Relationships with Physicians: How Work Stress Impacts Physician Relationships

by

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ABSTRACT

Individuals who enter the medical field are required to work extensive hours, invest significant money on their education, and can experience multiple relocations through the different levels of training. The demands of a career in medicine may create work-to-family conflict that could lead to physicians and their partners seeking services for mental health concerns or relationship dissatisfaction. Experiences of burnout in the physician population may be exacerbated due to the fallout of COVID-19. Systemically trained therapists are well suited to understand how the high career demands of the medical field influence the support systems of physicians, as well as advocate for third order change in the larger societal systems that physicians are in to support the next generations of physicians. The purpose of this study is to highlight the unique experiences of those in physician relationships to understand how the work demands of a career in medicine impact their relationships. The present study includes data collected from survey responses of (n = 35*)* individual participants who are in a physician relationship lasting at least 6 months and included both medical and non-medical partners within physician relationships. Results revealed 5 themes and 17 subthemes, which highlight the unique experiences of those in physician relationships. The results of this study identify aspects of physician relationships that mental health clinicians can use to guide therapeutic work with these clients in couple's therapy. Future research and clinical implications will be discussed.

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CHAPTER I

Introduction

One doctor dies by suicide in the United States every day, which is the highest suicide rate among any profession (Anderson, 2019). The rate of physician suicide is anywhere between 28-40 per 100,000 which is at least more than twice the rate of the general population (12.3 per 100,000) (Anderson, 2019). Psychological distress is common among medical students and physicians (Dyrbye et al., 2011). Psychological distress manifests in this population in a variety of ways including but not limited to burnout, depression, stress, low mental quality of life, low physical quality of life, and fatigue (Dyrbye et al., 2011). Stigma is a major obstacle to medical professionals who are seeking mental healthcare services, which may indicate that the prevalence of depression and suicidal thoughts in this population is even greater than reported (Riffel & Chen, 2020). Given the increase in psychological distress and suicidality, despite barriers to seeking treatment, therapists should be prepared to work with those in the medical field which includes learning more about a career in medicine and the impact this career path has on physicians and their relationships.

Individuals who enter the medical field are required to complete rigorous training through medical school, residency, and potentially fellowships. This training requires individuals to work extensive hours, invest significant money on their education, and can require relocation through the different levels of training. Additionally, according to the AMA, medical training requires significant time away from the family. Increased levels of job demands (i.e., paid work hours, hours on call, job strain, workplace violence, burnout, job satisfaction, income, etc.) are seen in medical careers (Lu et al., 2017). Higher levels of work demands that spill over and affect the family life correspond to decreased levels of couple satisfaction (Minnotte & Bonstrom, 2014). Increased work demands of medical careers may result in physicians being absent from the family for greater amounts of time, poor contributions to family life, and overall dissatisfaction with family life (Voydanoff, 2015). The couple relationship may be significantly impacted by the work stress that physicians experience. Work stress may impact the ability for physicians to participate in

emotion-work within their couple relationship, leaving their partner feeling emotionally disconnected and leading to lowered couple satisfaction (Stevens et al., 2005). Few studies have examined both physicians and their partners experiences when considering how the demands of a medical career impact physician couple relationships. Being inclusive to both perspectives will provide a holistic picture of these impacts and provide increased guidance on how to nurture physician relationships.

With such alarming numbers of depression, suicidal thoughts, and occurrences of death by suicide, there is critical importance to study the medical profession's impact on mental health and relational well-being of physicians. Further, given the high demands of the medical field, there is a lack of research concerning how pursuing a career in the medical field impacts these professionals' relationships and the mental health and well-being of their partners. Understanding how the high career demands of the medical field, including significant time away from partners and family, impact physician couple relationships is a way in which more attention can be given to addressing the negative impact of a career in medicine.

Inquiry Framework

General Systems Theory

This study will be conducted using a General Systems Theory lens. General Systems Theory is consistent with the assumptions of recursiveness, or reciprocal causality, in which people are seen in the context of mutual interaction and mutual influence (Kelledy & Lyons, 2019). Marriage and family therapy models operate under the assumptions of General Systems Theory. MFT researchers aim to understand situations in context, examining how each individual within a system interacts and influences another, instead of aiming to understand individual cases in isolation (Fingerman & Bermann, 2000). It is important to understand the way in which people and events are organized and the level in which these systems maintain equilibrium.

Organizational structures and homeostasis. Structures create a hierarchy in the system, which directly creates both overt and covert boundaries and rules between

and within each member of the system (Shaw et al., 2004). To be able to create change in the therapy room, a clinician must understand and attempt to restructure the system, which allows for both intersystem and intra-system changes in interactional patterns (Shaw et al., 2004). This concept explains that the way members interact in a system can be explained through predictable patterns and changing one part of the pattern in turn changes the entire system due to the interrelated nature of these parts. Patterning occurs because of a system's tendency to maintain a level of homeostasis (Kelledy & Lyons, 2019).

Feedback. Feedback refers to the process in which behaviors are fed back into a system in a circular manner (Kelledy & Lyons, 2019). The function of feedback in a system informs the way in which the system maintains or changes homeostasis. Feedback can be further divided into two differing types: positive feedback and negative feedback. Positive feedback acknowledges changes accepted by the system, where negative feedback indicates that a status quo within a system is being maintained (Kelledy & Lyons, 2019).

Using a General Systems Theory lens within this study allows me, as the researcher, to conceptualize a physician holistically in the context of the interactions around them. I aim to understand how work stress experienced by physicians may work to influence home life and the families of physicians. To understand how to address the increasing psychological distress in physicians, researchers must understand how people and events in physicians' lives are mutually influencing one another. Elaborating on these experiences provides increased amounts of context of the systems that physicians are a part of that impact psychological distress. This study uses the concepts of General Systems Theory in family therapy to understand the influences that work stress has on the dynamics of homeostasis and structure in physician relationships. Ultimately, the study results can be used to inform the way mental health clinicians use the feedback from a physician's couple system, so that these relationships can better serve as a protective factor for physician psychological distress.

Research Paradigm

The current study is qualitative in nature, and as the researcher, I conceptualize this study through a humanistic lens. Humanistic psychology emphasizes the importance of understanding, as opposed to explaining, individuals (Buhler, 1971). Benefits of this research paradigm include smaller sample sizes that generate rich and subjective theories that can guide quantitative research (Al-Ababneh, 2020). Using a qualitative, humanistic research paradigm has contributed to the study data highlighting authentic interpretations of participants' responses in their natural environment, with high validity (Al-Ababneh, 2020). I conducted this study under the assumption that the research is value-bound, with me, as the researcher, being involved in the research process, instead of separate, so the results and discussion of findings will include a degree of subjectivity. Criticism of the research design includes the low reliability of results translating from the sample to the population (Al-Ababneh, 2020).

Epistemology. Epistemology refers to the theory of knowledge and embodies a certain understanding of what is entailed in knowing (Al-Ababneh, 2020). This study operates under the philosophical grounding of subjectivism. Subjectivism refers to the meaning that comes from anything but the object to which its ascribed (Al-Ababneh, 2020). The study's theoretical foundation prescribes to the idea that all experiences detailed by participants will be subjective to the meaning that each participant ascribes to them based on their own experiences. In addition, the methodology of the qualitative content analysis will be analyzed subjectively and affected by the researcher's views, biases, and experiences. The study assumes the epistemological lens that social phenomena is created from perceptions and consequent actions of each individual (Al-Ababneh, 2020).

Research Philosophy. People's experiences of events about the world differ between individuals, and this impacts research design and procedures of research (Al-Ababneh, 2020). A theoretical perspective describes the philosophical stance of informing and determining research methodology (Al-Ababneh, 2020). The research philosophy in which this study is grounded in is interpretivism. Interpretivism

philosophy considers the situation in each individual as unique and differs from other situations others may experience (Al-Ababneh, 2020). Interpretivism avoids generalizability that is law-like in nature (Al-Ababneh, 2020). The analysis of the unique experiences of physicians and their partners/spouses have been interpreted as unique, where each participant is assumed to have had different experiences that are complex from one another. This study focuses on the detailed experience of each participant to understand their reality independent from others through the assignment of subjective meanings.

Research design and approach. The current study is an exploratory study in design. The aim of exploratory studies is to provide a better understanding of the nature of a problem, when there is little to no information known (Al-Ababneh, 2020). Although there is extensive evidence of research on factors of psychological distress, work-family conflict, and couple satisfaction, there is little attention given to the interconnectedness of these topics in physician populations. Therefore, a descriptive study was not appropriate at this time. An inductive research approach has been used for this specific study. The inductive research approach should be used when collecting data and developing a theory as a finding of data analysis (Al-Ababneh, 2020).

Study Overview

Physicians have been found to have high rates of depression, psychological distress, and completed suicide (Anderson, 2019). Physicians and medical students encounter significant stress, high financial and time commitments, and requires time away from home and family. As a result of these factors, work-to-home life spillover is likely to occur, negatively impacting relationship satisfaction and the romantic partners of the physician. High work-to-life spillover and lower relationship satisfaction have also been shown to negatively impact mental health (Akram et al., 2022; Minnotte & Bonstrom, 2014; Voyandoff, 2005) and conflict resulting from bringing work stress home has a substantial impact on decreasing levels of couple satisfaction (Minnotte & Bonstrom, 2014). Minimal work has been conducted by researchers to consider the impact of being in a committed relationship with medical

professionals, and how the demands of a medical career impacts relationship satisfaction. Therefore, this study adds to the body of literature rich descriptions of the unique experiences of how work-to-family conflict in medical careers impacts couple satisfaction of those in physician relationships. The research question this study explores is, how a career in medicine impacts physician couple relationships. This study specifically asked those in physician relationships to describe their unique experiences of how the job demands of medical careers impacts the ability to nurture couple relationships. Mache et al. (2015) states that social supports can serve as a protective factor for physician psychological distress. Examining how demands of medical careers uniquely impact physician relationships will help inform future research on how mental health clinicians can better help to cultivate couple relationships in psychotherapy treatment to address the systemic issues related to physician psychological distress. If mental health clinicians can better understand the challenges physicians and their partners face, we can plan interventions in psychotherapy treatment that targets the impacts of stress from a medical career and how it impacts the couple relationship of physicians.

To elaborate on the experiences of work-related stress and its impact on physician relationships, a qualitative survey was used to gather data from participants. The survey allowed individual participants the ability to describe their experiences related to work-to-family conflict, couple satisfaction, stressors of medical training, strengths and weaknesses of physician relationships, and recommendations to improve physician and physician-in training quality of life. The study was inclusive of both physicians as well as their partners. The study also gathered information from participants in different stages of medical training (i.e., medical school, residency/fellowship, attending) to understand the need of mental health resources across the medical training timeline, to better support this population.

Unique Contribution

There is no evidence of any qualitative studies that have been conducted to understand the unique ways a medical career impacts relationships with spouses/partners. There are studies that examine work-to-family conflict in medical

professionals, rarely do they include both the physician and their partner. This study was conducted by administering an online survey to participants individually (as opposed to relational interviews with all partners present) yet was inclusive of both physicians and their partners. This population has been overlooked in the literature despite alarming psychological distress exhibited by physicians. Most studies related to this topic are quantitative in nature that do highlight some issues within this population but have overlooked the way in which mental health clinicians can specifically help clients within the population with challenges that are unique to them.

In addition, little to no research has focused on this specific topic area since the emergence of the COVID-19 pandemic. The COVID-19 pandemic has likely created significant stressors and challenges related to physical and psychological well-being in most individuals globally. Physicians may be facing increased stressors from the COVID-19 pandemic that impact occupational burnout. Occupational burnout takes place when a person is incapable to meet constant job demands, feelings of being emotionally drained, and overwhelmed (Alrawashdeh et al., 2021). In a study of 973 primarily male (n = 69.8%) physicians from various geographical regions around the globe Alrawashdeh et al. (2021) aimed to understand how the effects of the COVID-19 pandemic effected physician burnout. They found that 57.7% of participants were experiencing occupational burnout. With an alarming level of occupational burnout resulting from the pandemic, critical research attention is needed to address the mental health concerns of physician now more than ever.

Purpose Statement

Given the indications of an extensive long-term commitment of medical training, the AMA recognizes that even the "most supportive partners are likely to wane their support". Researchers indicate that work-life balance significantly impacts couple satisfaction (Minnotte & Bronstrom, 2014). Professional organizations within the medical field are seen to influence the work-life balance for medical professionals by promoting work over family. Despite the evidence of the importance of a support system for physicians at home, the unique way that medical careers create the imbalance in work-family life is scarcely studied. The purpose of this study was to

gain insight into the experiences of individuals involved in a physician relationship, to further inform how these relationships can be best supported by mental health clinicians in therapy to serve as a protective factor for physician psychological distress.

Personal Interest and Reflexivity

This study began with outlining the theoretical framework and assumptions that I, as the researcher, utilized for this study. Palaganas (2017) emphasizes the importance of researcher reflexivity in qualitative social science research. Reflexivity refers to researchers acknowledging the changes brought about in themselves as part of the research process, and how these changes may have affected the research process (Palaganas et al., 2017). My journey to deciding to perform this research study in researching mental health distress in the physician population starts from my family of origin. I have lived experiences of witnessing the way that the work stress of physicians can impact their families by being a daughter of a physician. In addition, I have family members who had firsthand experiences with the infamous 'Dr. Death', where the case itself indicated to me that there is not enough attention on physician mental health.

The primary motivation for this study is my firsthand experiences with physician relationships. With my father being a physician, I have witnessed how his career in medicine has impacted his capability to foster both couple and familial relationships. I have been personally impacted by the negative ramifications of physician psychological distress with the occurrence of *Dr. Death*. In addition, I am currently in a physician relationship and would like to understand the unique challenges that my relationship may face. I am surrounded by medical professionals and medical professionals-in-training and have witnessed the psychological distress that is often overlooked in this population. To avoid more physicians turning to suicide or making headlines as the next "Dr. Death", it is paramount for mental health researchers alongside physician training programs to evaluate how those with the power to make life and death decisions are negatively impacted by the stress of their careers.

Presently, I find myself in a physician relationship. Conducting research highlighting the unique experiences that those in physician relationships face to help mental health clinicians treating physicians and their families in therapy, comes with the acknowledgement of inherent bias given my own personal identity as a member of the population of interest. In the current research study, this started with writing out this positionality statement, which asked me to be reflexive about my experiences with the population of interest and topic of my thesis. This statement helped with general trustworthiness practice and was something I could use when during the analysis process, specifically with memo writing and with external audits with my thesis chair. Additionally, because of the possibility of researcher bias, participant data was anonymized, and no identifying information was collected from participants. In addition, the researcher explicitly included a survey question to allow participants to acknowledge if they have a known relationship with the primary researcher, myself. If a known relationship was indicated, the participant data was excluded from the data set. This is an effort that the researcher made to minimize bias resulting from known relationships with participants (i.e., having information beyond what was reported in the participants' responses that would bias the way I interpreted and analyzed their responses).

My own experiences in a physician relationship helped me relate to the experiences that many of the participants of this study outlined and became apparent in data analysis when converging on the themes and subthemes of this study. By following the methodology outlined in Chapter III closely, as well as through memo-writing, and having external audits with my thesis committee chair, I feel confident that I was able to represent the participants and their experiences well with minimal researcher bias.

Conclusion

Given the high rates of psychological distress, low life satisfaction, and increased suicidality reported by physicians, action is needed to help reduce the impact of a high-stress career in medicine on those in the profession. Based on research from other areas of study, having supportive relationships is something that may potentially

serve as a protective factor to physician psychological distress. The forthcoming literature review will highlight the rigorous training timeline to become a physician; and how the stressors do not stop when a physician finishes their education. The literature review defines work-family conflict, and more specifically work-to-family conflict, and how work-to-family conflict may impact couple satisfaction in physician relationships. If unique impacts of work-to-family conflict can be identified within this population, mental health clinicians can have better guidance on how to attend to the needs of clients who are in physician relationships, as well as guide the advocacy of mental health awareness in the medical training system. This work can be used to create a better quality of life for physicians and their families.

Chapter II

Literature Review

With physician suicide being the highest suicide rate among any profession (Anderson, 2019), understanding the unique experiences of these populations will provide insight into protective factors. It is important for Marriage and Family Therapists, as well as medical training programs and hospitals, to understand the impact that the stress of medical professions have on physicians and their couple relationships. With alarmingly high amounts of work hours, chaotic schedules, and high stress working environments, it is not a surprise that this stress may impact the physician and create psychological distress which could spill over into the couple relationship and cause issues with relationship satisfaction. Systemically trained therapists can support physicians in their couple relationships, promote an increase in work-life balance, help teach physicians how to manage negative emotional experiences as a result of work, with the added bonus that couple relationships can serve as a protective factor to physician psychological distress. Increased awareness on how to treat relational issues that are uniquely experienced in this population can better inform treatment methods as mental health support for this population is becoming increasingly needed. If mental health clinicians can better understand these unique experiences, they can be better informed on ways to advocate for mental health and wellness in the medical system to initiate third order change. Third order thinking requires therapists to expand their view of their participation with families to more intentionally include the impact of societal systems and power dynamics that play a role in our client's lives, and to heighten sociocultural awareness more effectively in our practices (McDowell et al., 2019)

Understanding how the high stress of medical careers spill over into the family life of physicians is critical to determining how mental health clinicians can tailor interventions to better support these relationships. Yet, there is little to no attention given in the current literature that highlights the experiences of individuals in physician relationships and the unique challenges they may face. The stressors physicians face throughout long and rigorous training may increase the risk of work-

to-family conflict impacting couple satisfaction. Examining the unique experiences of work-to-family conflict in physician relationships will work to support how close relationships can serve as a protective factor for psychological distress.

For this specific study, I will be referring to the attitudes of satisfaction that individuals experience in their couple relationships as, couple satisfaction. Across the literature, the definition of couple satisfaction is often referred to as marital satisfaction and/or relational satisfaction. To be specific about romantic relationships and inclusive of all populations, the verbiage of couple satisfaction is used in this study. The following section examining past literature will use the verbiage that is specific to that study.

