Original Research Paper

Being the spouse of a general practitioner

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ABSTRACT

Background: GPs need a stable emotional platform from which to practise. One of the contributors to this platform is the doctor's spouse. There is a need to better understand the impact of general practice on the lives of spouses. Gaining better understanding of this may improve both personal relationships and the quality of the doctor-patient interaction.

Objective: To understand what it is like to be the spouse of a GP.

Method: Working from a New Zealand general practice, a letter was sent to 28 spouses of GPs, chosen at random from the list of members of the Royal New Zealand College of General Practitioners (RNZCGP). The letter explained the project and asked for a reply of up to 300 words, in any format, explaining "the nature of being the spouse of a general practitioner", from the respondent's perspective. Written narratives sent in response were analysed qualitatively for important and recurrent themes.

Results: Thirteen responses were returned from spouses who had spent between 10 and 35 years married to a GP. Many respondents referred to writing their narrative as a cathartic experience in itself. Positive aspects of their life as the spouse of a GP were documented in most replies, yet most also revealed deep regrets at the personal and unanticipated losses that were attributed to the career choice of their partners. Themes identified from the responses included: the much greater burden of responsibility which fell on the spouse for care of children, the GP, and support of the practice itself; suppression or realignment of the spouse's own career and associated tensions; the effect of expectations made of them by the communities in which they found themselves living.

Conclusions: Given the importance of relationship issues to the psychological wellbeing of doctors, this study provided insights on the impact that general practice may have on spouses, and on the relationship with their doctor-partner. There are aspects of being the spouse of a GP that it is important to make explicit, so that young doctors are better prepared for the challenges they and their partners face in adopting a career in general practice.

KEY POINTS

- To cope with the burdens of medical practice GPs need a "stable platform" from which to practice. Their spouses form an important part of this
- General practice affected the ability of GP spouses to provide this base. They shouldered greater family responsibilities, frustration of their own careers and community expectations of them, as well as feeling part of something important
- Young doctors should be prepared for the challenges they and their partners face in a career as a GP

INTRODUCTION

Medicine involves the exposure of doctors to complex personal processes and events, in a quantity that is largely outside the "normal" human experience. These include exposure to others' pain and suffering, fears, anxieties, depressions and sexuality, as well as to death and the dying process.[1] To cope with these burdens

and remain an effective agent of healing for patients, doctors need a "stable platform" from which to function. This platform of emotional stability is contributed to by the doctor's marriage, which is recognised as providing a secure base, intimacy, attachment and connectedness. It acts as a buffer against depression and low self-esteem, and contributes to wellbeing.[2]

Much of the research available has focused on suicide, divorce and substance abuse rates as they pertain to doctors and the general population;[3,4,5]on sources of conflict within medical marriages[6] that highlight differences in need for intimacy, perceptions of problems, and in communication styles; and on stress among GPs and their spouses.[7] We still lack an understanding of the way in which the practice of medicine impacts on the spouses of doctors and on their families.

In this paper we examine the experience of being the spouse of a GP, in the belief that not only are the spouses affected by the nature of general practice, but that their ability to nurture doctors and contribute to their stable platforms will likewise be affected. This research has implications for the preparation of young doctors for general practice, and is of special relevance to those considering rural practice.

METHOD

Working from W.C.'s practice in Feilding, a small town (population 15,000) in rural New Zealand, we selected spouses to contact by dropping a pencil on to the full list of members of the RNZCGP. This is a list of all living College members, including retired GPs. Twenty eight letters were sent, as we decided that this would provide a response rate of about 15, a number felt to be sufficient to identify major themes in the way spouses felt about their lives as partners of GPs. The letter was addressed to "The spouse of Dr ...." and asked the recipients to respond by sending back a letter of about 300 words.

Working independently at first, but checking, discussing and justifying the analysis with each other at each stage, the authors examined each returned script, classifying every part of the text of respondents' letters into categories arising from the content. Categories were organised under headings attempting to do justice to both specific content and the overall impression conveyed by the letter, using a process of consensus between the investigators.

