Stress among general practitioners and their spouses: a qualitative study

USHA ROUT

SUMMARY

Background. *Although research has been carried out on stress in general practitioners, little is known about the stresses experienced by their spouses.*

Aim. *This study was undertaken to identify specific pressures at work and at home experienced by general practitioners and their spouses and to highlight their coping strategies.*

Method. *In-depth interviews were conducted with 25 general practitioners and their spouses in the north-west of England.*

Results. The doctors' increased workload and decreased interest in their family are important stressors for the entire family unit. Other stressors include time pressure, out-of-hours on-call, lack of support and amount of paperwork. General practitioners work late in the surgery, bring work home and spend time away from home at meetings. Family life is constantly interrupted by telephone calls. Role conflict was one of the major sources of stress for women general practitioners. Doctors' wives expressed concern regarding their husbands' excessive commitment to work and problems with communication.

Conclusion. *Recent changes to contractual working conditions have caused general practitioners to focus their energies on their practice instead of paying attention to the needs of their family. Male general practitioners leave the bulk of responsibility for running the family and household to their wives, but women general practitioners appear to maintain domestic responsibility while spending as much time in medical practice as their male colleagues. This is only an exploratory study based on a small sample, and so the findings cannot be generalized; however, it provides in-depth information on stress among general practitioners and their spouses.*

Keywords: occupational stress; workload; doctors' health; doctors' spouses; doctors' families.

Introduction

GENERAL practice is a highly demanding job and the general practitioner faces many stresses caused by constant time pressures, problems of practice administration, heavy workload, patients' expectations, interruptions, emergencies, and conflict between the demands of home and work.[1-5] The primary work stress predictive of job dissatisfaction and lack of mental well-being for women general practitioners is job interference with family life.[2] Although several studies have focused on job-related stress in general practitioners,[1-5] none has looked at the stress experienced by their families.

It is the nature of most professions that the boundary between work and non-work is often indistinct, and inevitably, there is some degree of 'overflow' in both directions. Excessive involvement in demanding occupational roles can have an adverse effect on the family and most general practitioners complain that their practice seriously conflicts with their family life.[6-9,10]

Doctors' marriages are often unsatisfactory, even though they remain married.[11-13] A study of the marriages of a group of American doctors found that 'lack of time for self, family and fun' was a major source of conflict perceived by both partners.[14]

Almost all of the significant literature available on married doctors considers the traditional male doctor/wife partnership; very few studies examine women doctors and their husbands or any other stable relationships. Sakinofsky[15] found that wives of general practitioners were four times more likely to commit suicide than other women and psychiatric evidence points out that doctors' wives suffer from emotional stress.[16-18] Heins *et al.* found that women doctors spend almost as much time in medical practice as their male counterparts (approximately 90%), while tending also to assume direct responsibility for home and family.[19]

The causes of stress in the general practitioner's family have been analysed by several studies, but these papers are anecdotal and little research appears to have been undertaken in this area.[16,20,21] In-depth research seemed appropriate in order to gain accounts of stress experienced by general practitioners and their spouses and to isolate the specific stresses they experience. Identification of the sources of stress is a necessary first stage in improving the quality of life for general practitioners, their families, and above all, their patients.

The aim of this investigation was to extend our previous research by examining the impact of stresses on the families of general practitioners. Specifically, we wanted to pinpoint specific work/home pressures and to highlight the coping strategies used.

Method

Sample

The sample consisted of 25 general practitioners from the greater Manchester area: 14 men and 11 women. In 14 of the couples, both partners had careers (in eight both partners were general practitioners); in six, the wife was not a doctor; and in three, the husband was not. Of the 25, 16 were caucasian and nine Asian, six were in solo practices and 19 were in group practices. The ages ranged from 34 to 57 years.

The sample was selected randomly from family health services authority lists, by choosing one in 20 from their lists, to yield a total of 30 general practitioners.

After initial telephone contact, 25 of the 30 approached agreed to take part. The main reason given for declining was lack of time. In-depth interviews were carried out with all 25 general practitioners and their spouses in October 1993. The interviews explored personal and professional aspects of general practice, especially stress related to the job and possible overflow of stress into family life. Coping was assessed by asking respondents to describe a recent incident or situation which they found particularly stressful and the coping strategies they employed (critical incident technique).[22]

The subjects were interviewed separately at home or at work. Although the interview format was semi-structured, discussion

U Rout, BSc, MSc, PhD, lecturer, Department of Psychology and Speech Pathology, Manchester Metropolitan University.

Submitted: 14 February 1995; accepted: 1 June 1995.

was encouraged. The confidentiality and anonymity of the information was assured. The interviews were tape recorded with the respondent's consent and took 35–90 min. The tapes were transcribed and thematic analysis carried out. This is a coherent way of organizing interview material in relation to specific research questions. Readings were organized under thematic headings in ways which attempt to do justice both to the elements of the research question and to the preoccupations of the interviewees.