Medical Training

Training Timeline. Physician training is variable, but nonetheless a lengthy process. The American Association of Medical Colleges (AAMC) has published expectations on their website that are an accurate reflection of current prerequisites for those wanting to pursue a career in medicine. First, one must complete a bachelor's degree and although individuals do not have a specific major they must pursue, there are prerequisite courses that one must take to be a candidate for admission into medical school. In addition to a bachelor's degree, one must take the Medical College Admissions Test (MCAT) and their score is used competitively to compare an individual to other applicants.

Once admitted to medical school, one must undergo four years of coursework in classroom, clinical, and community settings. While in medical school, students will most likely complete exams during coursework that will vary by university. All U.S. medical students are required to sit for two out of the three exams required by the United States Medical Licensing Examination (USMLE) organization. According to the American Medical Association (AMA) the first of these examinations occurs after year two of medical school, and is called Step 1, while the second examination occurs during year four of medical school and is called Step 2. During the final year of medical school, students choose the type of medicine they wish to specialize in based on personal interests and clinical experiences, among other factors, and apply to

residency programs. Most students are matched to one of their preferred residency programs and residency training can last anywhere from three to seven years. The AMA states that the third exam offered by the USMLE is taken at least after one year of post-graduate training and is called step three. In addition, the AMA reports that medical residents typically complete an in-service examination at the culmination of every year of residency training. After completing residency, the AAMC states that some residents choose to complete a fellowship in a sub-specialty area that can be anywhere from one to three years. Once residency and fellowship are completed, many physicians take board examinations in their areas of study. Yet, after countless examinations, physicians may not be relieved about the grueling process they have just endured. This training process comes with a large price tag, the AMA released the average student loan debt statistics of medical school graduates for 2021. On average, 76%-89% of medical school graduates accumulate $203,062 of student loan debt, a daunting reality waiting for them on the finish line of their training.

Professional guidance. There are resources that can provide guidance for physicians that are navigating the challenges between their careers and family life. This guidance suggests that physicians should intentionally prioritize their couple relationships and attempt to reconnect with their partners at the end of each day (Fider et al., 2014). An important factor that inhibits the ability for physicians and their partners to nurture their couple relationship is the prevalence of young children in the family system (Fider et al., 2014). This finding may indicate that physicians in the beginning phases of starting a family may experience increased stressors associated with adjusting to childrearing. Mental health clinicians may focus support and advocacy for the portion of the population who are entering the childrearing phase to help physicians and their partners manage stress, nurture the couple relationship, and create a balance between family and work life.

The AMA has published resources on their website for medical professionals to consider when thinking of how to nurture their couple and family relationships. These resources can be seen to have an intention to provide helpful advice. Realistically, the messages they convey highlight a need for systemic change in the

way that professional organizations of the medical field view work and family balance. Specifically, an increased emphasis on the negative ramifications to starting a family is blatant in the literature the AMA provides. Many of these messages are seen to highlight the increased stressors female physicians may face and perpetuate inequitable gender expectations. Instead of working to address this need for systemic change, the resources highlight the experiences of increased negative impacts female physicians face when wanting to start a family.

In 2016, an AMA website publication reported that female physicians with children often must make more "intense soul-splitting" decisions regarding balancing their career with their family, in comparison to their female colleagues who don't have children or male colleagues. As a result, the AMA advises female physicians choosing to have children, or already having them, to think carefully about how their family will align with their long-term career goals and how the time they may have to take off could affect their career (Vassar, 2016). This publication highlights discrepancies in career disruptions experienced due to adding children to a physician's family constellation. Women physicians reported disrupting their careers for an average of 8.5 months whereas males reported disrupting their careers for less than one month (Vassar, 2016). There was no mention to any racial/ethnic demographic differences in this specific publication, however the AMA has released racial/ethnic demographics of active physicians in the United States, with 56.2% of active physicians identifying as White. If this sample is representative of the population of active physicians, it is worth considering how racial and ethnic minorities may have different experiences. Nonetheless, it is difficult for one to conclude that medical organizations value female physicians in the same light as their male counterparts. This perpetuates gender stereotypes that women are the primary partners who must have time away from careers for having children, whereas men should not be expected to do so. Mental health clinicians should be aware of the messages' physicians receive from their professional organization that promotes the choice of having children as a disruption to a physician's career, in contrast to using language that would support and encourage physicians to maintain a work and family balance.

While there are ample examples of medical organizations that consider career choices more important than family choices, there are some entities that have taken steps to provide workshops to prepare medical professionals with tools to maintain couple and family relationships throughout a career in medicine. Most notably, an article in the Canadian Medical Journal reviewed workshops that serve to promote the maintenance of relationships as a protective factor to promoting medical trainee wellness. These workshops address challenges and concerns physicians may experience regarding relationships throughout a career in medicine. Topics covered work to help medical trainees identify personal relationship threats, highlight tools to manage stress, teach skills to remain engaged in relationships and parenting, and provide information on communication methods that enhance friendship and intimacy (Lypson et al., 2013). Lypson and colleagues (2013) note the critical need to provide doctors in-training with exposure to issues of work-family balance as they prepare for careers in medicine. Mental health researchers may need to focus their attention on the effectiveness of these workshops to see if clinicians can use the topics addressed within them as a guide for interventions in psychotherapy.

Work-Family Conflict

To achieve a balance in work-family life, we must examine the ways in which work life and family life experience conflict with each other. Work-family conflict occurs when experiences in one domain negatively impact experiences in the other (Minnotte & Bonstrom, 2014). Work-family conflict encompasses both work-to-family conflict and family-to-work conflict. Family-to-work conflict occurs when one's negative experiences in the family domain spill over to result in negative experiences in the work domain that make it difficult to attend to work responsibilities (Minnotte & Bonstrom, 2014). Alternatively, work-to-family conflict occurs when one experiences work demands, stressors, and negative moods that result in negative experiences in the family domain and create potential threats to the well-being and social relationships of the family (Minnotte & Bonstrom, 2014).

Although both domains of work-family conflict have been linked to decreased marital satisfaction, higher levels of work-to-family conflict are shown to correspond

more to decreased levels of marital satisfaction (Minnotte & Bonstrom, 2014). Work-to-family conflict oftentimes manifests as negative feedback experienced at work that leads to an individual withdrawing when at home (Minnotte & Bonstrom, 2014). Voydanoff (2005) examined 2,155 adults employed in the civilian U.S. labor force with the majority (77%) being non-Hispanic/White identifying. In this sample, work-to-family conflict was associated with family absences, poor family-role performance, family dissatisfaction, and distress (Voydanoff, 2005).

Work-to-family conflict and family-to-work conflict are also seen to be reciprocal (Bakker et al., 2008). This means that when experiences of work stress occur, it can affect the way individuals interact with their partners and families, perpetuating stress in that domain. Then, the resulting family stress experiences can lead to marital dissatisfaction. These experiences in the family life may contribute to further psychological distress in physicians. These stressful experiences at home could then perpetuate increasing amounts of work stress when one goes back to work. This cycle is systemic in nature, so it can be assumed that an arbitrary starting point is present, and that both the home life stress and work stress of physicians can lead to psychological distress. This study focused on the work-to-family conflict experiences that may lead to psychological distress in physicians, but increased attention should also be given to family-to-work conflict's effect on physician distress as well.

Although it would be time consuming to identify a starting point in this reciprocal pattern, job demands increase the likelihood of conflict between work and family (Bakker et al., 2008). Bakker (2008) sampled 168 heterosexual couples of dual-earner parents in the Netherlands indicates that higher job demands are positively related to conflicts with intimate partners and result in decreased couple satisfaction. Cultural considerations exist in the study because work-family supports are universally provided by the state. In the United States, work-family supports are provided by employment entities and there may be observed differences in work-family supports across employers. High work demands seem to coincide with individuals taking work home, which creates a conflict with household responsibilities, potentially causing inequities in the division of household labor

(Bakker et al., 2008). Those with higher job demands are more likely to want to relax and recover from their work than to carry out household responsibilities which leads to partner exhaustion (Bakker et al., 2008). With these things in mind, one must consider, given the social and political nature of the U.S., how high work demands of a medical career coupled with a potential decrease in the work-family supports provided to physicians impact the degree to which they are affected by their job demands. Yet, household responsibilities only account for a portion of one, when there are many, different types of demands that perpetuate work-to-family conflict.

Work demands that perpetuate work-to-family conflict include within-domain and boundary spanning demands (Voydanoff, 2005). Within-domain demands are experienced when an individual is feeling demands congruent with the domain the individual is in at that time. Within-domain demands are further categorized into demands that are time-based or strained-based (Voydanoff, 2005). Time-based demands reflect the impact that the amount of time in paid work takes away from time to participate in family activities. Whereas strain-based demands include issues such as coping with the idea of job insecurity and workload pressures (Voydanoff, 2005). Boundary spanning demands address how work and family connect with each other as well as conflict with each other (Voydanoff, 2005). For example, boundary spanning demands include unsupportive work-family culture, working at home remotely, bringing work home, as well as commuting time (Voydanoff, 2005).

Voydanoff (2005) indicates that there is a positive relationship between paid work hours and work-to-family conflict. This study also found that workload pressures are consistently associated with high levels of work-to-family conflict (Voydanoff, 2005). In addition, unsupportive work-family culture is positively related with work-to-family conflict (Voydanoff, 2005). High workloads, working under pressure, work schedule irregularities, and delaying planned vacations are most notably predictors of work-to-family conflict (Mache et al., 2015). Overall, physicians score relatively high in areas of quantitative job demands such as high workload and working under pressure which can severely impact their relationships and their mental health (Mache et al., 2015).

Work-to-family conflict on physician mental health

Globally, there has been an increase in suicide risk among people in different professions, in a sample of 622 physicians in Pakistan where 54% were males, individuals working in the medical profession are at a greater risk of suicide (Akram et al., 2022). Suicidal ideation refers to the altered state of mind in which the ultimate solution to cope with one's stressors or problems is thought to be the ending of one's life (Akram et al., 2022). Work-family conflict can have an influence on personal, as well as professional, outcomes such as psychological distress, job satisfaction, and overall life satisfaction (Akram et al., 2022). There is a strong relationship between personal life events in medical students' lives and professional burnout, reminding advisors and mentors that personal issues along with career counseling should be addressed to balance quantitative job demands with family life (Harrison, 2008).

Quantitative job demands that are specific to medical professions include: working night shifts, minimal control over work hours, and unpredictable scheduling requirements which are all positively related to work-to-family conflict (Lu et al., 2017). In a sample of 300 physicians at both private and public hospitals in Turkey where the majority (64%) identified as male, high workloads that physicians experience can lead to feelings of being underappreciated and emotionally exhausted by both patients and hospital administrations (Tayfur & Arslan, 2013). Both workload and exhaustion increase work-to-family conflict (Tayfur & Arslan, 2013). Understanding the risk of conflict between work and family life in physician relationships is critical for mental health clinicians aiming to support this population, to attempt to lower the risk of suicide among physicians and physicians in training (Akram et al., 2022).

Younger physicians are more at risk for higher levels of work-to-family conflict than veteran physicians (Mache et al., 2015). This phenomenon may be exacerbated by the fact that many younger physicians are typically in a family founding phase with younger children, and potentially increased financial stressors related to student loan burdens (Mache et al., 2015). Older physicians may have had more time to adjust to work demands, have less financial instability, and have children

who are less dependent. It is unclear if work-to-family conflict during medical school and additional training years follow these trends.

Protective factors for physician psychological distress include influences at work, social supports, and sense of community (Mache et al., 2015). In addition, doctors who show higher levels of self-efficacy, resilient coping behaviors, and optimism are more capable of preventing work-to-family conflict impacting relationships (Mache et al., 2015). Ratzon et al. (2011) stated that less work-family conflict contributes to increased productivity, the retention rate of physicians, positive appraisal of one's job, shorter working hours, and reduces the negative impact on performance which in turn reduces stress fostering a safer and healthier working environment (Akram et al., 2022).

Medical professionals carry the lives of others on their shoulders. This stress and how it contributes to experiencing work-family conflict could lead to lowered life satisfaction and be a serious cause of psychological distress and suicide among physicians (Akram et al., 2022). Since the COVID-19 pandemic, these stressors have only been exacerbated with occupational burnout in physicians shown to be increasing to nearly 60% of the population (Alrawashdeh et al., 2021). By examining the bridge between work-to-family conflict and its impact on physician relationships, resources to balance work and family life can be developed to support physician mental health. While every country around the world can more holistically examine the impacts from the COVID-19 pandemic, it is now a crucial time to add increased attention to the mental health of physicians. Work-to-family conflict in physicians may lead to decreased couple satisfaction negating any protective benefits that could come from family and couple relationships.

Couple Satisfaction

Couple satisfaction refers to the attitudes of satisfaction that individuals experience in their couple relationships. Grove, Style, and Hughes (1990) and Mickelson (2009) indicate that affective and emotional spousal support predicts better marital satisfaction (Rostami et al., 2014). Although these findings are rather antiquated, it is logical that feeling emotionally connected to your spouse will increase

your satisfaction within the relationship. Other factors that contribute to marital satisfaction are, but are not limited to, positive daily marital events, education level, division of labor, gender, and emotion-work and will be discussed further.

Positive daily marital events are seen to contribute to higher levels of satisfaction in couples (Johnson & O'Leary, 1996). This study included participants in which everyone identified as white and given that this study occurred before Obergefell v. Hodges, we can assume that the study only included heterosexual couples. Daily marital events were essentially examined to be common marital events (such as events related to childcare, housework, intimacy, etc.) and scored based on subjective perceptions of individual participants finding their partner's behavior related to those events pleasing or non-pleasing. Having higher rates of pleasing relationship events was shown to discriminate between distressed and non-distressed couples (Johnson & O'Leary, 1996). The quantitative work demands of medical professionals previously discussed may impact physician ability to participate in daily marital events. The collection of experiences of those in physician relationships can help inform how work demands may affect a physician's ability to participate in daily marital events.

Division of Labor

For both men and women in the Stevens et al. (2001) study, satisfaction with the division of labor in housework and emotion work is a predictor of marital satisfaction (Stevens et al., 2001). The Stevens et al. (2001) study examined 156 dual-earner heterosexual couples and found that the division of household labor split does not need to sit at 50/50 for individuals to be satisfied in their relationship, but that both partners need to be satisfied with their arrangement (Stevens et al., 2001). Nonetheless, satisfaction with the housework arrangement and hours spent per week on housework were found to impact marital satisfaction for women not men (Stevens et al., 2001).

In a later study examining 96 heterosexual couples in dual earner households, marital satisfaction is highest for couples who have negotiated a mutually agreeable division of household labor (Stevens et al., 2005). Domestic labor includes household

work, emotion work in the relationship, and childcare responsibilities (Stevens et al., 2005). In this study, the more time women spend doing household labor, the more couples disagree and experience marital conflict (Stevens et al., 2005). When women report unfairness in their share of household labor, they tend to be less satisfied with their family life and marriage (Stevens et al., 2005). These women are also more likely to experience depression and decreased psychological well-being (Stevens et al., 2005).

Emotion Work. Emotion-work satisfaction is seen to be a mediator between domestic-labor performance and marital satisfaction (Stevens et al., 2005). When examining men in the study, perceptions of emotion-work satisfaction for both self and partner's performance were significantly positively related for marital satisfaction. (Stevens et al., 2005). For women, only their partner's emotion-work was positively correlated with marital satisfaction (Stevens et al., 2005). These correlations may heighten the risks of physician relationships where a male partner is a physician and experiences the quantitative job demands of their profession. Work-to-family conflict may be increased in this situation which could lead to decreasing abilities to provide emotion-work in their relationships.

Education and SES

Higher educational levels can possibly help spouses to become more open-minded, be better communicators, and have a wider view on their marital life (Rostami et al., 2014). Highly educated individuals may experience an increased SES. Higher education and SES have the potential of leading individuals to accessing an increased number of resources to aid in solving their problems (Rostami et al., 2014). With the mean salaries for physicians in the US ranging anywhere between $210,000 and $775,000, depending on medical specialty (Katzowitz, 2022) and the average household income in the US according to the 2020 census being $71,186, physicians experience an increased socio-economic status (SES). With an increased socio-economic status, physicians may be able to access resources to better support their relationships. SES differences occur during different phases of medical careers and the impact on being able to access these resources. During medical school, one does not

get paid unless they are employed outside their training programs. During residency, mean salaries in 2011 ranged anywhere between $48,460 and $63,837, depending on medical specialty, and may have increased in recent years due to inflation (Andrew, 2011).

Although medical physicians have a higher SES and more access to resources, it is important to note that there may be stigma from professional organizations for seeking mental health support which may affect physicians, as well as physicians-in-training, in seeking those services. A 2021 study assessing 214 pharmacy students in which many respondents were female and white (79.2% and 69.3%, respectively) noted that 63% of students experienced perceived stigma by others as a barrier to mental health care (Buige et al., 2021). Understanding how achieving high levels of education, such as a medical degree and training, may create unique experiences for those in physician relationships and lead to other areas of distress that impact the ability to maintain couple relationships.

An analysis of 787 heterosexually married individuals found that as educational levels are increased, there are increased indications of sexual adjustment problems (Jose, 2007). Huston and Vangelisti (1991) and Donnelly (1991) among others have shown that personal sexual satisfaction of one's spouse largely weighs on marital satisfaction (Jose, 2007). With these studies findings being approximately thirty years old, it is unclear if sexual satisfaction continues to play a large role in marital satisfaction today, as well as considering whether this finding would be generalizable to non-heterosexual relationships. This study does not directly examine the impact work-to-family conflict may have on sexual satisfaction, although it is possible this is an area of concern noted by participants and may require further research.

There are many factors discussed that impact couple satisfaction in both positive and negative ways. Examining the impact that work-to-family conflict has on couple satisfaction, specifically in physician relationships, is the aim of this study. Previous literature has highlighted the individual components of the specific ways that: work stress is elevated in physician careers, that work stress contributes to work-

to-family conflict, and the components of couple satisfaction. Now, I will apply all the previously discussed topics to the current study to hypothesize how work-to-family conflict may impact physician relationships to better inform mental health clinicians working with physicians and their partners to create more efficacious work-life balances in this population.

