How Can We as Physicians Care for Our Own Families?

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What follows was first a personal attempt to deal with anxieties arising over how my chosen profession might be affecting my wife and two young children. This concern was further fueled by discussions with my father and father-in-law, both successful in their professions (educator and businessman), who in their mid-50s' reflections expressed regrets over the time and concern given over to their jobs at the expense of their families. I am not foolish enough to think that I will make no mistakes or have no regrets but feel that I may at least minimize them and their toll on my family.

That our job and how we handle it affect us is undisputable. The exact toll varies depending on the individual. "All stages of our lives, from training to building a practice and eventually responding to patient, community, and administrative demands, seem to be overscheduled."[1] This pattern develops in the early years, as young physicians are often motivated, if not compelled, to work long and hard hours during internship, residency, and the early years of practice. There is the first flush of enthusiasm for medicine; also a desire to be established successfully for financial reasons as well as for reasons of personal pride.[2]

Although perhaps not generalizable, findings in an Australian study are interesting in that work-related sources (failure of treatment and diagnostic difficulties) made up the two greatest sources of anxiety for those physicians, with family-related issues placing third (impact of work on family life) and seventh (looking after colleagues and family).[3]

Malpractice, its threat, and the effects of litigation constitute the one major issue that differentiates the practice of medicine from other professions. In two studies of physicians' self-reported reactions to litigation,[4,5] two symptomatic complexes emerged: a depressive disorder in which physicians acknowledged a dysphoric mood with at least four additional symptoms from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) for communicative or affective disorders, and a second symptom cluster characterized by pervasive anger accompanied by at least four of the following eight symptoms: depressed mood, inner tension, frustration, irritability, insomnia, fatigue, gastrointestinal symptoms, and headache. In some situations the effects were not limited to the physician but also included their families.

If two of the qualities attributed to marriage are existence and persistence, then physicians' marriages are more stable than those of many other professionals, with a divorce rate ranking 11 of 12 (authors are first at 29.3 for every 1,000 marriages and natural scientists 12th at 16.1 for every 1,000 marriages).[6] The divorces that do occur are most likely to take place when the couple reaches the ages of 35 to 45 years, at a time when practices are being established, not during residency or medical school.[7]

Dr. Gordon Deckert's comments (personal communication, 1979) suggest that spouses of male physicians were willing to postpone their own careers and personal needs to compensate for career and personal demands on their husbands. Gratification was to come at the end of training. At that time, however, the physician is eager to explore his professional activities and devote energy to his practice. This disparity frequently leads to major conflicts as expectations of reassignment of roles and reward for delaying gratification in the service of training are frustrated when the practicing physician continues to work hard and depends on his wife to "run the family."

In their article describing marital therapy for physician marriages, Glick and Borus[8] found role issues, status, power, and priority issues to be the major sources of marital conflict. In dual-career marriages, determining who comes first at varying times was a particularly prominent source of conflict. They found

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that the very setting of life's major priorities concerning work, money, power, sex, and family responsibilities became the meat of family conflict between the physician and the spouse.

Lewis[9] noted three areas of marriage difficulty that preceded frank illness:

1. Difficulty in communication—Couples could rarely talk about their feelings whether positive (warmth, love, and tenderness) or negative (hostility and aggression).
2. Lack of clear role definition—There were smoldering conflicts about the rules of the game.
3. Low ability to tolerate conflicts—Reasonable conflicts found in most marriages were poorly tolerated in these marriages because of the presence of semi-hidden smoldering conflicts.

Taylor[1] has described several potential problem areas that face the children of physicians. Time is an issue with children, as they may be dealt a small portion of it and assume this means they are not important. Because of the physician parent's absence, the nonphysician spouse assumes child care responsibilities and is seen as the primary parent and source of authority. The children may be asked to live up to unrealistically high moral standards by the community and educational standards by their teachers. Of interest is that medical care may be fragmented, and illness may be seen by the child as a way of attracting attention from the physician parent.

Another issue addressed by Gerber[10] is that of the specialness of the physician parent. An account of some degree of resentment was expressed by the child of a physician when confronted with the many interruptions and inconveniences associated with this status. The specialness of the physician parent entitled him to an immunity from criticism or complaint for his activities of giving care to patients.

The articles, which were reviewed, have made several suggestions in both avoiding the pitfalls of life in a physician family as well as improving its quality. The following is a list of those suggestions that it is hoped will prove helpful[1,2,7,10,11].

1. *Time*—Actively set aside time for both work and play in appropriate proportions and place at least equal value on time for play.
2. *Personal assessment*—Recognize and admit your needs and set a hierarchy of priorities in your life. Acknowledge problems as they occur and seek help early.
3. *Role models*—Seek out other physicians or professionals who manage to meet the needs of their families while still enjoying personal success.
4. *Spouse support*—Actively and affectionately support your spouse. Encourage the development of spouse careers or personal interests.
5. *Support groups*—Seek them out, perhaps those whose physician membership is a minority in order to obtain other perspectives on family life.
6. *Accept limits*—Accept that there are limits of time, energy, and caring that all must face.
7. *Special status*—There should be no special status, or special status for all. The elimination of this status helps decrease resentment from the nonphysician members in a family or by broad application assigns values of equal import.
8. *Communication*—Openly and continually communicate with spouse and family. Discuss and create both short- and long-term family goals.
9. *Help*—Seek it early and cooperate as a patient, not as a physician.
10. *Do not wait for "someday"*—If plans are to be made for family activities, increase the certainty that they will occur by making specific plans and setting aside time.
11. *Become students in learning how to live*—Use the skills that we have as students and apply them to improving our personal lives.

The benefits of being a member of a physician family are many and include much more than the material. The opportunity exists to engage in personal and intellectual growth without limits while immersing ourselves in the milieu of life. Problems arise when unknowingly we cease to include those most dear to us in this process. Gerber[10] noted that those families that worked hard and also made time for each other and what they enjoyed during the training years continued this pattern after training and appeared the healthiest and happiest. It is never too late to start.

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