RESULTS

Thirteen replies were received, including one from a retired GP, whose spouse had no active experience of being a GP's wife as they had married after retirement.

Of the remainder, 10 respondents were female and three were male, including a male GP spouse of a female GP. No female GPs responded as spouses.

The ways in which general practice impacted on spouses were identified from the data as:

- The impact on family life
- The impact on spouse's careers
- The effect of community expectations

Impact on family life

Most spouses wrote that they had not expected the unequal extent to which they

would have to shoulder responsibility for the care of their family, while recognising this was an inevitable consequence of their partners' professions:

"Inevitably, patients came first, family second _ a bitter pill for me to swallow." (retired female spouse, letter 12);

" My life changed with the birth of our first child. I became the partner at home caring for our child. I remember crying after he had dropped our new son and I home in his "lunch" break to an empty, slightly tidied house then rushed back to his waiting patients. Could I really be jealous of these people?" (urban female spouse, letter 10)

Respondents were keenly aware of the conflicting demands of patients and family that doctors had to balance. They felt that they and their children often lost out to patients when simultaneous claims on GPs' time arose. One retired spouse (letter 7) illustrated this:

"I recall one Easter, three of our five children were home from the boarding schools they attended for their secondary education, and we had picnics and various family activities planned. We also had three maternity cases overdue; we all kept hoping but the children went back to school with the three ladies still overdue and our picnics in the freezer. Families had to be understanding and in most cases they were."

Others commented:

"Patients' health needs override many mundane but necessary family interactions and activities. That responsibility cannot be put `on hold'... Real effort required to prevent `the practice' gobbling up every waking moment. Spouse often under pressure and this is absorbed by the family." (rural female, letter 9)

"Our family time is often invaded by after hours work, obstetrics and other medical work. Solo parenting is not what I married my husband for." (urban female, letter 11).

Mostly, respondents commented negatively on the demands patients placed on their families:

"I particularly resented the early morning and night time calls of the few patients who had our phone number and I hated the interruptions during the night when he would have to leave." (letter 10),

but deviant case analysis showed that this was not always the case:

"I'm not resentful of the demands patients make of [my husband] _ I think usually they're quite reasonable. Only about every three years does someone really annoy me. I more often feel upset or sad or concerned, or pleased about or for them." (urban female, letter 8)

The nature of general practice impacted directly on respondents' lives, as well as indirectly, through its influence on their partners, as summed up by one spouse with experience of both rural and urban general practice (letter 1):

"I think his being a GP has directly and indirectly caused a lot of stress in our relationship."

This was demonstrated in physical outcomes, such as:

"sleeplessness, telephone calls [or waiting for the phone to ring!], on-call pressures, stress-related restlessness, concern when spouse is out on a call, especially late night country driving" (letter 9),

emotional outcomes:

"Loneliness, a real factor when the family was very young" (letter 1),

and social outcomes:

"many people value your company primarily because of your spouse _ can be cloying and best avoided. Limits your pool of potential friendships _ can make you wary and fed-up" (letter 9).

Conflict with spouse's career

Suppression or realignment of the spouses' careers and the associated conflict between their own needs and those of their families was commented on in over half of the replies. The letters showed spouses at risk of being engulfed by their GP partners' careers:

"I've always found great difficulty holding on to and actioning my own truths and ambitions." (rural female spouse, letter 6)

"They say if you can't beat `em, join `em. This was my greatest mistake! … I dumped my job and became his receptionist. Our relationship deteriorated …. I felt as though I had been living on another planet; my life had been so different in the world of business and I do believe that was when I first started to doubt my own self worth. This was a profession but not only that _ a vocation that I was up against and anything I was doing could never and would never have that same importance." (letter 10)

Some recognised that their own needs could only be met by deliberately avoiding involvement in their partner's practice:

"The first two years in [rural town] were difficult as I established, or tried to, a separate identity from my husband, eg, I wasn't a therapist for the women to come and talk to … I have a separate career from my husband." (letter 1);

"Over the years I have developed quite a separate and independent life, and this is probably a good thing." (letter 8);

"… but I feel I have now created my own niche in life and can feel proud of my own achievements once again." (letter 10).