Work-to-family conflict and couple satisfaction in physician relationships

A healthy, intimate relationship is vital to most physicians (Myers et al., 2001). Professional responsibilities and/or a physician's temperament may be at odds with this goal, and the medical profession needs a cultural shift from the belief that physicians' calling transcends family life (Myers et al., 2001). The traits that make good physicians, such as control, perfectionism, and dedication, often work against creating and maintaining healthy relationships and marriages (Myers et al., 2001). Most medical students tend to be academically focused, studious, and hardworking and take their profession seriously, which may hinder the intimate relationships that are essential to their success (Myers et al., 2001). Physicians trying to balance work and family life may take work stress home. When one takes work stress home, role overload may be experienced. Role overload occurs when employees feel that they have too many responsibilities compared to their available time, abilities, and other constraints (Carnes, 2017). In addition, role conflict occurs when the demands of various roles in an individual's life are not compatible with one another (Carnes, 2017). Role overload may work to perpetuate work-to-family conflict in physicians.

A 2022 study examining the work-to-family conflict experienced in 622 physicians in the Punjab province of Pakistan, found that doctors experienced a difficult work environment, long working hours, emergency calls on holidays/weekends, and patient overload, identifying that these are some of the factors that hinder a balance between work and personal life (Akram et al., 2022). These difficulties can also result in causing work-family conflicts among medical professionals (Akram et al., 2022). There are many circumstances of a medical career that make maintaining intimate relationships difficult. For example, physicians working in rural or underserved areas often work extremely long days and have

grueling on-call schedules that give them little time to engage in relationship or family life (Myers et al., 2001). Those in demanding branches of medicine, such as neonatology, transplant surgery, high-risk obstetrics, and neurosurgery have little control over their professional lives, their work is less predictable, and family plans often get disrupted (Myers et al., 2001). Further, incurring huge educational debts during medical training may influence physicians to develop the mindset of trying to "catch up", which diminishes time with loved ones (Myers et al., 2001). Working "double time" to support members of extended families outside the country is a circumstance in which some international medical graduates and physicians from ethnic minority groups may also find themselves in (Myers et al., 2001).

Work stress may threaten marital satisfaction, Story and Repetti (2006) and Roberts and Leveson (2001) have corroborated with evidence that work stress negatively impacts marital satisfaction. When 652 medical staff members in heterosexual marriages in Tehran were sampled, those who are exposed to stressful work experiences reported more marital dissatisfaction and less marital support (Rostami et al., 2014). Stress negatively affects marital satisfaction in three ways: it influences couple communication, decreases the time spent together, and increases health problems (Rostami et al. 2014). These findings are almost a decade old, and may have contextual factors impacting responses, so examining the impact work-stress has on couple relationships specifically in the U.S. physician population may yield differing experiences. Due to high levels of work stress in physician careers, emotional spousal support may be limited for physicians in relationships leading toward lowered couple satisfaction and may not be the only impacting factor unique to these populations impacting couple satisfaction in either direction.

There is little research highlighting physician spouses' perceptions of their physician relationships. Shanafelt (2013) sampled 891 spouses/partners of physicians with the majority (73.2%) being female, and again contextual factors surrounding when this study was conducted assume that only those in heterosexual marriages participated. The study highlighted that spouse's satisfaction of physician relationships strongly related to the amount of time spent awake with their physician partners each

day. This finding may impact the Voydanoff (2005) findings that paid work hours are strongly related to work-to-family conflict. This indicates that if physicians can maintain higher paid-work hours, yet still provide adequate time spent awake with their spouses, marital satisfaction may not be affected at a high degree. Yet, it is clear to see that paid-work hours coupled with time constraints may make time spent awake with their partners difficult. Several studies suggest that hours spent at work may indirectly influence satisfaction by contributing to role conflict (Shanafelt et al., 2013). Despite physician partner's overall satisfaction in the Shanafelt (2013) study, spouses/partners reported their physician partners frequently came home irritable, too tired to engage in home activities, or preoccupied with work.

Physician relationships face some unique challenges because of the protracted training process, the high levels of educational debt physicians incur, the demanding practice schedule, a mentality of postponing gratification, and a professional culture that often prioritizes work responsibilities over personal responsibilities (Shanafelt et al., 2013). Physicians are nearly twice as likely to be dissatisfied with their work-life balance, which indicates an entire systemic change is needed in the medical field to support physicians and physicians-in-training (Shanafelt et al., 2013). While physicians may have increased risks to be dissatisfied with their work-life balances, divorce rates for physicians are seen to be lower than other occupations.

Divorce Rates

Data collected from census surveys from 2008-2013 considering more than 40,000 physicians, 200,000 other health professionals, and over 6 million individuals in other careers suggest that both men and women physicians are at lower risk of divorce (24%) than individuals in other occupations, including other professional careers, such as lawyers and engineers (35%) (Shanafelt et al., 2013). Specialty choice was associated with divorce in this cohort, with the highest divorce rates at 30 years observed among psychiatrists (50%) and surgeons (33%). The lowest divorce rates were observed among pediatricians, pathologists, and internists (30-year cumulative incidence, 22%-24%) (Shanafelt et al., 2013). This shows that physicians and their partners may be more likely to remain married. The study noted that this may be due

to factors such as financial security or social status as potentially working to increase marital satisfaction (Shanafelt et al., 2013).

Two decades ago, medical students and young physicians were among the largest cohorts of adult children of divorce that has ever studied medicine (Myers et al., 2001). Physicians and physicians-in-training may have been impacted by their experiences in divorced households. Some may approach intimacy and commitment to relationships with ambivalence and fear (Myers et al., 2001). Communicating in a mature way in a relationship or a marriage is not innate, and this type of communication is not taught in medical school (Myers et al., 2001). The expectations and rigors of training in some residences are seen as "toxic" and antithetical to healthy relationships at home (Myers et al., 2001). All relationships require care, patience, and nurturing, and couples therapy often restores intimacy, happiness, and personal well-being (Myers et al., 2001). There is no clear literature to determine if this trend in medical students and young physicians continues today. Nonetheless, medical professionals are in rigorous programs that teach important concepts, which may result in personal topics being overlooked in curriculum.

Role conflict and gender

Relationship conflict can occur when one domain of an individual's obligations (i.e., work or family life) make it difficult to attend to the other domain's needs (Minnotte & Pedersen, 2013). The Minnotte and Pedersen (2013) study looked at the impact gender role ideologies of work-family conflict have in dual earner relationships. There was no consideration to specific careers in this study, instead it purely examined heterosexual couples where both partners worked any number of hours. In the study, an individual's well-being was enhanced when they were congruent with each other's gender ideologies, and alternatively reduced when they violate them (Minnotte & Pedersen, 2013). Specifically, women with egalitarian gender ideologies are more likely to be dissatisfied with the division of labor inequities than women with traditional gender ideologies (Minnotte & Pedersen, 2013). However, a 2014 study with 101,110 participants in heterosexual relationships reported a lack of gender differences as it relates to marital satisfaction (Jackson et al.,

2014). Although, the study did indicate that unequal balances of power are associated with lower marital satisfaction (Jackson et al., 2014). Physician relationships may be at an increased risk to experience power differences for a variety of reasons, especially if the other partner is not considered to be involved in a career that is perceived as prestigious. In addition to unequal balances of power, a lack of inequitable division of household labor was also found to lower marital satisfaction in the same study (Jackson et al., 2014). Female physicians may also experience increased stressors and experience role strain which could work to exacerbate unequal balances of power and inequitable division of household labor lowering couple satisfaction.

For female physicians who would like to make the decision to bear a child, many experience role strain while trying to juggle being a physician, partner, and parent (Myers et al., 2001). Unfortunately, they may have to face their patients feeling abandoned when they choose to become pregnant or experience messages of disappointment when wanting to work part-time only (Myers et al., 2001). Medical colleagues, employers, or program directors may imply that these physicians are less "dedicated" in these scenarios; some may experience their partners or spouses being insensitive to these desires for them to continue generating income (Myers et al., 2001). Physicians who can balance work, family, and physical, emotional, and spiritual needs in harmony are happier, healthier, clearer in thought, more energetic and more accepting (Myers et al., 2001).

In a study of 415 heterosexual married physicians with children (64% being male), role conflict affects marital satisfaction in an inverse relation (Warde et al., 1999). Role conflict is defined as the perceived frustration resulting from the competing demands of career, marriage, and family (Warde et al., 1999). The Warde et al. (1999) study highlights that it is not the number of hours worked that affects satisfaction with marriage, but rather the role conflict experienced by the physician (Warde et al., 1999). Minimizing the level of role conflict and having a supportive spouse are associated with higher levels of marital satisfaction in physician relationships (Warde et al., 1999). In the Warde et al. (1999) study those who reported high levels of marital satisfaction also had higher levels of work satisfaction, lower

levels of work stress, and higher levels of family competence. Women physicians are more likely to experience role conflict than their male colleagues, and younger male physicians are more likely to experience role conflict than older male physicians (Warde et al., 1999). Women in particular report more job stress, lower perceived wellness, and more burnout than men which is potentially due to role conflict (Warde et al., 1999).

Dual physician relationships. When using a sample of 1,209 physicians in either dual-physician or single physician heterosexual relationships, individuals in dual physician relationships are seen to have lower incomes and more active participation in childrearing than single physician households (Sobecks et al., 1999). Marriage between physicians is seen to be associated with higher total family income, more enjoyment and satisfaction from shared professional interests, and more involvement in child-rearing for both partners (Sobecks et al., 1999).

The literature indicates that women in dual doctor relationships are impacted by making career limiting choices more so than their spouses. Female physicians in dual physician relationships often are faced with choices involving limitations in personal income and professional life in favor of fulfilling family roles (Sobecks et al., 1999). Limitations exist in that this study did not include same-sex couples; the results of this study indicate that for heterosexual relationships, even dual physician relationships fall into normative societal pressures that result in women making professional limitations based on household responsibilities (Sobecks et al., 1999).

Conclusion

There is a strong research base dedicated to understanding work-to-family conflict and couple satisfaction. Despite the many decades of research, an understudied population is physician relationship satisfaction and the contributing factors to preserving physician relationships. Studying this population would work to highlight the factors that are contributing to increased levels of psychological distress in this population. In addition, more research in this area could be used to increase job satisfaction of physicians, decrease the risks of burnout, and positively impact physician work-life balance and couple/family relationships. To date, research that

specifically focuses on physician relationships has almost completely focused on the physician's perceptions of their relationship with little inclusion on spouse/partner perceptions. Further, the studies that examine physician relationships have primarily been narrowly focused on heterosexual couples, that also lack inclusion of people of color. Although a slight increase in media attention surrounding and highlighting the psychological distress in physicians is apparent, most of the scholarly literature on this topic was conducted in the late 1990s and early 2000s and are quite antiquated, resulting in the increased need for new studies to be conducted. The current study collected responses from physicians and their partners to describe their experience of how work-to-family conflict impacts their relationship.

Purpose of the study

Psychological distress is high among those in a medical career. Researchers have noted that couple and family relationships can serve as a protective factor to physician's negative psychological symptoms. Physicians experience a heightened amount of stress related to their careers that can impact the way that these relationships can be successfully maintained to increase mental health wellness in this population. To bring systemic change to the medical system, mental health researchers can focus on highlighting and advocating for the unique experiences that physicians and their partners have related to work-to-family conflict. Further, this study hopes to increase the body of literature pertaining to how therapists can best support physician relationships in couples' therapy. Examining how systemic therapists can support physician couple relationships can have the added benefit of reducing psychological distress and risk symptoms in the physician population. Due to this need, this study collected individual responses of those who are in physician relationships concerning their work-to-family conflict experiences. The research question set out to be answered by this study is: How a career in medicine impacts physician couple relationships. Specifically, the study elaborates on experiences related to (1) how work-to-family conflict is experienced in physician relationships (2) the unique challenges and strengths of physician relationships, and (3) the recommendations physicians and their partners have for developing better work-life balance.

Chapter III

Method

The present study takes a subjective interpretivist stance to describe the unique experiences that medical professionals and their partners experience in physician relationships related to work-to-family conflict. This study is a cross-sectional design using a convenience sample. The benefits of using this design include time and financial efficacy, increased participation and avoiding drop-out, increased sample size, and ease of data collection and analysis. Limitations of the research design include the exclusion of individuals unable to access technology due to the survey being electronically administered, the inability to understand how unique experiences may be affected longitudinally, and self-selection bias where individuals who participated were more likely to do so for unknown factors and may have differing experience than those who did not select to participate.

Participants

Inclusion criteria for the study required participants to be 18 years or older and involved in a physician relationship. For the purposes of this study, a physician relationship is defined as any committed relationship lasting at least 6 months, in which at least one partner is within the medical field training timeline. Being in the medical field included individuals who were medical students, residents, and fellows, and attending physicians. A distinction between the stage of the training processes the medical partner within the relationship is in was emphasized in the study survey. Dyadic data was not collected, and each response was analyzed individually. There were no exclusion criteria within the study based on relationship type. Although not all relationship types participated, the inclusion criteria of the study were inclusive of individuals who were dating, cohabitating, engaged, married, and remarried. In addition, the study was inclusive of heterosexual, bisexual, and gay/lesbian relationships, as well as polycules. This sample selection will address the gap in the literature examining the experiences in physician relationships throughout training, and the lack of literature highlighting the experiences of those in bisexual and lesbian/gay physician relationships. In qualitative studies, it is common that data are

based on 1 to 30 informants (Bengtsson, 2016). Given the personal relevance of this study to the researcher's life, there is a potential for conflicts of interest to arise. Due to the study being anonymous, the researcher included a question in the demographic questions where participants indicated whether they have any known relationship with the researcher. Ultimately, when cleaning the data, no such participants were removed for this reason.

Recruitment and Procedure

Following Institutional Review Board approval, participants were recruited online through advertisements on Facebook and Instagram. Participants were also recruited utilizing an email advertisement that included a link to the online survey. I targeted recruitment strategies to local hospitals, sending the email advertisement to multiple coordinators of student wellness at southwestern university medical schools, a southwestern university medical center, and other southwestern community hospitals. All the forms of recruitment allowed for snowball recruitment methods. Once participants accessed the link, they were directed to the first page of the study which included an informed consent for research participation. Participant confidentiality was maintained with the selection of the "Anonymize" function in the survey software, Qualtrics. This function removed identifying information including IP addresses from the participant responses. Additionally, Qualtrics is a password protected survey site, which allowed me to store the initial data.

The goal of this study was to be inclusive of a diverse sample. I achieved this goal by promoting an inclusive research process. Researchers in organizational psychology have found that more diverse recruitment advertisements positively impact perceptions of organizational attractiveness, perceived compatibility, and evaluations of the organization's image (Ahmad et al., 2019). The advertisements for this study overtly advertised that students of all backgrounds are encouraged to participate (Ahmad et al., 2019). The researcher aimed to recruit at least 50% of the data used for analysis with participants identifying in gender and racial minorities. Based on the specific population, female physicians are a minority demographic, and will be

considered minority status for this study. Once data collection ended, I downloaded the data from Qualtrics and stored it on a password protected computer.

The study collected data from 35 participants. Data saturation is a topic that needs to be addressed when conducting qualitative research. Data saturation is reached when there is enough information to replicate the study (Fusch & Ness, 2015). Participants who volunteered to participate were shown an informed consent that described the procedures, risks, and benefits of participation. The informed consent also informed participants that they maintained the right to skip any question or stop participation at any point in the study without consequence. After agreeing to the informed consent, participants completed the proposed study survey consisting of 5 sections. Participants answered questions based on *(1) demographic information, (2) perception of time-based, strain-based, and behavior-based components of work-family conflict, (3) perception of relationship satisfaction, (4) unique experiences in physician relationships, and (5) recommendations for increased support.* I used the demographic information provided by participants to track participants for data analysis to be inclusive of minority identities, as well as report demographic information of participants in the results of the study (Table 1). The researcher used the survey measures that collected the unique experiences of participants in physician relationships as well as their recommendations and advice to perform the qualitative content analysis. The study will continue to gather participant data to be able to perform a correlational analysis of participant responses in sections (2) and (3) of the survey, for a future project. Participants were not compensated for participation.

Measures

Demographic Questions. The participants were asked to identify demographic information about themselves and their relationship. The demographic information that participants were asked included gender, age, relationship status, sexual orientation, children, education level, household income, identity within the relationship, stage of medical training, and amount of relocation due to medical training. In addition, the study did not collect dyadic data and to avoid responses from partners in the same relationship, participants were asked if they had knowledge of

their partner's participation in the study. To avoid accumulating essentially duplicate responses, those who had knowledge of their partner participating in the study were not administered the remainder of the survey, and their responses were removed from the data set.

Work-Family Conflict Questions. Work demands have been seen to perpetuate work-to-family conflict (Voyandoff, 2005). Participants were asked nine dichotomous questions regarding whether they agree to experiencing components of work-to-family conflict because of work demands of medical school/professions. These nine questions are categorized into the experiences of time-based, strain-based, and behavior-based within-domain and boundary spanning demands, with three questions attributed to each category of demands. These questions are adapted from the Final version of Work-Family Conflict Scale proposed by Carlson, Kacmar, and Williams (2000) and solely include the questions regarding work demands that create interference with family (Carlson et al., 2000). The reliabilities within the scale exceeded the conventional level of acceptance of .70 (Nunnally, 1978): time-based work interference with family (WIF) = .87; strain-based WIF = .85; and behavior-based WIF = .78. In addition, discriminant validity was shown within the measure (Carlson et al., 2000). These reliability measures are taken from sources that validated the assessment measure, reliability statistics for this specific sample will be run for this measure once the final quantitative sample has been received to do the future analysis project following the completion of my thesis.

Couple Satisfaction Questions. Higher levels of work-to-family conflict are shown to correspond to decreased levels of couple satisfaction (Minnotte & Bronstrom, 2014). Because of this finding, the participants were asked to answer two questions related to couple satisfaction. Participants were asked to respond with their perception of couple satisfaction in their physician relationship using a 6-point Likert scale measurement where *0 = extremely unsatisfied* to *5 = extremely satisfied,* with higher scores on the measure indicating higher satisfaction. An example question in this section is as follows: *Please indicate the degree to which you are satisfied in your relationship.*

Unique Experiences Questions. Unique experiences of individuals were measured using open-ended questions within the survey. Participants responded to questions asking them to describe in detail the challenges and benefits they have experienced due to being in a physician relationship that they believe relationships outside of the medical community may not encounter. In addition, I utilized open-ended questions within the survey, so participants were able to describe in as much detail as possible the degree in which the demands of medical careers impacted a physician's ability to participate in the couple relationship, and the coping strategies that have been implemented to combat challenges unique to physician relationships.