A qualitative approach was adopted because the aim was to understand how the participants themselves perceived and experienced stress. Criticisms of traditional stress research using questionnaires to assess the presence of certain stressors and reported strain suggest arguments for using a qualitative approach, particularly in an exploratory study.[22,23] Most questionnaires assume that everyone understands the meaning of certain terms in relation to stress — for example, work overload — but qualitative methods allow a deeper understanding.[22,23] Questionnaire methods cover the ongoing or chronic stressors rather than acute stressors, and therefore, may give only a limited picture in any context.[24]

Results

Data from the interviews were wholly qualitative. Responses were analysed to identify recurrent themes concerning stress at work and at home. The sample contained only three non-doctor husbands, and the information from these interviews was insufficient for an in-depth discussion: these are not discussed further here. The stressors and coping strategies concerning male and female general practitioners and doctors' wives are discussed below.

Stress experienced by male general practitioners

All the male doctors experienced moderate to high stress at work, specifying paperwork as a high-pressure activity. Other stressors included time pressure, night calls, being on-call, telephone interruptions, and lack of support from their wife.

Time pressure. All the men in this sample felt very busy most of the time and commented that their stress was caused by time pressure, identifying especially the lack of time spent at home. They felt that their day's work impinged on their family life (e.g. returning home late and feeling tired).

> 'When my first child was young I was able to come home in the evening and have dinner with him, take him to bed.... But for the second child I simply can't make it because of increasing demand on my job, especially due to mounting paperwork after the 1990 contract, and excessive demands from patients.'

Night calls. Although some general practitioners prefer to do their own night calls these perturb family life and may wreck personal intimacy. This is not without detriment to the general practitioner's health and family life.

> 'When the telephone rings at night-time or early morning, it disturbs not only me but also my wife. Therefore for several months we have been sleeping in different bedrooms.'

On-call. Some men expressed unhappiness regarding their on-call commitments:

> 'The uncertainty about the content of an on-call day makes me really unhappy. Any moment the telephone might ring. Even though there are less than three calls in an on-call day, I have to wait until 11 o'clock at night.'

Telephone interruptions. Interruptions of any kind were considered very stressful:

> 'Often the telephone calls come seconds after entering the front door. At other times it is annoying to return home from one visit only to receive a request from their next door neighbour.'

Lack of support. Lack of emotional support from their wife was one of the major complaints:

> I get no emotional support at home. I feel that my blood gets sucked at work and I need a sympathetic attitude from my spouse to recover, but this does not happen.'

Coping. A common coping strategy is exercise: jogging, swimming, walking. However, these activities are not pursued regularly because of commitment to work. Some subjects admitted that they relax with a drink in the evening:

> 'As soon as I arrive at home I treat myself with a good glass of gin and tonic, without which I can't relax.'

Stresses experienced by women general practitioners

Sources of stress for women doctors were time pressure, role conflict, work overload and lack of support.

Time pressure. The stress most frequently reported was guilt about having too little time and attention to give to their children, and fatigue resulting from working long hours. They felt deprived of time for themselves. The wives of the male doctors took over the responsibility for housekeeping and child care, but the women doctors handled these on their own.

> 'There is always shortage of time for me ... continuous on-call responsibility and demands of the workload ... too many things to do.... This is different for my male colleagues whose wives take over domestic responsibility.'

Role conflict. Role conflict results from difficulty women encounter in meeting two or more significant role obligations: the role of woman and the role of doctor. Carrying out both their traditional gender role (spouse and mother) and their professional role in a satisfying way requires time, energy and commitment. Women general practitioners had no time to rest and relax.

> 'I do not get any attention from my husband. His attitude to my career is totally unsupportive. I am unable to attend any meetings because of family constraints. It is still a man's world. We have rows over children's responsibility and housework.... Also I feel I have to perform better than others at work because I am a woman.'

Work overload. Although women work full-time in professional jobs they are often still expected to take all the responsibilities in the house. One of the woman doctors claimed that she was constantly under pressure because of overload at work and at home. She illustrated this problem by saying

> 'I am constantly under pressure at work and at home. My husband complains that I do not do enough for entertaining ... friends. I have so much to do in the surgery but I am still expected to do the housework.'

Lack of support. Professional colleagues do not appear to offer help. As one woman doctor put it:

> 'I have no one to turn to for help. My partners are not interested to know my condition as they always want the job to be done.'

Coping. When asked how they cope with stress, one woman commented:

> 'I always discuss it with my husband. He usually gives me good support and this is an advantage. I also talk things over with my mother — that helps at times.'

