray, dear God get me through this. I've learned not to take on as much.

When I am stressed I exercise, talk it out, and pray.

Even in medical school I made a pack with God that I would not turn my back on Him, and I have kept that pack even today.

When I am stressed I just pull out my Bible or read a good book and get some sleep.

We go to the Buddhist temple and pray.

I have had to reduce my ambitions on how fast I should take my doctoral. I have had to slow my progress over many years because I wasn't able to put as many hours into work as was needed.

I try to have a little spot like a half an hour to myself where I can do things that I feel are very important.

Don’t worry. You just talk to God about it you have established a relationship with Him.

You have to pray about this, you have to consult Him you don’t want to go against him because if you do nothing is going to work out well.

Spiritually helps me, so reading and praying, then Sabbath is really a social time for me.

Everything that I do when I go to work, do my work. In doing that I’m going to be serving God, as a mom, doing it as a wife.

Well the things that actually work for me when I do them is walking, riding the stationary bike, reading my Bible works for me when I am really stressed.

**Reaching Out**

We do relationally is to distraction if we are under stress. Let's go out to dinner. We have this thing that we call fiestida, little party. We'll call from work and say today we are having fiestida.
When my friend and I talk and laugh and do things and leave the kids with the husbands sometimes and go off and occasionally go to the movies, which doesn’t happen often, but it helps me to have conversation with friends.

He’s (husband) my balance. If I’m starting to do too much he will let know so I can back off. It works and I am able to do more of what I want because we may cut down on the amount of time I may do it.

I talked with people and other therapists. I went to see another Psychiatrist in a different county. I actually went to the beach for an hour instead of rushing home. That was very, very helpful.

It’s called communication. We have an open relationship. We have a night where we discuss what they (kids and husband) like and don’t like.

My husband made it easier to operate because that stress and tension of caring for my family wasn’t there.

I would take my son with me to the hospital in the morning because my husband worked the night shift and he got off at 7 am, and if I had to come in early, my son was on the street with me in his carrier, at that time of morning, and I would take him to the kitchen where my husband worked and he and his friends would put him in a basket in the dietary department and would keep him until my husband got off shift.

He (husband) made it easy so I felt less guilty about being away so long because somebody was taking care of the kids. I didn’t have to carry them to a baby sitter. I didn’t have to wonder who is going to be abusing my kids, if they were going to be molested, and were they going to be treated right.

I thank God for my husband because if it wasn’t for him and his selfless watching over the kids, I couldn’t have completed my training. As a matter of fact when my third child was born, we worked at the same hospital, he decided to take maternal leave, and he started his own business and that allowed him to help out more with the kids and have more time for the family.

I had four people I could talk to. I had a Chaplin and I had three girlfriends, my twin sister and two other girlfriends, so you wouldn’t overload one person.

I think basically what we all do is talk to each other. Like my colleagues that are in the different rooms, if you have someone who is just like a really difficult patient and I can’t believe that this person did this, I’ll go into my colleague’s room and say I can’t believe that this happened and five seconds of talking, we vent on each other. That’s just enough, you get validated.

I have my spin bike upstairs in our little exercise room. Go up there, close the door, turn on the TV, put on the IPod and have an hour of veg time.
Some years back as a Christmas present I asked to have the weekend off and I would go to the movies. I like art house films, so I would have to go to Santa Monica for that, and I don’t know what happened to that. I guess the gift ran out.

I exercise more and ski every weekend I can.

I love to travel, that’s my number one vice. I read travel magazines. Actually I went to Greece by myself and I was telling someone about it. I want to go to Italy next.

I have a really good friend, he is just so excellent, and he is a Christian also, so we talk and we vent to each other and that helps a lot. We love to laugh.

We (physician and spouse) have this New Year’s resolution and that we should share jokes with each other and try to make each other laugh, we call it laughing therapy.

He has a more definite schedule than me, so he has been taking on the brunt of the work when it comes to taking care of the kid, like picking her up and taking small course with her. He does a lot of it.

Yoga has been a great meditation to relieve the stress.

Sometimes just calling him (husband) and talking to him that kind of releases the stress.

Even if sometimes I just finished with a rough patient, he says calm down, calm down. Just he being there for me to talk is a big help.

Him (husband) being there...just the fact that we are able to see each other when we come home, and talk to each other. That makes it good for me. Just to be able to talk and to know that he is there.

I talk to my friends. I talk to my mom and sisters. I like to talk. We do a girl’s night out once a month. We go see a movie together, I do exercise for a while, I do yoga once a week and I go running.

Working part time and staying home part time. Having two days off to be mommy and go on field trips with the kids. The mommy part of the life gets satisfied.

So the process of going through medical school is a very isolating experience and you emerge with only your closes friends that can understand that it is not you as a person, but the job that demands your time and they are available when you need to talk, any time of the day or night.

We (physician and spouse) do Kung Fu, we spar and beat up each other and get away with it. You can get out your frustrations.
My sister helps in an emergency. Her office is a few blocks away from their (the children's) school and if I can’t get them she will pick them up and take them to her office until I can get them.

One of the big things I do is get together with my girlfriend every Friday and we spend four hours together getting our hair done.

On the weekends I get together with sister and my friends and we have dinner. We get together and just sit around and talk.

My husband and I became certified scuba divers and we do that sometimes. We don’t get a chance to do it often. We like to travel and we travel when we have a chance both in the United States and out. We have been to Europe and we go on cruises.

Actually as a mommy I did something different with my office. I built an apartment in the back so they (the children) can come over and stay with me when they are out of school or sick. The staff can always use the apartment for their kids if they are sick. I need them to be at work. There is a full bedroom, bathroom, kitchen, and living room with cable.

I have a three day work week, I do surgery on Tuesdays, and I take Fridays off. I am part of a call group so I am only on call one weekend a month.

My husband and I have switched roles. He does the laundry and irons. He gets the kids ready and takes them to school. And when I come in from work (night shift) I can sleep.

Basically I go to work and come home. He (husband) takes up the slack and does everything else. He handles the finances and manages the household.

Having a person there to clean the house allows me to do more things. We have always had someone at our home to help with the housework and child care. We love having her around. Before she came to help us out the pastor’s wife came and helped us out.

Things have to go. I had a residency director in New York who was very wise. She took all the women aside and she said, you don’t need to darn socks and you don’t need to patch holes, and you don’t need to clean toilets. You work really hard and you make a lot of money so you can pay someone to do that!

I find exercise to be a great stress reliever, and focusing on things that you sometimes forget to focus on like personal health.

Before we moved back to the area, my in-laws were a great source of support. And thank goodness for phones and emails, there are huge sources of support long distance.