Recommendations. Open ended questions were once again be utilized to collect descriptions of recommendations that those in physician relationships have for other couples, training facilities, and employers to better support physician couple and family relationships. The participants responded to questions asking them to describe in detail recommendations they have for mental health professionals to consider when working with clients involved in a physician relationship, recommendations for medical training facilities to consider supporting physician work-life balance, and advice that those in physician relationships would give to others who plan to initiate physician relationships.

Data Analysis

Following IRB approval the researcher recruited participants in physician relationships through social media, emails to liaisons and directly to participants, as well as promoting word of mouth or snowball recruitment methods. Data cleaning was performed to remove participants who did not meet the inclusion criteria of this study. In addition, the researcher removed responses indicating that the participant had knowledge of their partner's participation in the study. Data collection resulted in a total of 47 participants. After downloading data from Qualtrics, the data was uploaded into SPSS (IBM Corp, 2023) to clean the data and run sample characteristics of the participants. During data cleaning, participants were checked to ensure they met the inclusion criteria. 5 participants were removed from the study at this point. Additionally, any participant who failed to answer any open-ended unique experiences

questions were also removed from the study. 7 participants were then removed. This resulted in a final sample size of 35 participants.

In SPSS descriptive statistics were ran on the demographic characteristics of the final sample (n = 35). In addition, two new variables were created: work-family conflict severity, and couple satisfaction severity. Work-family conflict severity was calculated by coding the individual questions on the work-family conflicts scale dichotomously (*0* = 'No', *1* = 'Yes). Then, the sum of responses was taken to calculate the overall severity of work-family conflict for each participant. Couple satisfaction severity was calculated by coding the 6-point Likert scale measurement for each question (*0* = 'extremely unsatisfied', *6* = 'extremely satisfied'*).* Then, the sum of responses was taken to calculate the overall severity of couple satisfaction for each participant. The qualitative data was translated to Microsoft Word, and participants were assigned coded names and the qualitative content analysis was performed.

Qualitative content analysis. Qualitative content analysis contributes to an understanding of the human condition in different contexts of a perceived situation (Bengtsson, 2016). This study aims to understand the perceived experiences of individuals in physician relationships. The goal of qualitative content analysis is to reduce the volume of text collected, identify and group categories together, and seek some understanding of it (Bengtsson, 2016). Because the aim of the study is to identify common experiences in physician relationships and identify targeted areas of awareness for mental health clinicians, the research design elicited shorter responses from the participants, which best lends itself to a content analysis approach. There are four main stages of qualitative content analysis: decontextualization, recontextualization, categorization, and compilation (Bengtsson, 2016). For this study, each stage of the analysis was conducted at minimum two times. Performing each stage several times maintains the quality and trustworthiness of qualitative content analysis (Bengtsson, 2016).

Decontextualization. The researcher conducting qualitative content analysis must familiarize themselves with the data (Bengtsson, 2016). During this stage, I read through the transcribed text in its entirety to note any patterns in the right-hand

margins before breaking it down into smaller meaning units. A meaning unit is the smallest unit that contains some of the insights the researcher needs to answer the question set out in the aim of the study (Bengtsson, 2016). The research questions set out for this study are *(1) how work-to-family conflict is experienced in physician relationships, (2) the unique challenges and strengths of physician relationships,* and *(3) the recommendations physicians and their partners have for ways in which mental health clinicians can better support the couple relationship?* When conducting the first read through of participant responses, the first thing that stuck out was contrasting experiences surrounding societal views about physicians during the COVID-19 pandemic. One participant's experience outlined that they experienced negative judgment by society and non-medical peers as a result of the COVID-19 pandemic, yet a separate participant shared that they felt their experience was that there was more respect for healthcare professions because of the pandemic. Another experience that stood out during decontextualization was participants who experienced blame when a patient under their care experienced an adverse outcome. This was a powerful message during the first read through because although physicians are trained to fix health problems, the unrealistic expectations of perfection placed on physicians are not only present in medical organizations, but society as a whole.

The second time I read through the transcribed text in its entirety, I identified meaning units and labeled them with a code. This process is recognized as the "open coding process" and facilitates the identification of concepts around which the data can be assembled (Bengtsson, 2016). I recorded the codes in a master coding list in a separate document while reading through the text the second time. For example, using the following participant quote:

> The ever increasing mental emotional and physical demands of being in healthcare leaves nothing left of the healthcare professional. They've been complained at yelled at problem solved and worked until they can hardly think their own way out of a box. The sleep schedule sucks and is so taxing on overworked healthcare workers. I also want to add the healthcare worker is so

> alone due to hipaa they're never allowed to just vent or throw down or let it all out.

The codes, 'work demands', 'physician burnout', 'physician abuse', 'overworked', and 'physician isolation' were identified from this participant quote at this stage of the analysis.

The coding process was performed repeatedly in this study to increase the stability and reliability of the analysis (Bengtsson, 2016). To account for this, each participant's responses initiated a reset of the coding process, and each set of responses was independently analyzed for meaning units and independent codes.

Recontextualization. After all the meaning units were identified and coded, I re-read the original text alongside the final coding list. The aim of the recontextualization process is to check to make sure all aspects of the content have been covered in relation to the coding list. I performed this process twice and utilized the highlighter function in Microsoft Word to color code areas in the original text that correspond to the list of codes. The first time recontextualization was performed, I read the original text alongside the master list of identified codes and meaning units. I would examine a code alongside the quote in which the code was pulled from to see if the original code was reflective of the message of the participant's experience. For example, looking at the code 'death at work', I highlighted the following quote from the original text, "A year and a half ago I had a baby die postpartum and it sent me into a deep depression – I felt isolated, and no one could understand how I felt about this event", and evaluated how well the code represented the participants words. I felt that the code 'death at work' did not capture the participant's experience as well as it should and revised the previous code resulting in the code 'impact of experiencing trauma at work'.

After performing this process for all codes once, the second read through focused largely on the original text that was left unmarked. I read through this unmarked text to consider if there were any pieces of information that should be included in the coding list. All unmarked text that did not correspond to the aim of this study was not considered with the final coding list. An example of unmarked text that

did not correspond to the aim of the study that was left out of the final coding list was when a participant shared, “He is not a fussy eater”.

Categorization. Before I could begin to create categories, extended codes had to be condensed which entailed reducing the number of words without losing the content of the code (Bengtsson, 2016). An example of a code that was condensed during this phase of the analysis was the initial code ‘support within the couple relationship’ resulting in the condensed code ‘partner support’. Another example of the code condensing process was when I condensed the original code ‘physician limited participation in household tasks’ resulting in the final code ‘physician disengagement’. I analyzed the final code list two times independently and after finishing this, compared each condensed code for reliability. To increase reliability in a qualitative content analysis, the coding process is performed carefully and repeatedly (Bengtsson, 2016). Reliability was determined to have been achieved when comparing the independent coding lists to ensure that the coding lists contained the same codes, and analyzing any differences between the independent coding lists to see if adjusting the final coding list is necessary. I then utilized post-it notes and transcribed the final list of codes onto a note. Each code received its own post-it note.

Next, themes and categories were identified within the codes. Identified themes and categories should be internally homogeneous and externally heterogenous meaning that data should not fall between the groups or fit into more than one group (Bengtsson, 2016). I utilized the previously constructed post-it notes to generate appropriate themes and categories that are internally homogenous and externally heterogenous. For example, there was a separate subtheme identified that was named *Difficulty Connecting*. When analyzing the themes and categories, I determined that many of the experiences within *Difficulty Connecting* were homogeneous with experiences in either the *Medicine, a Tempting Mistress* and *Partner Burnout* subthemes. Therefore, I condensed the experiences of the *Difficulty Connecting* subtheme into the two subthemes that showed homogeneity. I recorded the initial categorization and repeated the process from the beginning and compared any

differences in each categorization. Categorization is complete when a reasonable explanation has been reached (Bengtsson, 2016).

Compilation. When performing a qualitative content analysis, the researcher must consider the collected data from a neutral perspective and consider their own objectivity. I performed a manifest analysis by working my way gradually through each category and through the themes in a latent analysis (Bengtsson, 2016). I used the informants' words, and through a manifest analysis, was able to refer back to the original text in order to stay closer to the original meanings and contexts of participant responses (Bengtsson, 2016). The latent content analysis is most often defined as interpreting what is hidden deep within the text, and it is the researcher's role to discover the implied meaning in participants' experiences (Kleinheksel et al., 2020). An example of a product of the latent analysis was identifying the hidden meaning implied by participants when considering the *Medicine, a Tempting Mistress* subtheme. Throughout the participant responses in this section, a career in medicine was seen to impact the couple relationship on a much deeper level than overtly shared by most participants. For each category or theme, I chose appropriate meaning units presented in the running text as quotations (Bengtsson, 2016). After performing this two times, I created a summary of themes and subthemes as a table to allow readers to have a quick overview of the results in addition to a discussion of the results.

Future analysis. The aim of this study is to elaborate on the unique experiences of those in physician relationships. The collection of the quantitative data with the three measures proposed in this study will primarily be used for the purposes of providing additional information about who the study represents. Additionally, the data collected in the work-family conflict section and couple satisfaction section could be used for quantitative analysis following the completion of my thesis. I plan to continue to collect data to perform a future correlational analysis to determine if there is a relationship between responses on the work-family conflicts scale and reported levels of couple satisfaction.

Trustworthiness

The trustworthiness of qualitative content analysis is often presented by using terms such as credibility (Elo et al., 2014). Credibility means that researchers must ensure that those participating in research are identified and described accurately. To address credibility, I gathered demographic data about participants, the stage of medical training they or their partner was in, and whether they were the medical provider or partner of a medical provider. Additionally, by collecting data on couple satisfaction and work-to-family life conflict, I was able to describe relevant information about the participants' relationship to tell us who the themes of this study might represent.

In addition to steps to support the credibility of my study, I also engaged in several other strategies that increase the trustworthiness of the study. I utilized strategies such as: memo-writing, reflexivity, and external audits. Analytic memos are write-ups or mini analyses about what you think you are learning during your evaluation and are typically written both during and after data collection. Related to memo-writing is the process of reflexivity, the practice of identifying aspects of my experiences, values, and biases that could impact the trustworthiness of this study. Throughout memo-writing, I was attentive to ways in which my own experiences could be impacting how I interpreted the data.

The final strategy I utilized was an external audit. According to the Qualitative Research Guidelines Project, external audits involve having a researcher not involved in the research process examine both the process and product of the research study. The external audit process began with my thesis chair reviewing my data coding process through each phase of analysis. We then met and my chair asked me questions about each theme and subtheme, which helped me to both further account for potential researcher biases as well as strengthened the categorization phase of data analysis. For example, in explaining the theme *Partner Burnout*, my chair inquired about how subtheme *Medicine, a Tempting Mistress* and the *Partner Burnout* subtheme were homogeneous enough from one another to constitute a singular subtheme. In our discussion and reviewing the coding process I determined that these two subthemes

were heterogenous and resulted in them remaining separate. Another example of the external audit process included the discussion around the *Medicine, a Tempting Mistress* subtheme. Initially, I had named this subtheme *Physician Self Focus,* however after reviewing the data and contents of the subtheme with my external auditor, I determined that the in-vivo quote referencing medicine as a tempting mistress best aligned with the experiences participants outlined in their responses, resulting in the subtheme being named *Medicine, a Tempting Mistress*. In addition, to know when data saturation was achieved, I utilized the external auditor to conduct an independent analysis (Fusch & Ness, 2015).

Chapter IV

Results

Sample Characteristics

The sample characteristics of this study are described in Table 1. The participants range in age from 22 to 67 years old (M = 35.9, SD = 12.6). Gender demographics for the sample included 62.9% (*n = 22)* of participants identifying as 'female' and 37.1% (*n = 13)* of participants identifying as 'male'. Out of the 35 participants, 10 (28.6%) identified as being 'medical trainees' meaning they were medical students, residents, or fellows, 7 (20%) participants identified as being a 'partner of a medical trainee', 12 (34.3%) participants identified as being an 'attending physician', and 8 (22.9%) participants identified as being a 'partner of an attending physician.'. Within these four groups, 9 (25.7%) attending physicians were females while 3 (8.6%) were male, 5 (14.3%) partners of attending physicians were female while 1 (2.9%) was male, 1 (2.9%) medical trainee was female while 9 (25.7%) medical trainees were male, and 7 (20%) partners of medical trainees were female while no participants identified as being male and a partner of a medical trainee. 28 participants (80%) identified as 'Caucasian', 4 participants (11.4%) identified as 'Asian', 2 (5.7%) participants identified as 'Biracial', and 1 (2.9%) participant identified as 'Middle Eastern'. The study gathered data from a sample that was predominantly heterosexual, with 31 participants (88.6%) identifying as 'heterosexual'. 2 participants (5.7%) identified as 'gay', 1 participant (2.9%) identified as 'lesbian', and 1 participant (2.9%) identified as 'bisexual'.

The range of relationship lengths in the sample was between 1 year and 50 years (M = 12.62 years, SD = 10.6). The sample was largely construed of individuals who were married, where 28 participants (80%) endorsed this type of relationship, 3 participants (8.6%) identified as 'dating', 2 participants (5.7%) identified as being 'engaged to be married', 1 participant (2.9%) identified as 'cohabitating', and 1 participant (2.9%) identified as being 'remarried'. 20 participants (57.1%) identified that their physician relationship started before the medical partner entered medical school. 7 participants (20%) indicated that their physician relationship started when

the medical partner was in medical school. 4 participants (11.4%) shared that their physician relationship started when the medical partner was in residency or fellowship. While 4 participants (11.4%) said that their physician relationship started after the medical partner completed training entirely. 22 participants (62.9%) indicated that they had children while the remaining 13 (37.1%) indicated that they did not have children. Within the sample (n = 35) the range of children that participants had was from 0-5 (M = 1.37, SD = 0.49).

Within the sample (n = 35), the range of participant income was large, $0-$900,000 in yearly household income (M = $205,545.45, SD = $201,988.10). This suggests a wide range of income, as well as large deviations from the mean within the sample. This could be accounted for by the different phases of medical training and the disparities in income between each phase. Within the sample (n = 35) the range of relocations due to medical training ranged from 0-11 (M = 2.21, SD = 2.46). Table 1 contains the demographic information for participants (n = 35).

Table 1

Participant Demographic Information (n = 35)

Variable	*M* or %	*SD*	*Range*
Age	35.86	12.35	22-67
Race			
White	80.0%		
Asian	11.4%		
Biracial	5.7%		
Middle Eastern	2.9%		
Gender			
Female	62.9%		
Male	37.1%		
Sexual Orientation			
Heterosexual	88.6%		
Gay	5.7%		

Table 1 Continued

Bisexual	2.9%		
Lesbian	2.9%		
Relationship Status			
Married	80.0%		
Dating	8.6%		
Engaged	5.7%		
Cohabiting	2.9%		
Remarried	2.9%		
Relationship Length (years)	12.62	10.6	1-50
Relationship Start			
Before Medical School	57.1%		
During Medical School	20.0%		
During residency/fellowship	11.4%		
After the completion of training	11.4%		
Children	1.37	.490	0-5
Yes	62.9%		
No	37.1%		
Education			
Physician or physician-in-training	51.4%		
Bachelor's	28.6%		
Graduate or Professional Degree	17.1%		
Associate's	2.9%		
Income	205,545.45	201,988.10	0-900,000
Relationship Role			
Attending Physician	34.3%		
Medical Trainee	28.6%		
Partner of Attending Physician	22.9%		
Partner of Medical Trainee	20.0%		
Medical Timeline			

Table 1 Continued			
Attending Physician	51.4%		
Medical Student	28.6%		
Resident/Fellow	20.0%		
Number of Relocations	2.21	2.46	0-11

In addition to demographic information, participants were asked about their current level of satisfaction in the relationship and their work-to-family life conflict. For each participant Work-Family Conflict (WFC) was measured by taking the severity or sum of the participants' responses of each question on the dichotomous measure. The range of responses for the sample (n = 35) was from 0-9 (M = 4.06, SD = 2.22) (Table 2). For couple satisfaction, the responses were scored on a 6-point Likert scale measurement for each question. For each participant, a severity or sum of their responses on both questions were added together to result in the severity of their couple satisfaction. The range of responses for the sample (n = 35) was from 1-10 (M = 6.80, SD = 2.18) (Table 2). Table 2 contains the descriptive statistics for WFC severity and couple satisfaction severity for participants (n = 35).

Table 2

Descriptive Statistics for WFC Severity and Couple Satisfaction Severity (n = 35)

Variable	*M*	*SD*	*Range*
Work-Family Conflict Severity	4.06	2.22	0-9
Couple Satisfaction Severity	6.80	2.18	1-10

The qualitative content analysis resulted in the extraction of five themes. They were classified as: *(1) medical career toll, (2) relational stressors, (3) career benefits, (4) recipe for relational success, and (5) areas for intervention.* The findings of the content analysis will be presented by defining the themes and subthemes of the

analysis with demonstrative quotes presented to support the theme/subtheme descriptions. Each quote will include a citation of the participant with an indication of whether they are a 'Medical Trainee' (MT#), 'Partner of a Medical Trainee' (PMT#), 'Attending Physician' (AP#), or 'Partner of an Attending Physician' (PAP#). This transparency is used to demonstrate that although participants represent different stages of their medical career and relationship, results show homogenous experiences across all participants. Table 3 providing a cohesive depiction of the themes and subthemes of this study.