Male respondents (who included a male GP) also drew comparisons and contrasts between their own careers and their spouses' but did not convey any sense of being overwhelmed by their partners' occupation:

"We both job share _ working about half time each." (letter 4);

"As two professional people in our respective careers life was full and interesting. We both learnt new skills. For me I learnt how to wake up in the middle of the night and make intelligible conversation on the phone with a patient, while [my wife] was out on call. [She] learnt to … appreciate different aspects of my career." (letter 2)

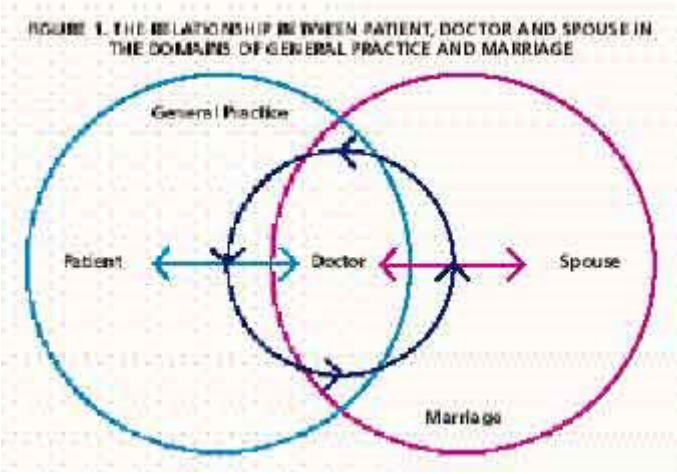
The careers of both the writer of letter 2 and his wife had changed recently, and our respondent recognised that his wife *"… has made family a greater priority than*

career at this time."

Some respondents expressed mixed feelings about the career path they had chosen:

"There is no way that I am going to juggle children, household management with the constraints that another job would entail, especially with organising paid care….Sometimes I feel regretful that I'm not more `important' in the world, and my feminist beliefs seem right out of kilter with my life. But I ***do*** *believe in children having a loving caregiver, and it might as well be me as a succession of other women."* (letter 8);

"I do somewhat regret not pursuing a career myself…I see my main contribution outside the family as the supportive role I played to my husband in his work." (retired rural spouse, letter 12)



Community expectations of the spouse of a GP

Spouses from both rural and urban settings commented on the roles imposed on them by the community in which they lived.

"In a small community our name is known by a lot of people and I sense a certain expectation on me, of how I `should' be, what I `should' wear, do in the community etc." (letter 6);

"people have strong views on the role you should play." (letter 9);

"They intertwine you so closely with `the practice' that you are constantly working to create your own identity. Often called `Dr Mrs …'. One is forced to become a moral pillar of society, if you want to or not _ quite a burden when one is still young." (letter 1)

In the face of strongly felt community expectations, most respondents expressed their need to forge a separate identity for themselves. Sometimes this involved keeping their maiden name:

"I'm glad I've kept my maiden name because it's helped give me some privacy and allowed me to impress other people as myself rather than as `Dr's wife'." (letter 8)

Some respondents were aware that their acquaintances and friends would also be patients of their GP partner, and that this often involved intimate contact:

"I think the most difficult thing about being the wife of a doctor [as opposed to being the wife of another occupation, or the husband of a doctor] is the more public profile one has, and the more interest other women have in you. We've lived in the same area and [my husband] has been in the same practice ever since we married so I've met lots of women who've had [him] as their doctor, or who've got friends who know [him]. Sometimes they know [him] better than me. And as these are the childbearing years they generally know one another rather more intimately than most women know their friends' husbands!" (letter 8);