Table 3

Themes, Subthemes, and Demonstrative Quotes

Themes	Sub-Themes	Quotations
Career Toll		
	Career demands	"My husband and I are both in the medical field and have to work weekends, evenings, and holidays" (PAP1)
	Negative work Environment	"Don't ignore the reality that physicians are expected to be perfect. These [medical trainees] spent their entire lives being high achieving individuals they emotionally can't handle messing up. Normalize being human!" (PAP2)
	Emotional toll	"A year and a half ago I had a baby die postpartum and it sent me into a deep depression. I felt isolated and no one could understand how I felt about this event. My spouse often thought that I was upset at him when in reality I was struggling to handle my emotions about the work-related event" (AP2)

Table 3 Continued		
Relational Stressors		
	Medicine, a tempting mistress	"They [physicians] also tend to be very tunnel vision and self-focused, he didn't ask how life was or really parent" (PAP2)
	Partner burnout	"It's frustrating that so much falls back on me, after I've also had a very long day of parenting" (PMT8).
	Financial insecurity	"When your spouse is in medical school, they are studying the amount of hours that they would be working. Except that there is no income which creates financial stress and pressure on the other partner" (PMT2)
Career benefits		
	Financial Security	"The job and financial security that is almost guaranteed after training" (PMT5)
	Rewarding	"When you are able to help a patient, it's a fulfilling/rewarding position to be in" (AP6)
	Increased access to medicine	"I'm a pediatrician which give me a lot of knowledge and confidence as a mom" (AP4)

Table 3 Continued		
Recipe for relational success		
	Communication	"Take the time to communicate your needs to your partner and your stresses" (PMT1)
	Prioritizing	"Decide on what is important and prioritize those things" (AP1)
	Perseverance	"If you can figure out the stress and balance during such a tough time one day you will realize how much better your relationship is in difficult situations or stressful times than those who haven't been pushed so hard" (AP4)
	Outside Support	"We rely on our family to help with our kids (pick up from school, holiday coverage)" (PAP1)
	Alternative Options	"If you can see yourself being happy in any specialty besides surgery, do that instead. Reach out for help when you need it. The school is rooting for you." (PMT5)
Areas of Intervention		

Table 3 Continued		
	Mental Health Awareness	"More examples of where people can go to get support for things like childcare, counseling, etc." (AP7)
	Mental Health Clinicians	"In our experience, therapists have been intimidated because we are medical professionals and expect us to treat ourselves" (AP8)
	Medical Systemic Change	"Spouse of trainees and physicians can benefit from support systems as they often spend long hours away from their spouses caring for children solo" (AP2)

Theme 1: Career Toll

Career toll describes the experiences of physicians and their partners on how a medical career impacts the medical partner individually in the relationship. Although many responses within this theme are coming from medical trainees and attending physicians, many partners were able to comment on experiences of personal observations of how the medical field is taking a toll on their partner. Within this theme, three sub themes have been identified: *(1) career demands, (2) negative work environment,* and *(3) emotional toll.*

Career demands. Being in the medical field resulted in numerous career demands placed upon the medical partner, including demanding work hours, scheduling unpredictability and conflicts, and non-regular work hours (e.g., working nights, weekends, and holidays, as well as interruptions due to call scheduling) and these demands took a toll on the medical partner and their families. Regardless of which stage of the medical career participants were in, they all spoke to the impact of a demanding scheduling with time away from home being significant. Medical students shared: "During the training, I needed to move to different places, which

influenced the time with family. The time on duties also impacted the family time" (AP12), "For me, it's mostly fatigue and time away from home" (MT8), and "Medical school is stressful and very time consuming" (MT7). While a medical resident reported: "The rigorous, abusive, and demanding work hours of residency… I live life in grayscale while going through the motions of keeping up with residency time demands" (MT3). Finally, PMT8, the partner of a medical resident, provided a partner's perspective of the demands mentioned by MT3: "The amount of hours/days/nights that are spent working is just overwhelming. Changes in plans when spouse gets called in with no warning to help with OB patient."

In addition to the increased time on duty, participants also talked about career demands impacting their partners and families due to the challenges related to unpredictable scheduling. MT4 shared that a challenge of a career in medicine was the "Unpredictable schedule during residency", while MT7 shared they also experienced similarities in their medical school training "Lack of a schedule and time demands." Throughout the responses, many participants detailed the demands of an irregular work schedule, and its impact. Participants in dual physician relationships stressed how unpredictable schedules created unique challenges in their relationships. "Trying to balance responsibilities when we both have call schedules and also when we are both emotionally shot from bad days at the same time, it is hard to even find the energy to eat" (AP9), while another participant described:

> Both of us are in the medical field and its very common that we are both on schedule during different times and do not see each other for a day or so at a time. We both tend to be stressed at the same time due to workloads over the year (MT1).

PAP1 who is also an employee within the medical field outlined the demands that both her and her partner face when trying to navigate two conflicting, yet simultaneously demanding schedules: "My husband and I are both in the medical field and have to work weekends, evenings, and holidays." She goes on to say: "Expect long-hours, on-call, missing evenings/weekends family time."

These challenges seemingly were exacerbated in these dual physician households, while single physician relationships outline similar experiences with career demands. AP6 shares the interruptions they experience while on call: “Phone calls in the middle of the night. Having to leave social functions because of work.” Which is expressed in AP11’s responses: “Being on call. The stress which gets carried home.”

Career demands also impacted sleep schedules and medical professionals feeling overworked. “I work a lot of nights and weekends… I work long shifts and do get very tired and stressed sometimes” (AP7), “Sleep deprivation… [a career in medicine] completely takes over most responsibilities…[I’m] tired a lot, not as active, but still able to contribute” (AP3), and “The ever increasing mental emotional and physical demands of being in healthcare leaves nothing left of the healthcare professional… The sleep schedule also sucks and is so taxing on overworked healthcare workers” (PAP2). Even after giving birth, a physician reported the demands of their career made them feel pressured to be away from home and back at work. “6 weeks post-partum leaving baby home for 24+ hour shifts” (AP4).

Negative work environment. Many participants experienced a negative work environment due to the toll of a career in the medical field. Specifically, participants described the physicians being exposed to verbal abuse at work, as well as in-vivo references to working in medicine being a toxic environment, adverse patient experiences including witnessing trauma, pressure to not make mistakes, and exposure to disease and pandemic related stressors, all creating an extensive toll on medical providers and their partners. PAP2 described their experience of observing how a negative work environment affects their medical partner:

> The ever increasing mental emotional and physical demands of being in healthcare leaves nothing left of the healthcare professional. They've been complained at yelled at problem solved and worked until they can hardly think their own way out of a box… Medicine can be really toxic with the attitude of ‘it was hard for me it has to be hard for you’.

An overwhelming number of medical trainees and attending physicians outlined the impact of experiencing traumatic events in their work environment. Many of these experiences are seemingly normal everyday tasks in the medical field. One participant explained, "There's stress of witnessing death and suffering firsthand and feeling helpless in preventing suffering despite the tools we have with modern medicine" (MT8). While another participant who works with pediatric patients reported: "Watching people die at work is a real mood killer" (AP9). Despite the normality of patient death within this profession, participants described how these losses led to mental health symptoms including PTSD and depression. "The PTSD associated with exposure to the day-to-day traumas in the Emergency Room" (PAP6).

> A year and a half ago I had a baby die postpartum and it sent me into a deep depression - I felt isolated and no one could understand how I felt about this event. My spouse often thought that I was upset at him when in reality I was struggling to handle my emotions about the work-related event (AP2).

AP2's words show how the experiences of patient loss also impacts their partners. AP2 goes on to share that the negative work environment should necessitate access to mental health services:

> Debriefing with offers of mental health support should ALWAYS be offered after adverse patient outcomes to prevent the physician from becoming the second victim (including physicians who are not direct employees of a hospital system). I am in private practice and the hospital never once asked if I was okay.

Others shared the pressure they experienced, or observed in their partner, of not directly witnessing loss in a case, but the constant threat of an adverse patient outcome. AP7 shared: "It is really important to not make a mistake at work since it could impact a human in a very bad way." While MT7 echoed the shared experience while being in medical school: "Stress of having patients' lives on the line can overlap at home." PMT9 shared a partner's perspective of the impact the reality or threat of patient loss:

> The first time your medical partner makes a mistake at work, or their team loses a patient. I work in finance, and I have bad days sometimes, but no one ever dies. It's almost traumatizing to the individual who has to go through that. The hardest part is hearing about this scary experience at the dinner table, and then watching your partner leave for work the next morning to do it all over again (PMT9).

While patient loss and fear of patient loss were the most common examples of negative work environment participants also described challenging interpersonal interactions with patients and colleagues, as well as potential risks to health. For example, one participant wrote, "Being taken advantage of by patients time and time again, but still having to trust every new patient you meet in hopes that they will be different" (MT8). While another spoke to medical risks "Exposure to infectious disease" (MT5). The aforementioned areas of demands of a medical career have been exacerbated by public health crises, specifically the COVID-19 pandemic. AP5 shared that their biggest challenge in their career has come from "public health crises" (AP5). Others, shared contradicting accounts of how societal views have differed during this time, impacting physicians and their families: "Societal/Peer Negative Outlook on myself/spouse/family for my job as a physician during COVID. And judgment for my work as being negative for those who were anti-COVID" (AP1). "I feel like there is more respect for the healthcare community after Covid" (PAP1).

Emotional toll. Due to a career in medicine physicians experienced fatigue, exhaustion, and burnout, as well as a range of emotional experiences such as anxiety, guilt, and fear of failure. Participants wrote about the ways in which the emotional toll of work spilled over to their home life. AP6 shared that they experience a "high stress level. Needing to help other people all the time may make it harder to be present psychologically at home." And MT3 wrote, "I come home drained. I am constantly on edge." The emotional toll is poignantly described by AP2 who outlined that with physician fatigue, burnout, and exhaustion from work impacting their home life, "Very commonly I am very done "peopling"/being 'on' for others at the end of my

day/shift and it causes me to lose interest in being plugged in at home with my family and spouse".

For those in the medical profession, there is a lot of pressure to succeed, which creates a challenging emotional toll. For medical students, the emotional toll of seeking a career in medicine is described as stunting their emotional growth. MT7 explains:

> Most of us are consumed with knowing the facts about everything about the human body. However, the process of doing so has weakened our ability to connect with our emotions. Medical school is hard and has its mental toll. When medical school students need help, they might not know how to ask or even express their emotions.

But these pressures do not go away after medical school. AP4 emphasized the emotional toll of the pressures of a career in medicine as well, noting a fear of failure is common for physicians. "We are all afraid of failure and just because we keep going doesn't mean if you pushed harder, we would feel relieved to unburden everything." PAP2 provides a partner's perspective to these high expectations on our medical professionals even starting at the beginning of training, "These kids spent their entire lives being high achieving individuals; they emotionally can't handle messing up. Normalize being human!"

The emotional toll of medicine was captured by partners as well. Some partners discussed emotional tolls of the matriculating through medical school, "Anxiety—I think my partner will always have nightmares about match!" (PMT9). Other partners described emotional tolls related to stress and guilt, seen in PAP1's words: "Stress comes from finding good childcare to avoid missing work, and the feeling of guilt from being away from our kids." Finally, the systemic impact of work-to-family stress is exemplified by PMT2 who shared: "But also, I think that my husband is so stressed all the time that if there's a problem in the relationship, it becomes an added stress and then he will have a limited capacity to deal with the issue."

Theme 2: Relational Stressors

The second theme identified within the data is the relational stressors experienced within the physician relationships. This theme is captured with the negative impacts that a career in medicine has on the couple relationship. This includes things that affect individual partners specifically but affect the ability to participate within a relationship that are unique to physician relationships. Within this theme, there are three subthemes that have been identified: *(1) medicine, a tempting mistress, (2) partner burnout, (3) financial insecurity.*

Medicine, a tempting mistress. Physicians and their partners shared how a career in medicine can lead to a hyperfocus on medicine, taking away time from the couple relationship. So much so that this is captured in a way that a medical partner's schooling or career is acting as a 'mistress,' in the ways that it takes the medical partners' time, attention, motivation, and emotions away from their relationship. This subtheme is expanded upon with accounts of medical partner career selfishness, unavailability, missing family time, addiction to medicine, disruptions with couple intimacy, and difficulty connecting mentally, physically, and emotionally due to the overwhelming dedication medical partners have to their career. MT8 shared that the major factor impacting their relationship participation was "For me, it's mostly fatigue and time away from home. It's hard to connect with my partner when I am drained and there's not much free time to do so." MT8 went on to explain:

> Medicine is a tempting mistress. I think all physicians in relationships should be careful to not become addicted to medicine, because it can be easy to slip from being unintentionally over worked to being intentionally over worked, which can put relationships in jeopardy.

MT2 shared the impact their medical training, with an added factor of being long distance, has on their relationship "When stressed, it's hard to communicate as well when you have to balance studying especially when long distance." Yet, finding the balance still proves to be difficult when couples are not long distance with AP2 sharing:

> I often don't want to engage in small talk when I get home after talking to 30+ people and problem solving all day. During times when I have had hard days at work I am disengaged from my spouse as a way of handling my feelings"

AP7 sharing very similar experiences:

> Most of us physicians are selfish about our careers. It is important to not make a mistake at work since it could impact a human in a very bad way. Because of that we are not going to give to our spouse when we give all our time and energy to work. Most of us want to work so we aren't very good at cutting back.

PMT4 and PAP6, partners of medical professionals at different points in the training timeline share similar experiences from an alternative perspective in the relationship. Yet, although their partners are at differing points in their medical career, they outline very similar experiences of how their partner's relationship participation is impacted due to medicine:

> Time for family activities, immediate and extended family is less. Time for just the two of us to spend together was limited, even before kids due to studying a lot in the early years of medical school. Getting adequate help in household chores/activities is challenging… They [medical professionals] get consumed almost in their own world. I go through spurts where I feel my relationship is suffering and getting put on the back burner. (PMT4)

With PAP6 sharing:

> It IMMENSELY affects romantic relationships, it makes it very difficult for them [medical professionals] to participate mentally, emotionally, and physically on the day-to-day without dissociating from family just to have a mental break where your brain isn't always "on."

PAP2, AP8, and MT7 are all different relationship roles, and points within the training timeline. Yet, they all outlined the challenges they experience with physical, emotional, and sexual intimacy because of stress and hyperfocus of medical trainees and attending physician's work. PAP2 shared, "The stress kills sex drive so that was hard to not be hurt by. It was also always hurried due to crappy night schedules, so we

didn't learn each other". PAP2 also went on to describe how difficult it is to maintain attraction when their medical partner is too focused on their career:

> They also tend to be very tunnel vision and self-focused, he didn't ask how life was or really parent. If he did ask or show interest, he had zoned out by the time you could answer. It's hard to stay attracted and interested when things are that way.

AP8 shared aspects of difficulty with both physical and emotional intimacy, "Connecting emotionally is challenging (especially during physical intimacy) when one spouse brings up things from work. It's incredibly distracting and putting off. Spouse who works longer, busier hours is emotionally unavailable and is short fused when coming home". MT7 offering this viewpoint while still in medical training:

> Being in a medical relationship can be hard especially if your partner has no medical training. Sometimes, it can be hard to connect with your partner because they don't understand the mental toll of medical school. Picking studying over hanging out with my partner is a big challenge.

Partner burnout. The relational stress of being in a physician relationship and the toll of this career has likely contributed to partner burnout. This subtheme refers to non-medical partners' burdens increasing due to the medical partners' hyperfocus on their medical career, leading to partner burnout. Medical partners described burnout, frustration of an increase of burdens, partner sacrifices, forcible relocation to undesirable places due to a medical career, partner isolation, feeling that their relationship is on the backburner, and an imbalance of household tasks. Interestingly, medical partners were candid about the impact of their career on their non-medical spouses, with AP1 writing "Extra burdens on my spouse when I'm on call at the hospital for a weekend in terms of childcare/house responsibilities." And AP8 identifying:

> The other spouse doesn't receive enough credit for working full time too because it wasn't as demanding of a day. One spouse wants to go to bed at 8:00 pm right when the kids are asleep, so the other spouse feels neglected and there is not time set aside to connect.

Many of the experiences of partner burnout are highlighted in the responses from non-medical partners. Many of these responses outline the frustration these partners experience from inconsistent help in the household, feeling like they come second to a medical career, and even feeling like a single parent. PMT5 shared that their partner is helpful at home, but on an inconsistent basis:

> When my husband is home, he is an extremely active participant in our household tasks and kids. The time that he is home is inconsistent though which leaves me totally alone for the entire time kids are awake many more days a month.

Most other partners did not experience the same level of engagement when their partner was home. “It’s hard from a spouse’s perspective when you're doing everything that should be equally divided, living broke likely somewhere you don’t love, putting your schooling wants, hopes, dreams on the back burner” (PAP2). PMT8 echoed these same frustrations:

> [The] spouse is so worn out at the end of a long workday, that he doesn't have much left to give to kids, household chores, me, or any other parts of his life. It's frustrating that so many falls back on me, after I've also had a very long day of parenting.

Another participant wrote about not receiving support from their medical spouse. PAP3 shared “I cannot rely on my spouse for a consistent help at home. I cannot rely on him to go places with me and be on time…You raise your kids as a single parent.” Other partners described how burnout came from knowing the career demands on their partner and yet still wishing their partner did more. PMT2 detailed the experience of guilt they feel when needing their medical partner’s help or participation in the relationship:

> There’s also a lot of guilt associated. If you have a need you don’t want to disrupt your partners studying and they fail a test. But also, a lot of the household responsibilities can fall on the other partner if you don’t have good communication and then as a partner you feel burnt out emotionally and physically.

Partners also described the complexities of supporting their partner but dealing with their own emotions alone, specifically around critical mile-markers in medical training. For residency match day, PMT9 described that the fear of not matching "dominating our lives for months," and went on to share, "It was hard to be a constant cheerleader and reassure my partner that I would move anywhere we needed to go. I had to be this cheerleader while being anxious and scared myself."

A final factor that exemplified partner burnout was the sacrifice medical partners reported having to make. PMT9 outlined the following:

> I was willing to move wherever we needed to go so that my partner would have the best education possible. I would also say that I run 70% of the household. I make these sacrifices because my partner and I believe in investing in his education and the benefits a successful medical career will provide for us in the future. I'm the breadwinner and I'm doing most of the work so my partner can focus on medicine. I choose to do most of the household work because I want our free time to be spent on enjoying each other's company and connecting emotionally. It's tough, but I think it will all be worth it!

PAP1 also shared the choice to sacrifice aspects of their own medical career for their full-time medical partner:

> My husband is a physician, and I am a pharmacist that works part-time. My schedule is more flexible and therefore take on all the household chores, as well as the kids school responsibilities. I've had to work less to be able to keep up with household responsibilities. I made the choice to work less to spend more time with my 3 kids. Working less helps me to participate more in our romantic relationship and be more accepting to his intense schedule/stressful career.