"When my husband is on call for other GPs and friends of mine phone for medical help and their call has been diverted to our home. An embarrassing situation for me as I do not wish to enquire about their problem when fielding such calls." (letter 11)

Insight into the nature of general practice

The replies showed that spouses were not only aware of the impact of general practice on themselves and their families, but also of its effect on their doctor partner. They appreciated the pressures and demands under which GPs work, although they were not asked about this when we requested their participation in the study. One spouse wrote:

"I really try to consider what his day has been like and understand the enormous stresses and strains of the job." (letter 10)

Several expressed a pride in the work that occupied their partners:

"I am also immensely proud of my GP … and think it's great that he is able to contribute to society in this manner" (letter 10),

a pride that impacted positively on their relationship:

"Because [my husband] is in a caring profession, and people seem to think he's good at it, he is generally well thought of…. it makes me feel good about his work. (I think it is a worthwhile job too!)" (letter 8).

However, not all responses were so positive. One partner of a retired GP, reflecting on the end results of several decades of general practice work, was more ambivalent:

"Being a dedicated doctor, he was unable to turn patients away or give half measure. Eventually, the continued workload and stress took its toll with chronic illness forcing his retirement. Resentment still bubbles to the surface if I see my husband struggling either mentally or physically, as the legacy of his life as a GP persists." (letter 7)

DISCUSSION

This study explored the experiences of a small group of spouses of GPs, using written narratives with an open prompt. This technique reduced the researchers' influence on responses, but was demanding on the respondents themselves. The extent of this demand was reflected in the relatively poor response rate. However, the consistency of emergent themes was such that it is likely that these results have high transferability to the spouses of other GPs.

In our preparation of young doctors for general practice we pay attention to the development of self-awareness and an understanding of the life cycle, in order to bring trainees closer to an understanding of the reality of their patients' illnesses. We as doctors have our own life cycles, and these intimately involve our spouses who, from this research, are at risk of having their expressions of self consumed by our lives in general practice. In 1991 Karol London, wife of a rural New Zealand GP wrote "A marriage is not working when one partner is never wholly available to the other, is always at the bottom of the other's list of priorities, is expected to love support and care for the other without reciprocity, and [while one] is the recipient of constant affirmation in the form of patient gratitude and admiration while the other is perceived as simply doing her duty".[8] The current study demonstrates the potential risk general practice poses to a marriage.

We have shown how the spouse of a doctor is drawn into the stressors that impinge

on their partner's life, and those stressors, such as the price paid for being "Mrs Dr So and So", that are peculiar to spouses themselves. With the burden of responsibility for raising a young family, and the suppression or realignment of their own careers being a reality for most spouses in this study, the ability of a doctor's spouse to contribute to the stable platform is called into question.

From the data, we developed a model of the levels of interaction between doctors, spouses and patients, illustrated in Figure 1.

The quest for realistic solutions to the issues raised starts with an acknowledgement of the special nature of the GP-spouse relationship. We cannot significantly change the nature of general practice with its burdens and responsibilities of patient care. We can, however, bear witness to the pressures placed upon both partners, and respond by putting in place support systems that minimise them.

These will vary with life cycle and individual circumstances, but should seek to maximise the amount and quality of time that doctors and spouses can spend both together and apart, in activities that meet their particular needs. Not all spouses wish to work outside the home or to distance themselves from the demands of child rearing, but if these are relevant issues, they need to be discussed and facilitated. The pressures of living in a community need to be addressed, recognising that the urban environment does not always provide anonymity, nor the rural community, support. The concept of self-sacrifice seems inevitable for both doctors and their spouses, but must be a matter of degree, negotiated and monitored to minimise its intrusion into their relationship.

CONCLUSION

To meet our patients' needs, we as doctors must function from a stable platform where our own needs are recognised and met. The burden of providing this platform falls heavily on our spouses, and yet general practice itself places demands on spouses that limit their ability to do this. We need to recognise this and move to prevent a cycle of repetition where each new generation of doctors is condemned to repeat the experiences of the past.

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