Financial insecurity. The final subtheme related to relationship stressors, financial insecurity, captures the participants accounts of financial insecurity during training, financial burdens with the completion of training including debt, financial liabilities due to the nature of a career in medicine, and the challenges within the

relationship as a result. Participants highlighted the financial struggles experienced during medical training "When your spouse is in medical school, they are studying the amount of hours that they would be working. Except that there is no income which creates financial stress and pressure on the other partner" (PMT2). And "Also pay the residents, they're starving!" (PAP2). These financial struggles continue beyond medical school. Participants wrote about student loan repayment, saying "Financial struggles paying off two medical student loans" (AP8). And "Extreme debt and financial burdens without many ways to remedy the situation other than years passing and getting closer to the end of training" (PMT5). The other aspect of financial insecurity was described around the cost of the legal liability of a career in medicine:

> The constant financial insecurity associated with the realization that you can be sued for any number of reasons, even if they're completely baseless--it makes you rethink how you handle family finances and you not only keep things separate more so than most other couples, but you also put in near excessive extra protections in the form of financial hoops that other families rarely have to go through (PAP6).

Theme 3: Career Benefits

Although there are definitive personal and relational aspects that affect physician relationships, career benefits capture the unique benefits that partners in physician relationships experience due to a medical career. These benefits are more directly related to the medical career, and experienced gains or things that participants 'get' from one or more partners having a career in medicine. Within this theme, three sub-themes were identified: *(1) financial security, (2) rewarding,* and *(3) increased access to medicine.*

Financial security. The first subtheme identified as a benefit to a career in medicine refers to the financial security and stability that medical partners and their families experience due to a career in medicine. Although, this theme is captured with attending physicians and their partners outlining their financial security having completed training, this theme is also captured in many medical trainees and their partners outlining a "when both of us are stressed, there's always a light at the end of

the tunnel financially" (PMT3). While PMT5 shared, "The job and financial security that is almost guaranteed after training". This highlighting the security trainees feel that when they are finished, their financial gains will increase exponentially. PAP6 shared how their partner's career in medicine helps provide for a family financially, "When things are good financially, they're definitely good--it is very nice having fewer financial worries when it comes to the bare minimum of keeping a roof over your head and food on your table". A career in medicine provides a "good standard of living" (AP4), "lowers financial worries" (MT4), and provides financial and job security for physicians and their families (AP5).

Rewarding. The second subtheme that emerged as a benefit to a medical career entailed the rewarding nature of a medical career. This subtheme is captured with participants having opportunities for public service, advocacy, travel opportunities, healing others, their career being enjoying and fulfilling, and the social status within the community and being seen as a role model for their families. PMT1, PMT2, and MT6 all shared the benefit of achieving career goals and learning alongside each other while in a physician relationship. PMT1 shared that "Seeing him grow into the career of his dreams. Learning alongside with him is always fun! Supporting him during this time has been something I love to do!". While PMT2 echoed the same sentiments, "It's super heartwarming to see my partner when they are excelling in something that they've worked hard to get into for the past 5+ years". AP5 disclosed that there is a benefit of traveling when pursuing a medical career, "Conferences provide opportunity for travel".

AP1 elaborated the benefits they experience of providing a community service, and the impact it has on their children:

> My children see that my career is a service to humanity and are inspired to help others in their own way; My children and spouse advocate for the underserved in a unique way because of what they hear from my experiences.

PAP6 sharing that, "When you are able to help a patient, it's a fulfilling/rewarding position to be in." MT8 experiences a benefit from having high expectations in medical training by turning stress tolerance into a strength, "I can handle stressful

situations with much more grace than I previously could. I get to witness miracles occur when people heal, and then I get to share those stories with my partner". AP2 echoing the same phenomenon as an attending physician: "I feel like I have a good perspective on what truly matters (life/death vs petty things). Working in a high stress environment has allowed me to be able to handle high stress/emergencies at home without letting my emotions takeover." PMT9 shared the benefit they see their partner experience from the bonds they were able to form going through medical training with peers, "The second benefit is the intense bond that the students and interns form with one another. Even when classmates move for residency, the bond that is formed is very strong—they are friends for life!".

Increased access to medicine. The final subtheme identified within the data, increased access to medicine, occurs frequently in participant responses. This subtheme captures medical partners having medical knowledge as well as knowledge of the medical system. This knowledge is used to help serve their loved ones in accessing specialty specific services, assisting in medical issues at home, and an increased access to medical resources overall. AP12 detailed how their specialty medical knowledge and access to medical resources is a benefit in their relationship, "As a psychiatrist, knowledge in mental health helps me improve my relationship with my partner. The resources I have in the medical field benefit my partner's physical and mental health". AP4 stated that they are "a pediatrician which gives me a lot of knowledge and confidence as a mom". AP8, in a dual physician relationship, shared how dual medical knowledge in their relationship has been a benefit to them and that they both, "have helped each other medically at home". AP3 also uses their medical knowledge to "assist with medical issues" with their family, yet having knowledge of how the healthcare system works is also beneficial in physician relationships with AP1 sharing that they find "easy access to specialty medical care".

Theme 4: Recipe for Relational Success

In addition to benefits that are afforded to individuals in a medical career, there are also things that participants highlighted that guide them towards a recipe for relational success in physician relationships. The fourth theme identified within the

data, recipe for relational success, captures the personal qualities, behaviors between partners, and thought processes that participants experienced as helpful within their relationship. These processes were identified by participants in either recommendations, or through experiences of what is successful in their own relationships. Five sub-themes were extrapolated within this theme: (*1) communication, (2) prioritizing, (3) perseverance, (4) outside support,* and *(5) alternative options.*

Communication. Communication refers to the verbal and non-verbal communication between partners within the physician relationship. Many participants advised those entering physician relationships to communicate with one another, communication struggles within their own relationship, alternative ways to communicate within a physician relationship when medical career demands limit in person interactions. Many participants experienced a sense of forced communication learning in their relationship due to the nature of a medical career. Overall participants outlined that communication within the couple relationship contributed to their own relational success. As with any life change, communication in the couple relationship may shift. In MT1's relationship their "communication skills had to adapt to our work life balance and thus we are good at communicating our needs". And goes on to recommend to those beginning physician relationships "take the time to communicate your needs to your partner and your stresses" (MT1). Verbal communication isn't the only way that medical couples foster meaningful communication in their relationship. MT2 shared that within their relationship they are "patient and find other ways to communicate, such as letters or small gifts". Communication is shown to be important to PMT2 within their relationship as they advise those beginning physician relationships to "learn how to communicate! Find the balance between work, school, and know your limits. It's a really challenging process that can make you question why you entered the relationship". MT7 also shared some examples of ways they communicate in their relationship to maintain a strong couple relationship through communication:

> Know your partner and give them as much attention when you can. Make sure to talk to them about your plans and tell them when you are going to have a busy day/weekend. Involve them in your life so they don't feel left out.

Prioritizing. The second subtheme accounted in the recipe for relational success, prioritizing, refers to the experiences related to prioritizing the couple or family relationship over medicine. This subtheme captures nuances from participants relating to relationship before career, intentional couple time and vacations, creating priorities for alone time and individual time with friends, references directly quoting prioritizing, as well as emphasizing shared hobbies/activities outside of medicine. Many participants also commented on creating boundaries between work and home life including, boundaries with work hours/study hours and boundaries with conversations surrounding medicine while at home.

An anecdote to successful physician relationships is knowing that "The relationship is more important than the job" (AP8). It is important to "put your relationship before your career. Example. Try to rearrange schedule to be there for important things. Find time every day to be present with your partner. If both in medicine find non-medical interests to share." (AP9). AP1 shared how to put their relationship with their partner and family before their career, "in order to be a great help with household chores and family time, I have to prioritize my schedule in a way that allows me to be fully invested in home such as getting up earlier, staying up later, planning ahead". AP1 went on to recommend, "Don't try to do it all- your journey is different than others; Decide on what is important and prioritize those things". MT2 prioritizes their couple relationship by "set[ting] time aside each week for dates and calling each other every night before bed".

PAP1, PMT3, MT7, and MT8 all shared that they have hobbies and activities with their partner outside of medicine to prioritize couple time. All these participants noted going to church as one of the activities that helps them prioritize their relationship with their partner and family. PAP1 sharing:

> God, communication, love for our family, and teamwork help to strengthen our relationship…We prioritize our family and home. We spend as much time as

> possible with our kids. We rarely spend time with friends or go on vacation (without our kids).

PMT3 echoed very similar things as PAP1. It seems that PMT3 and their partner find shared activities outside of medicine, sharing the importance their religion in the relationship has been to achieve this:

> Finding something outside of school or work to latch on to as a couple, for us it's church/Bible study groups/ and going to lunch every Sunday after church has helped our relationship tremendously because it's about 3 hours of the week where we invest in our relationship and something bigger than ourselves without career/schools name all over it.

MT7 shared activities they do with their partner in addition to going to church or church-related events, "we go to church together, workout together, cook together - create hobbies we both enjoy". MT8 adding that church is included in their activities outside of medicine that cultivate their couple relationship, "Church. Taking at least one day off every two weeks. Chores around the house together. Videogames. Movies". MT8 even went on to outline the importance of prioritizing, "pick your priorities early and continue to make them your priorities throughout the process. Try to have fun when you get the chance".

Participants shared the boundaries they have in their relationship to help differentiate home and work life. Their relationships institute these boundaries to be able to prioritize the couple relationship. PAP2 shared that they must give up income to be able to maintain these boundaries, "we give up money to avoid working nights, we set hard boundaries on hours. We prioritize talking over zoning out with tv". MT6 maintains similar boundaries with work hours, as well as prescribing to couple time without technology. In their physician relationship they place an importance on "weekly time set aside to be with one another -no tv or phones. Just talking and doing something together". It may be easy for medical partners to spend extended times at home focusing on their career, but PMT1 and their partner shared the boundaries on work hours and work conversations in their relationship. "In essence, he works

medical school like a 9-5 job. He is done at 5 and does not study nor talk about medical school after that" (PMT1).

Perseverance. The next subtheme identified in the recipe for relational success, perseverance, refers to those in physician relationships persevering through the high demands of medical training and a medical career. This theme is captured with reference to the temporary nature of stressors within medical training, pushing through, survival, having patience and understanding within the relationship, giving grace, and achieving dreams.

Several participants were candid about how difficult the medical training process and career are on their relationships. The guidance they all suggested alluded to the temporary nature of the stressors of training or adapting their relationships to medicine. They all shared the importance of 'sticking it out' and how relationships can be tested during this time, but usually result in strength. PMT1 shared, "Stick it out because it is only a small portion of your time together. Support your partner and their dreams! Try to understand where they are coming from and put yourself in their shoes". Sometimes in AP7's relationship medical training can be difficult, "When training is rough, remember it is temporary. Just give it time. If your partner is safe, it's probably worth sticking it out for a couple decades". PMT8 had a very similar experience, looking toward the future to get over rough spots in the present. PMT8 shared "Once we're done, we can be excited that we survived". They went on to share the way they, "just push through it until we get to a rotation that isn't quite as demanding. Then do it over again". AP4's experience may best encapsulate what it means to persevere in a physician relationship:

> It gets better eventually. If you can figure out the stress and balance during such a tough time one day you will realize how much better your relationship is in difficult situations or stressful times than those who haven't been pushed so hard.

Outside support. This subtheme, outside support, refers to utilizing those outside the nuclear family or couple relationship for various kinds of support. Many participants detailed the extent of support they received from the community of

medical families around them having similar experiences. This theme is also captured with nuances of trainee bonds, peer support groups, extended family support, hiring household support, hiring documentation support, and fostering a sense of community throughout training. PAP1 shared how extended family members help support their family, "we rely on our family to help with our kids (pick up from school, holiday coverage)". Hiring documentation support or household help could ease the stress that those in physician relationships experience. PAP2 shared, "We pay for a scribe to free up his time and decrease some stress, I rely heavily on a weekly housekeeper". It seems that support systems are extremely impactful in physician relationships, and a "good support group of both medical and non-medical friends" can help those in physician relationship cope with stressors (AP1). PMT4 shared that "spouse support from other medical field friends" was helpful for coping with their stressors in a physician relationship. While PMT5 shared that they have created "Close knit relationships that form with fellow medical families who support each other" to cope.

Alternative Options. Lastly, the final subtheme within the recipe for relational success, alternative career options, is observed in responses from several participants. Although the previous themes were more hopeful in detailing what aspects of relationships can be particularly successful in cultivating physician relationship success, this subtheme captures experiences from participants accounting that if they could go back in time, the most successful way to carry out a physician relationship is to not pursue medicine at all. This subtheme is detailed by accounts to avoid medicine, avoid specific specialties, or in-vivo quotes from participants like MT3 simply stating "Don't".

MT1 shared that physician relationships may not need to be completely avoided, but physician relationships during training may bring on too many stressors. MT1 sharing, "do not try and kindle a brand-new relationship while in training, especially with someone who is not in the medical field. I would assume that level of stress would not be suitable for a new relationship". PAP2 candidly expressing that "if there is any other option, pick that. Otherwise, be patient hang in there it won't always be this hard get therapy in the beginning not the end and no matter what do not lose

yourself to medicine". AP8 echoed PAP2's response by cautioning those that, "if you are doubting going into medicine at all, don't go into medicine. It's not worth it!". While previous participants noted avoiding medicine entirely, PMT5 cautioned against a specific specialty sharing, "if you can see yourself being happy in any specialty besides surgery, do that instead. Reach out for help when you need it. The school is rooting for you".

Theme 5: Areas for Intervention

The fifth and final theme identified within the study is the areas for intervention. This theme is captured with the needs for resources, change, and awareness of unique issues within the population. This theme was identified through participants describing what is needed to initiate change, or how medical trainees, physicians, as well as their families can better be supported by the systems around them. Three sub-themes were highlighted within the theme: *(1) mental health awareness, (2) mental health clinicians,* and *(3) medical systemic change.*

Mental health awareness. It is evident in participant responses that there is an overwhelming need for mental health awareness. Participants outlined the need for an increased accessibility for mental health treatment, mental health support for adverse patient outcomes, mental health and wellness awareness being modelled within medical training, as well as outlining the current experienced barriers to accessing mental healthcare and the stigma associated with mental healthcare within the medical system. AP1 and PMT2 shared that there needs to be a culture shift in the world of medicine, advocating for work-life balance and wellness curriculum and modelling from those who train the next generation of physicians. AP1 shared the need for, "wellness- modeling it within the culture and advocating for it at all levels". PMT2 outlined that they "think that med schools could incorporate more work life balance curriculum and mental health awareness."

There is a need to "prioritize mental health and well-being" (PMT6). This may be achieved in the medical field by "normaliz[ing] individual, couples and family therapy. Warning on the behavior of taking relationships for granted that leads to

affairs, discordance, etc." (AP9). PAP6 shared the stigma to mental health care that physicians and medical trainees experience as a deterrent to seeking help:

> The amount of undiagnosed mental health problems like Major Depression. Paper trails for mental health issues ding people in certain lines of work and those paper trails follow them forever (doctors, pilots, etc.) ... so, they're less likely to seek help when they need it but more than that, less likely to open up FULLY if you can manage to get them in the door to speak with a mental health professional. Opening creates a paper trail that can hurt their career down the road.

Mental Health Clinicians. Participants outlined recommendations for mental health clinicians to consider when working with this population, and areas to target for intervention based on the unique experiences of the sample. Physicians and their partners had experiences of mental health clinicians being intimidated in therapy, feeling misunderstood by mental health clinicians, the need to provide a space to vent, the need to understand that "power and earning differentials exist in the relationship" (AP5), challenging stereotypes in physician relationships, as well as considering fostering support groups for non-medical spouses. AP8 shares challenges physicians, and their families experience with accessing mental healthcare for mental health clinicians to be mindful of when seeing clients within this population:

> Physicians are highly resistant to mental health support in fear of career repercussions, privacy breaches, and lack of time to go to therapy. In our experience, therapists have been intimidated because we are medical professionals and expect us to treat ourselves.

PAP2 offered areas of advice to mental health clinicians based on their experiences in physician relationships:

> Throw out stereotypes (gold-digger spouse) and do not be blind to personality disorders or poor mental health just because they represent themselves well and are high functioning humans. Both individuals are good people but there's a lot of hard shit to survive and to work through.

And goes on to say:

> Don't ignore the reality that physicians are expected to be perfect while the general public blames them for everything. They're doing their very best as is everyone around them.

Mental health clinicians may benefit from working to better understand this population of interest. MT3 highlighted experiences feeling misunderstood by therapists they have sought out for services, sharing that they have "seen a therapist or two and they "get" it, but I frequently don't feel understood entirely in trying to describe how I feel and why I'm empty when they just parrot back "residency takes a lot of time and energy". Therapists may work to better understand the significant amount of stress and workload associated with this job." (PMT6). It is also imperative to understand that "specialties are extremely different and bring unique issues. You can't treat an orthopedic surgeon family the same as a pediatrician family." (PMT5). AP2's experiences highlight how mental health clinicians can help support physicians and medical trainees in a therapeutic setting:

> Physicians need a soft place to land at home and a nonjudgmental place to vent those feelings. We often feel isolated as nonmedical family and friends don't understand the emotional toll of the things we see or do at work every day.

Mental health clinicians may be able to help physicians and their partners in finding where boundaries can be created between work and home life. MT2 shares that, "setting boundaries and finding the balance are really difficult and knowing how to communicate to get to a healthy place isn't really mentioned anywhere". Mental health clinicians can also work with couples in physician relationship by helping them develop common interests. AP9 sharing that with their partner they "try to spend time everyday debriefing about medicine and then MOVE ON. Develop common interests that are NOT medically related".

Medical Systemic Change. There are calls to promote change, balance, and wellness for physicians and their families. Medical training facilities and physician employers to provide curriculum on work-life balance and how to maintain healthy relationships, "cut back on work hours" (MT8), promoting part-time employment, "provide more financial support and scholarships" (MT7), maternity/paternity leave,

providing more information on how to access resources, while also increasing the number of resources available especially childcare resources. PAP1 highlighted the need for "Resources for reliable childcare services (in home). Childcare coverage on holidays, evenings, sick days would be helpful". In addition to childcare coverage, the need for parental leave and "better support for the father of a newborn including time off" (MT6).

Fostering community between medical partners and non-medical partners would go a long way to helping cultivate these couple relationships. "It would really be neat if the medical school could facilitate a way for partners and spouses of med students to connect because it's hard feeling like you're alone" (PMT2). Or even "more events for spouses and students together to meet each other and build community" (PMT4). Fostering community across the training process may look like "offer[ing] easier access to mentorship, mental health support, and allowing work leave to obtain such services." (AP8). PMT1 also wishing that there were "more shadowing opportunities for residency programs and discussions on work life balance". AP2 shared the need for the medical system to provide mental health support and check-ins for physicians and trainees to access when they have experienced adverse patient outcomes:

> Debriefing with mental health support should ALWAYS be offered after adverse patient outcomes to prevent the physician from becoming the second victim (including physicians who are not direct employees of a hospital system). I am in private practice and the hospital never once asked if I was okay.

PMT9 shares experiences related to the match process for residency. They share the impact of how public match day was, and the impact that had on them and their medical partner, and recommended change. PMT9 sharing, "don't make match day so public. It's huge news and many people would rather process the information in private instead of in front of all of their family and friends".

Chapter V

Discussion

This study resulted in the emergence of 5 themes and 17 subthemes which together describe the impact of being in a physician relationship. The findings of this study will be discussed in consideration of existing research and is organized by the research questions that guided the study.

Research Question 1

The first question that this study aimed to answer was how work-to-family conflict is experienced in physician relationships. Participants outlined that overwhelming 'career demands' relating to 'high stress', 'pressure to perform', 'scheduling unpredictability', 'non-regular work hour interruptions' resulting from having 'call schedules', and 'toxic work environments' all spill over to their home life. High workloads, working under pressure, and work schedule irregularities are most notably predictors of work-to-family conflict (Mache et al., 2015). Therefore, the experiences of participants in this study are consistent with Mache et al. (2015) who say that physicians score relatively high in quantitative job demands which can severely impact their relationships. The demands of training and a career in medicine contribute to medical trainees and physicians experiencing 'fatigue', 'exhaustion', and even at times accounts of medical partners experiencing a dissociative state. This toll of medicine proves to be difficult for medical partners impacting their ability to 'be present', 'interact with family', and create a need for 'alone time' when they get home despite being away from their families for as long as 24 hours or more while on service. These findings support Bakker et al. (2008) who indicate that those with higher job demands are more likely to want to relax and recover from their work than interact with the family and carry out household responsibilities. These findings also support Tayfur and Arslan (2013) who highlight that the high workload physicians experience can lead to feelings of being underappreciated and emotionally exhausted.

In addition, its apparent that physicians' (depending on the specialty) everyday routines at work could qualify as traumatic experiences. Many participants noted the impact physically, emotionally, and mentally that witnessing 'death at work', 'trauma

in the ER', 'patient losses, and 'adverse patient outcomes' have on medical partners. Post-Traumatic Stress Disorder (PTSD) results from real or perceived exposure to life threatening trauma, and few people recognize that PTSD in physicians may occur as a byproduct of medical practice (Lazarus, 2014). The findings of this study are consistent with Lazarus (2014) who say that mental health clinicians should be aware of five types of physicians that are particularly prone to developing PTSD: emergency physicians, physicians practicing in remote or underserved areas, physicians in training, physicians involved in malpractice litigation, and physicians who are 'second victims' in that they are indirectly exposed to trauma (Lazarus, 2014). These experiences were elaborated on by participants as impacting their ability to 'communicate emotionally' causing 'confusion in their non-medical partner' and left many physicians feeling 'isolated' from not only their partners but from everyone due to HIPAA privacy protections. Mental health clinicians can work to advocate for support of physicians and physicians in training when adverse patient outcomes are experienced.

The demanding nature of medical training and medical careers were experienced by participants as impacting the family life. Many participants noted 'difficulty connecting', 'limited time for in-person interactions', 'challenges with physical intimacy', 'lack of understanding', 'decreased sex drive', 'unavailability', 'career selfishness', and 'ego' to describe how medical training and careers impact a medical partner's ability to participate in their relationships. These findings support a 2023 American Medical Association (AMA) publication highlighting the symptoms of physician burnout. Physician burnout is a response to a long-term stress reaction and can include the following: emotional exhaustion, depersonalization, and feeling of decreased personal achievement (AMA, 2023). It is not surprising that these experiences of physician burnout can affect the way that physicians are connecting with their partners.

A unique finding of this study is the comparison of a career in medicine to the experience of being in an affair. A hyperfocus on medicine, or as one participant noted an 'addiction to medicine' can be clearly seen as having an impact on the couple

relationships of medical trainees and physicians. These experiences are so frequent in the data, and rich in their descriptions, that the impact of work-to-family conflict in a medical career is seen to create similar impacts to relationship participation as infidelity does. Emotional infidelity is defined as the occurrence of emotional involvement with a third party that violates the ground rules established by the couple which can include: trusting another, sharing your deepest thoughts, falling in love with each other, being vulnerable with each other, and committing to each other (Rokach & Chan, 2023). Participants outlined that a career in medicine impedes on physician couple relationship by creating difficulty for physicians to be connected to their spouses and partners, difficulty in sharing emotions and vulnerability, difficulty trusting a physician's ability to be available to cultivate the couple relationship, and difficulty for non-medical partners to feel attracted to their medical partners. When considering participant responses, the impact of a career in medicine is consistent with Rokach and Chan (2023) who outline the definition for emotional infidelity.

Research Question 2

The second question of the current study aimed to understand the unique challenges and strengths of physician relationships. The discussion to follow will separately address the challenges and strengths of physician relationships and provide guidance for mental health clinicians treating this population in couples' therapy.

Strengths

Participants noted that being in physician relationships was shown to have the benefit of financial security. Although the specific way financial security was experience in a physician relationship varied depending on the medical partner's progress in medical training. Participants stated things such as 'high income', 'financial stability', and 'financial security' as career benefits that prove to be a strength of physician relationships. Those still in training outlined a similar phenomenon, 'future financial security', 'light at the end of the tunnel financially', and 'future job security' as benefits to pursuing a career in medicine that worked to reduce stress in the relationship. These reports are consistent with Kao et al. (2018) noting that a high income is a benefit of physician careers, and that career satisfaction among

physicians across specialties has been found to be positively associated with self-reported income. These findings are also supported by Maisel and Karney (2012) who say that in the scope of general couple satisfaction, the association between stressful life events and relationship satisfaction was stronger for those with low-SES as compared with those of higher- SES.

Other strengths of physician relationships were seen to be in the fulfilling nature of medical careers providing opportunities for 'travel', 'advocacy', and 'public service'. Physician relationships were seen to have a strength of 'high social statuses and other messages relating to positive societal views of the couple relationship. In addition, those in physician relationships noted that another strength was seen in 'increased access to medicine', 'access to specialty healthcare', and 'medical knowledge'. These experiences point to the medical partner being able to assist their non-medical partner, as well as other family members, when medical issues arise through either their personal knowledge, personal or professional relationships with other physicians, or their increased knowledge of how to navigate the medical system. These benefits have not been emphasized in the current literature at this time, and future research may need to focus on how these aspects of physician careers benefit the couple relationship.

Participants shared the need for increased communication in relationships due to the demands of a medical career, which they noted was beneficial for the couple relationship. An overwhelming number of participants outlined that 'shared activities' and 'boundaries with work' were beneficial in physician relationships. These findings support Fider et al. (2014) who outline guidance for physicians in relationships and mention that physicians should intentionally prioritize their couple relationships. Medical professionals are trained in patient interactions and many of the skills that are used at work for handling situations with patients are benefits within their couple relationships as well. Many non-medical partners bragged that their medical partner was a 'good listener', 'caring', 'compassionate', 'kind and understanding', and at times 'patient'. The idea of perseverance was also important in physician relationships and had many different meanings in the participant experiences. Some participants had

experiences of perseverance that resembled ‘survival’ or ‘pushing through’. Trainees, physicians, and their partners noted that the high stress of medical training and career work provided an ‘increased capacity for stress’ that was beneficial when dealing with conflict or crisis in the couple and family relationship. In addition, participants outlined that persevering and having patience in their relationship saw the ‘achievement’ of many goals and dreams that all partners had within the relationship.

Challenges

Financial experiences in participants were the chief difference noted between participants depending on their progress in the medical training timeline. Many participants where the medical partner was in training noted ‘financial insecurity’ or ‘financial burdens’ due to the absence of pay or being underpaid while in training. Financial stressors did not seem to cease when the medical partner finished training but mutated. Participants in this category referenced financial stressors related to ‘student loans’, ‘debt’, and ‘financial liability’ in cases of adverse patient outcomes. Mache et al. (2015) indicates that medical students and younger physicians face the increased stressors financially and are more at risk for higher levels of work-to-family conflict. Overall, speaking to literature outside physician relationships, these findings are also supported by Kelley et al. (2018) who say that for both husbands’ and wives’, financial stress were negatively associated with relationship quality. This is something that mental health clinicians can make themselves aware of when treating couples in physician relationships where the medical partner is either still in school, or recently out of training. Nonetheless, financial insecurity proved to be a relational challenge evident at all points on the training timeline.

Also, non-medical partners felt burnout because of their medical partner’s career. Medical partners and spouses often experience ‘extra burdens’, that their ‘relationship is on the backburner’, ‘spousal isolation’, must make ‘sacrifices’ that sometimes are forced rather than chosen, ‘guilt’, ‘single parenthood’, and imbalances with household participation. Stevens et al. (2001) asserts that the division of household labor did not need to be an even split between partners, but mutually agreeable. There are instances where non-medical partners report an imbalance in

household labor and sacrifices, but most notably when participants noted that these actions were forced, instead of chosen, that there was frustration within the relationship. In Stevens et al. (2001), for both men and women, satisfaction with the division of labor in housework and emotion work is a predictor of marital satisfaction (Stevens et al., 2001). Therefore, the results of this study may highlight an area for intervention among those in physician relationships. Mental health clinicians may want to place specific attention to how household labor is divided in physician relationships when assessing and treating these couples.

Research Question 3

The final research question aimed to gather recommendations from physicians and their partners on how mental health clinicians can support their relationships and advocate for systemic change for the medical system. Physicians, trainees, and their partners discussed the ways in which mental health clinicians can best support this population while providing therapeutic services, as well as areas for mental health researchers to pursue third order change and advocate for systemic change in the medical training system and organizational employment (McDowell et al., 2019). This may be achieved by 'wellness modelled as a whole', referring to mental health wellness needing to be modelled to medical trainees at the beginning of training, also incorporating 'work-life balance' and 'mental health wellness curriculum' in medical training. In addition, participants mentioned the need for an increase of examples on how this population can 'access resources' for support.

Evidenced by participant experiences in the *Career Toll* subtheme, participants felt that they did not have time to spend in beneficial things, like creating balance at home and having limited time to access mental health resources. Yet, the biggest barrier to physicians seeking mental health services is the systemic barriers in place. The American Association of Medical Colleges (AAMC) created a publication that accessing mental health care may have the consequence of having physician's privacy invaded, paying more for or unable to get malpractice insurance, fear of losing hospital privileges, and the possibility of not having their medical license renewed (AAMC, 2020). With only 18 state licensing boards, as of 2018, following the

American Disabilities Act standards for asking about mental illness, a crucial component of normalizing mental health treatment would be for medical training programs in the remaining states to remove questions from their licensing processes that are illegal and stigmatize physicians seeking mental health treatment (Jones et al., 2018). Then training facilities and employment entities can work to allow those wanting to seek these services the time to do so. Participants also shared that there are barriers to this population accessing mental health services including phrases like 'career repercussions', 'paper trails', and how being labelled with mental health diagnoses could put a physician or trainees' career in jeopardy. The responses of participants in this study are consistent with Riffel and Chen (2020) who highlight that perceived systemic stigma may work to increase mental health distress in physicians and medical trainees.

Mental health clinicians may benefit from understanding the unique challenges that this population face. Participants identified areas that mental health clinicians can work on to provide better support with this population noting the need to 'challenge stereotypes', 'understand power differentials', 'proper assessment', 'providing a safe space to vent', and to understand that many trainees and physicians may even experience an 'addiction to medicine'. In couples therapy participants outlined areas that mental health clinicians can work to support in couple and family therapy including 'intentional relationship time', 'intimacy and attraction', 'support for the non-medical spouse', 'effective communication skills', and issues surrounding the division of household and childrearing tasks. The suggestions provided by participants support Lypson et al. (2013) who provide an overview of topics that workshops can address to aid the challenges and concerns physicians experience regarding their couple relationships. In addition to the participant suggestions, identifying threats to personal relationships, tools to manage stress, and skills to remain engaged in relationships would also be beneficial in couples therapy (Lypson et al., 2013).

Mental health clinicians may want to target areas that were identified in the *Emotional Toll* subtheme. With the Buige et al. (2021) study highlighting that 63% of students in the study perceived stigma as a barrier to accessing mental healthcare, it is

not shocking that participants largely called for systemic change in the medical system. Marriage and Family therapists need to increase attention on promoting third-order change in society. Third order thinking requires therapists to expand their view of their participation with families to more intentionally include the impact of societal systems and power dynamics that play a role in our client's lives, and to heighten sociocultural awareness more effectively in our practices (McDowell et al., 2019). Currently, systemically trained therapists must turn their attention to naming injustices in the societal systems that our clients are a part of, and advocate for change in these systems to promote third order change and to provide a voice for those who have been silenced (Knudson-Martin et al., 2019). When considering the population of those in physician relationships, therapists may advocate for increased 'childcare resources for non-regular work hours such as: weekends, holidays, and nights', an increased need for 'mentorship opportunities', and more 'time off', especially for 'paternity and maternity leave' all to alleviate the stigma that physicians and their partners face when accessing therapy services. Additionally, being involved in advocacy work that targets changes to the remaining licensure boards that violate ADA regulations on not requiring physicians and physicians in training to disclose mental health diagnoses would help reduce barriers to this population seeking appropriate mental health care.

Clinical Implications

The results of this study can be used to help support the mental health and relational support desired by medical professionals and their partners. Based on the findings of this study, there are clear implications for mental health professionals, especially systemically trained therapists, to assist in strengthening the couple relationship for this population. By helping address the challenges of being in a physician relationship, the hope is to improve relationship satisfaction with the potential added benefit that improved relationship satisfaction will reduce high psychological distress reported by physicians. The following section will be discussed in terms of tasks mental health clinicians can pursue (i.e., education and competency considerations), then transition to addressing treatment implications that can work to

create change within this population, and finally by addressing ways that mental health clinicians can work to create third-order change.

The first area therapists can address is competency for working with medical providers and their families. Several participants described experiences with mental health providers in which therapists were perceived as incompetent. These responses alluded to experiences of ineffective rapport building of the therapeutic relationship. Although physicians and trainees may experience stigma from their organizations that serve as a barrier for accessing mental healthcare, experiencing perceived intimidation from mental health clinicians, or feeling stereotyped and misunderstood by therapists may work to exacerbate unwillingness to seek therapeutic services in this population. Mental health clinicians may want to pursue training in medical family therapy to better understand the systems that are impacting their physician clients, which can help clinicians develop more sociocultural attunement in their practice. Socioculturally attuned practice recognizes inequitable social structures and resources while seeking to apprehend each client's unique confluence of social identities and being aware that identities and power positions are fluid across time and place as well as influenced by historical legacies of injustice (Knudson-Martin et al., 2019). Socioculturally attuned practice helps us expand our abilities to conceptualize and understand the impact of power dynamics and societal systems on what is presented in therapy and allows family therapists to tailor interventions in ways that promote just solutions to presenting problems (Knudson-Martin et al., 2019).

Another area that impacts physicians and their partners' attending therapy has to do with scheduling limitations. There is an overwhelming number of time related demands of a medical career that physicians, trainees, and their partners experience in physician relationships, scheduling concerns are prevalent in participant responses, and call for clinicians to consider scheduling flexibility within reason for this population. Mental health clinicians can consider the use of teletherapy as a way to increase access therapeutic services for those in physician relationships seeking couples' therapy. This could eliminate time that medical partners need to set aside for couples therapy by eliminating the need to commute to and from a therapist's office to

seek services. Medical Family Therapists can advocate for the continued integration of onsite mental health services in medical settings, which would increase the ease of access to services for physicians and their partners.

Assessment. The results of this study stress the importance of couple relationships, aspects of successful relationships, and how to achieve a work-life balance. Considering work-to-family conflict, medical students and physicians reported experiencing PTSD, depression, anxiety, fatigue and burnout, disengagement from their couple relationships, and the pressure to perform while non-medical partners experienced making sacrifices, burnout, feeling ignored, unimportant, and frustrated. In addition, the reports that allude to a career in medicine being similar to having a 'mistress', are all themes that reveal a number of areas that therapists should consider when assessing clients in this population. Given previous literature highlighting the high prevalence of physician suicide and psychological distress, safety and risk assessments should always be conducted. Administering the Work-Family Conflict Scale proposed by Carlson, Kacmar, and Williams (2000) regarding both work-to-family and family-to-work conflict could be the first step to assess how a career in medicine is impacting physicians and their partners in the couple relationship.

Treatment Recommendations

Based on the emergence of the *Career Toll* theme, I recommend implementing relaxation and mindfulness-based interventions with medical students and physicians aimed at reducing anxiety. Topics therapists can explore with these interventions can include awareness of thoughts and feelings, perceptual biases, and filters, dealing with pleasant and unpleasant events, managing conflict, reflecting on meaningful experiences in practice, setting boundaries, examining attraction to patients, exploring self-care, being with suffering, and examining end-of-life care (Wiederhold et al., 2018). Therapists should attune to contextual factors (i.e., race, gender, medical specialty) when treating physicians to tailor interventions and avoid a 'one size fits all' lens of therapy.

In couples therapy, therapists can focus on an integrated approach of the Gottman method and Emotionally Focused Therapy pioneered by Sue Johnson that was posited by David (2015). The aim of the Gottman approach is designed to help couples deepen their friendship, build their trust, strengthen their conflict management, and create shared meaning and purpose in their relationships (Gottman, 2011). The goal of EFT is to help couples curtail these cycles of negative interaction, become more responsive to their attachment needs, and establish a more secure bond in their relationship (Johnson, 2013). Integrating these two approaches results in the following five stages of treatment: (1) alliance/assessment, (2) stabilization, (3) enhancement, (4) conflict management, and (5) integration (David, 2015).

The alliance/assessment phase concentrates on establishing a solid alliance with the couple and conducting a thorough assessment of their relationship (David, 2015). At this phase in treatment, considering the themes *Career Toll* and *Relation*al *Stressors*, therapists can focus on the assessment measures relating to work-to-family conflict to better understand how a physician's career may be impacting the couple relationship. The stabilization phase works to stabilize the conflict in the couple's relationship so they can have greater access to one another's emotional needs (David, 2015). This phase of treatment can focus on implementing communication skills that those in physician relationships outlined as necessary for the efficacy of their relationships, highlight places in which boundaries between work and home life can be implemented, or any areas that emerged in the *Recipe for Relational Success* theme. Once emotional access is accomplished, the next phase is enhancement in which the therapist works to enhance closeness in the relationship so the partners can become more secure and responsive to one another (David, 2015). This is where the therapist can focus on the experiences outlined in the *Medicine, a Tempting Mistress* and *Partner Burnout* subtheme of this study to help those in physician relationships foster a strong foundation for intimacy and connection in the relationship. The conflict management phase builds on the couple's enhanced closeness, and treatment shifts to their unresolvable and resolvable differences so that the partners can more effectively manage their conflict with one another (David, 2015). This will be important for

therapists to cover as those in physician relationships face stressors from larger systems that physicians are a part of in society, especially those that emerged in the *Medical Systemic Change* subtheme and may be unresolvable within the relationship. Lastly, the ending of therapy concentrates on reinforcing the positive changes the partners have made in themselves and in their relationship (David, 2015).

Third Order Change

Beyond traditional therapy practices, therapists are encouraged to consider ways in which they can be advocates for this population in increasing attention to mental health needs and barriers to care. There was an overwhelming response by participants of the need for mental health and wellness awareness within this population. This is not shocking when considering previous literature from Anderson (2019) and Dyrbye et al. (2011) who claim that the physician suicide rate is more than twice the rate of the general population and that psychological distress is common among medical students and physicians, respectively. Although some participants highlighted that the medical system has worked to make some changes to benefit trainees and physicians' well-being, it is seemingly not being implemented effectively at this point in time. It was clear in participant accounts that medical professionals may harbor fear of seeking out mental health treatment due to a history in the medical training system, and employment of these entities keeping tabs on certain diagnoses and impacting the way physicians view mental healthcare with fear. Given the findings of Jones et al. (2018), a majority of state medical licensing boards do not comply with following the guidelines of mental health questions that they ask physicians to complete when apply or renewing a medical license. A task for mental health clinicians to advocate for third order change would be to challenge medical boards to follow the American Disabilities Act in the licensing procedures. In the meantime, treating therapist should proceed with caution when diagnosing mental health disorders in this population. Having conversations with clients regarding their fears and potential career ramifications of receiving a diagnosis is imperative to validating the concerns physicians and their partners have when seeking help. The use of insurance may lead to unintentional disclosures of mental health disorders to

employers, and mental health clinicians should familiarize themselves with HIPAA privacy rules to determine what information is actually private and protected from employers. Nonetheless, mental health clinicians should not ignore mental health symptoms of physicians or fail to treat a mental health diagnosis of individuals in this population, because not treating these clients could result in harm to the client, which is unethical practice.

Mental health clinicians can advocate for third order change in the medical system by advocating for paid parental leave for physicians. According to Bullinger (2019), California's expansion of paid family leave policies from six to twelve weeks has improved maternal employment outcomes and wages, while placing little to no financial burdens on employers (Bullinger, 2019). In 2019, the AMA also produced a publication reviewing childbearing and family leave policies at 15 graduate medical education institutions. Childbearing leave was defined as a leave of absence taken by birth mothers, while family leave was defined as additional leave provided to birth mothers after childbearing leave or to fathers or nonbirth parents with a new child (AMA, 2019). Just under half of the institutions (seven out of fifteen) provided paid childbearing leave with an average duration of 5.7 weeks, while the average paid duration of childbearing leave is 6.6 weeks (AMA, 2019). Seven of the programs also lacked provisions beyond sick or state-funded disability leave for birth mothers or had policies on paid family leave for nonbirth parents (AMA, 2019). Female medical residents get less paid maternity leave than physicians at other points in their career, and with the average age of a female medical resident in the United States being 28 years old while the average age at which a woman has a child is 26 years old, it is a possibility that female medical residents need the most support for paid maternity leave (AMA, 2019). The reality of the injustices in the medical system is pressuring female medical residents to choose between their residency education and starting a family at a developmentally appropriate stage in their life. Therefore, this is an area that is paramount for mental health clinicians to name the injustices of, noting the benefits for employment entities to extended parental leaves that have already been seen in this country.

Another area in which mental health clinicians may be aware of to promote third order change within the medical system is the need for advocacy surrounding the prevalence of 24-hour continuous shifts in medical residency, and upwards of 80-hour work weeks. According to Weiss et al. (2016) medical residents are allowed a maximum hours of work per week to be averaged at 80 hours over four weeks, 16-hour continuous shifts for resident interns, and as residents advance, they are allowed to work upwards of 28 hours continuously, but not receive new patients after the initial 24 hours of their shift (Weiss et al., 2016). In addition, medical residents are allowed at a minimum of 24 hours off-duty within a 7-day period, averaged over 4 weeks (Weiss et al., 2016). These alarming demands for work hours are related to adverse outcomes with patients, as well as overall negative aspects of well-being in medical residents. Extended-duration work shifts are associated with adverse effects on patient safety, such as fatigue related significant medical errors and preventable adverse events, including those resulting in fatalities (Barger et al., 2006). At times when residents experience five or more extended-duration shifts in a month, they are significantly more likely to fall asleep during surgeries, examining patients, and during rounds (Barger et al., 2006). In addition to the risk of workplace errors being elevated due to the presence of extended-duration shifts, resident well-being is also impacted. Extended-duration shifts adversely affect mood of medical trainees, adversely affect cognitive functioning, and have been associated with physical risk to medical trainees such as exposure to blood-borne pathogens and motor vehicle accidents (Weiss et al., 2016). I urge mental health clinicians to be involved in advocacy efforts of healthy limits on work hours for medical residents, not only to alleviate the psychological distress that physicians may face due to sleep deprivation, but to create a safer healthcare environment for patients seeking care.

These are a few areas that mental health clinicians can target for advocacy increase the quality-of-care patients are receiving, and the quality of life that physicians are experiencing. However, needs within this population are do not end there. Mental health clinicians can be advocating for a myriad of other issues that are a need within this population of interest. Many participants within this study noted a

need for consistent and reliable childcare coverage for physicians who are on call. This need may be exacerbated in households where physicians may be single parents and may find experience increased difficulty finding childcare if they are called to the hospital in the middle of the night, and do not have an additional partner who would be able to care for their children. Participants within this study also shared that they felt abandoned after experiencing an adverse patient outcome, so mental health clinicians could focus advocacy to efforts to partner with hospital systems to provide mental health support for physicians who experience trauma during their shifts or adverse patient experiences. Scholars should focus academic attention to this population to understand uncover more areas of injustice within the medical system, so that mental health clinicians can focus advocacy efforts to alleviate harsh power dynamics within the societal systems that their physician clients and their partners may find themselves in.

Limitations

As with all research, there are limitations present in this study that must be discussed. The most notable limitation of this study would be the sampling method taken. Convenience sampling was used in this study design due to the cost and time effective nature of this sampling method. In addition, using contacts at southwestern medical schools and university sponsored hospitals allowed for snowball recruitment. This study was also disseminated on many social media pages that had members from across the United States. Because there was no geographic data collected from participants it is unknown where this sample is geographically concentrated. Because of the focus of recruitment on one specific southwestern university medical school and university sponsored hospital, it is likely that many participants were localized to a singular mid-sized city in the southwestern United States. The aim of qualitative studies is to focus in depth on smaller samples (Bengtsson, 2016), therefore the aim of this study was not to be widely generalizable to the population, and further research would benefit from efforts to gather a sample intentionally aimed at recruiting across the country. In addition, a university sponsored hospital and medical school used for the primary emphasis of recruitment may be more focused on promoting student and

trainee wellness, providing differences in responses provided by the sample and the entire population of interest.

Second, as is common in qualitative research, a small sample size was collected. Although this study aimed to garner a sample where at least half of the participants had one minority identity (given the demographics of physicians in the U.S., female physicians were considered a minority identity), which was achieved, the sample can be seen to be identifying as predominately white (80%) and heterosexual (88.6%). In addition, the study did not receive any responses from participants identifying as a gender minority. Given the homogeneity of the racial and gender makeup of the sample, the generalizability of this research may be limited. Further research would benefit from targeting racial and gender minorities within this population. Given the larger systemic discrimination members of these marginalized communities face, it may be even more pressing to understand how being in a physician relationship is impacted.

Third, this study recruited both medical and non-medical partners across all points in the medical training process (i.e., student, resident, fellow, attending physician). Because I found no literature supporting any differences between groups across the training timeline, and after careful consideration with my thesis committee, it was decided that this study would be inclusive of those at any point in the training timeline. The findings of this study did not identify any major thematic differences in responses of participants based on their progress through training. The only minor differences in participant experiences were in the financial security and insecurity subthemes. Medical trainees, their partners, attending physicians, and their partners noted high income as a benefit to a medical career. However, trainees more often shared a "light at the end of the tunnel" experience, meaning that although they may not be seeing an income at this point in time, or a drastically smaller income, the future financial status is seen as a benefit. When considering financial insecurity, participants from all groups shared experiences of financial insecurity. Attending physicians shared more experiences related to financial liability, and student loan repayment burdens, while medical trainees shared lower incomes, or burdens related

to living off of student loans while in school. Because this study found no major differences between groups, it does not mean that there is an absence of differences between the participants across the training timeline. Most attending physicians in this sample (9) were female, most partners of attending physicians in this sample (5) were female, most medical trainees in this sample (9) were male, and all partners of medical trainees in this sample (7) were female. Given the noticeable differences in gender breakdown across groups, there is a limitation within this sample. Future studies could work to have better balance between gender demographics within each group. Including participants at all stages of the training timeline may limit the generalizability, reliability, or validity of the results.

Inherent to conducting research is the potential for researcher bias to impact the study, which could be considered a limitation to the study. The entirety of the data analysis process was filtered through my own biases, which is also reflected in the nature of the research questions and literature that was presented for review. Steps were taken to address this limitation of the current study and included: memo writing and external audits with the chair of my thesis committee. Through these actions, this data can be presented as authentic accounts that are based in the participant data.

Future Research

Further research considering the relational components that could be incorporated in wellness and work-life balance curriculum during medical training should be examined through a systemic lens. The literature review highlighted that there are already instances of workshops for medical trainees promoting many of these topics within the system (Lypson et al., 2013). While increased psychoeducation and support through workshops might be beneficial to physicians and physicians in training, research has yet to test the effectiveness of these practices. Increased attention should be given to evaluate the effectiveness of these programs, and how many training facilities are implementing effective wellness curriculum. Specifically, Marriage and Family Therapy researchers are well-equipped to design and analyze studies with systemic lenses. Throughout the literature review, there were little to no occurrences of studies that included any relational components to understand the

complex web of feedback that can contribute to physician psychological distress. Much of the research available is often one-sided, most commonly accounting for the responses of physicians in isolation from the perspective of medical partners. This does little to understand how negative interactional cycles are maintained.

It would also be extremely beneficial to expand on the prevalence of a 'second victim phenomena' looking at the implications of trauma and death witnessed by medical trainees and physicians. This phenomenon was highlighted in an in-vivo quote referring to instances where physicians could become a second victim when there is an occurrence of an adverse patient outcome. Future attention should be given to highlight the prevalence of a phenomena such as this, understand the impact of prolonged trauma exposure as a byproduct of medical practice, and work to highlight if there are ways for mental health clinicians to advocate to support physicians in these instances.

Additionally, some participants shared experiences highlighting potential competency dilemmas in mental health clinicians when seeking therapeutic services. Future research should focus on attitudes of mental health clinician competency treating physician relationships from the perspectives of both mental health clinicians, and those in medicine or physician relationships as the clients. Future research could better understand if participants referencing perceptions of a lack of clinician competency when treating this population are outliers, or if there is a larger scale competency issue with mental health clinicians treating those within this population.

Conclusion

This study examined the experiences of medical trainees, attending physicians, and their partners. The findings of this study elaborate on topics already highlighted in previous literature; medical trainees and physicians experience harmful amount of work/school demands that make it difficult to maintain relationships and individual health and wellness. My hope was to address gaps in previous literature, of which many are antiquated and do little to highlight rich and thick experiences of physicians and their partners. In addition, I hoped to add to the current body of literature, a systemic mental health research lens given my background as a student Marriage and

Family Therapist. I remain eager to disseminate the findings of this research study to help promote clinician competency when assisting those in physician relationships in therapeutic services. I hope that larger organizations responsible for training and employing physicians can see the value of this research to help support the next generation of medical professionals in this nation and end a seeming epidemic of physicians in this country with distressing mental health.

This study has developed with me as I journeyed through a master's program. I am extremely thankful for the participants who challenged the system to speak out to initiate change, my thesis chair for providing me with the tools and support to succeed, my thesis committee for helping me develop personally and professionally in the scope of this topic, and the liaisons who supported my work and helped in recruitment. I am grateful for the opportunity to shine a light on a population who have been on the front lines of our communities for the past 3 years battling one of the gravest and mysterious illnesses of our generation. Just like the pandemic they've been battling, physicians in our country are dismissed and overlooked, as well as wielding a potential for catastrophic damage. The case of *Dr. Death* should never have happened. The way to prevent more instances like it, shine attention to this population, and not operate under the assumption that degrees equate to health. After all, physicians hold our lives in their hands.

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APPENDIX A
SURVEY

Demographic Information
1. What is your age? _____
2. What is your racial identity? ☐ White ☐ African American/Black ☐ Mexican American/Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaska Native ☐ Middle Eastern ☐ Biracial ☐ Other
3. What is your gender identity? ☐ Female ☐ Male ☐ Transgender female ☐ Transgender male ☐ Nonbinary ☐ Gender Fluid ☐ Other
4. When is your sexual orientation? ☐ Heterosexual ☐ Bisexual ☐ Lesbian ☐ Gay ☐ Other
5. What is your current relationship status? ☐ Dating ☐ Cohabitating ☐ Engaged to be married ☐ Married

☐ Remarried
6. How long have you been in your current relationship? _____
7. When did your relationship start in terms of the medical training timeline? ☐ Before medical school ☐ During medical school ☐ During residency/fellowship ☐ After the completion of residency
8. Do you have children? ☐ Yes: (Skip logic questions) IF YES how many children ☐ No
9. What is the highest level of education you have attained or your current educational level if you are not a physician or physician-in-training? ☐ Less than a high school diploma/GED ☐ High school diploma/GED ☐ Some college ☐ Associates Degree ☐ Bachelor's Degree ☐ Some graduate or professional schooling ☐ Graduate or professional degree ☐ I am a physician or physician in training
10. What is your yearly household income? $_____
11. If you are a medical professional (or in-training to be one) or a partner of a medical professional (or one in training)? Which of the following statements best describe your medical professional relationship (select all that apply)? ☐ I am pursuing a career in medicine ☐ I am currently in a career in medicine ☐ I am a partner of someone who pursuing a career in medicine ☐ I am a partner of someone who is pursuing a career in medicine
12. What point are you or your partner at in your/their career?

☐ Medical Student ☐ Residency/Fellowship ☐ Attending Physician
13. How many times have you moved due to you or your partner's medical training and career? _____
14. To the best of your knowledge, has your partner participated in this survey? ☐ Yes ☐ No
15. To the best of your knowledge, do you have a personal relationship with the researcher (Kathryn Wagner) involved in this study? ☐ Yes ☐ No

Questions about work-to-family conflict* *Work-Family Conflicts Scale*		
For each item, please indicate whether you agree with the following questions related to how the work/study life of medical professionals (or those pursuing a career in medicine) interferes with family life.	Yes	No
1. A medical career keeps myself or my partner from family activities more than I like.		
2. The time one must devote to a medical career keeps one from participating equally in household responsibilities and activities.		
3. Those in the medical profession miss family activities due to the amount of time they must spend on work responsibilities.		
4. Having a career in medicine makes one too frazzled to participate in family activities/responsibilities when they get home from work.		

5. A career in medicine is emotionally draining and when one gets home from work, it prevents them from contributing to their family.		
6. Due to all the pressures at work, medical professionals come home and are too stressed to do the things they enjoy.		
7. The problem-solving behaviors medical professionals use in their job are not effective in resolving problems at home.		
8. Behavior that is effective and necessary for medical professionals at work would be counterproductive at home.		
9. The behaviors medical professionals perform that make them effective at work do not help them to be a better parent and/or spouse/partner.		

*Questions 1-3 measure time-based work interference with family, questions 4-6 measure strain-based work interference with family and questions 7-9 measure behavior-based work interferences with family

Questions about couple satisfaction						
Please indicate how much you agree with the following statements	Extremely Unsatisfied	Moderately Unsatisfied	Slightly Unsatisfied	Slightly Satisfied	Moderately Satisfied	Extremely Satisfied
I am satisfied in my relationship.	0	1	2	3	4	5
I feel that the demands of a careers in medicine help maintain a satisfying couple relationship.	0	1	2	3	4	5

Questions about unique experiences in physician relationships
Please describe, in as much detail as possible, 2 or more challenges that you have experienced in a physician relationship that relationships outside the medical community may not encounter.
Please describe, in as much detail as possible, 2 or more benefits that you have experienced in a physician relationship that relationships outside the medical community may not encounter.
Please describe, in as much detail as possible, how a career in medicine affects you or your partner's ability to be an active participant in the romantic relationship. (For example, describe how work stress impacts a medical professional's participation in household chores or connecting emotionally in the relationship).
Please describe, in as much detail as possible, one or more coping strategies that you or your partner have used to combat the challenges faced in your physician relationship that stem from how work/school stress of a medical career interferes in the relationship.

Recommendations for change
Please describe, in as much detail as possible, one or more factors related to being in a physician relationship that you believe mental health professionals should know to aid in support physician relationships.
Please highlight one or more recommendation(s) that you feel should be taken under consideration by medical schools, medical training facilities, or hospitals/employers to better support medical students, residents, fellows, and attending physicians in their relationships and/or family life.

Please share two or more pieces of advice you would give to those beginning a physician relationship, or those in relationships at the beginning of pursuing a medical career.