However, most of the respondents experienced little family support:

'He does not want to know about my work anyway.... I don't have anybody to talk to.... I try to cope by working harder.'

One woman coped with stress by separating her work from her home life. The ability do this can help to alleviate the effects of stress but most of the female doctors found that this separation strategy was impossible when on-call:

'It is difficult to separate home life from work life ... because mostly work spills over to home life when you are on-call.'

Stresses experienced by the wives of general practitioners

Every wife expressed dissatisfaction about her husband's detachment from family, concern regarding his workload, communication problems and interruptions.

Detachment. One wife despondently wrote:

'Nowadays he is detached, indifferent and only loves his work. There is no communication between us and no intimacy between us any more.'

Communication problems. A major theme running through the interviews was that of problems with communication:

'We are unable to solve little problems at home as we have no patience to listen to each other. I feel a barrier has developed between us, causing difficulty in communication ... this barrier I am sure is his work pressure.'

Concern regarding husband's workload. Some wives felt that their husband's work pattern has been changed by the National Health Service reforms. Their men are working harder and spending much less time with their families. These wives were sympathetic, but at the same time resentful, towards their husbands:

'He is physically and psychologically exhausted and gets irritated by very little things.'

'Nowadays he spends time away from home for post-graduate meetings and I am stuck at home with the children.'

Interruptions. Telephone interruptions are a major source of irritation for the entire family:

'The main thing that irritates me is the interruption of our family life by constant ringing of the telephone. It is so regular that sometimes I wonder how the patients know the precise minute we start our family dinner.'

Coping. Most wives simply ignored the problems of stress. Typical of the comments were:

'I try not to worry or think about it. You get used to these types of situations.'

'I have nobody to talk to about these problems.... I keep them within myself.'

Discussion

The important sources of stress for general practitioners were time pressure, lack of support and interruptions. The time pressures reported are in line with previous research.[3,5] Women general practitioners also reported pressure caused by the conflict between their career and family, work overload and the inconsiderate attitude of husbands and colleagues to their career. The wives found communication problems, their husbands' excessive commitment to work and detachment from the family, and interruptions were important sources of stress, but they were willing to express their feelings openly. The men in the study did not, and used alcohol to some extent to cope with stress. On the positive side, the male doctors commonly took exercise to cope with stress; however, they did not use this positive coping strategy regularly because of time constraints.

One of the major stressors experienced by women general practitioners is role conflict. Although a high level of commitment to either profession or family reduces this conflict, high commitment to both increases it severely.[24] It may be that role conflict leading to stress depends to some extent on the coping techniques used. The group studied were either highly committed to both work and home or used negative coping techniques which did not help them overcome their stress. The most effective technique for coping with role conflict may be to redefine or renegotiate the expectations of others.[25]

While the nature of general practice and the role of the general practitioner continues to change, the external stressors affecting them and their families are likely to increase. Neither the general practitioner nor his or her spouse has much control over health care delivery, or the public's attitudes to and demands on them. General practitioners and their spouses need to change the strategies they use to deal with stress-related problems; for example, expressing their feelings, talking their problems through and working out ways of solving them.

The results reported here indicate that qualitative methods are critical in an exploratory study of this nature. Our interviews demonstrated the contradictions in individual accounts, which may reflect the ways individuals construct their realities, but which tend to be obscured in questionnaire studies that pursue a more singular view of reality.[26] Qualitative methods allow deeper understanding of individual differences.

This study did encounter some difficulties. The results should be interpreted with caution as it is based on only a small sample limited to the greater Manchester area, which limits the generalizability of the findings. However, it does provide in-depth exploratory information, which has important implications for the well-being of general practitioners and their families. Work/family stresses feed back into occupational experience and further research is needed to explore the impact of this stress on how general practitioners perform.

References

1. Porter AMD, Howie JGR, Levinson A. Measurement of stress as it affects the work of the general practitioner. *Fam Pract* 1985; **2:** 136–146.
2. Cooper CL, Rout U, Faragher B. Mental health, job satisfaction, and job stress among general practitioners. *BMJ* 1989; **298:** 366–370.
3. Howie JGR, Porter AMD, Forbes JF. Quality and the use of time in general practice: widening the discussion. *BMJ* 1989; **298:** 1008–1010.
4. Rout U, Rout J. *Stress and general practitioners.* London: Kluwer Academic, 1993.
5. Rout U, Rout J. Job satisfaction, mental health and job stress among general practitioners before and after the new contract — a comparative study. *Fam Pract* 1994; **11:** 300–306.
6. Burke R J, Weir T, Duwors RE. Type A behaviour of administrators and wives' reports of marital satisfaction and well being. *J Appl Psychol* 1979; **64:** 57–65.
7. Burke RJ, Weir T, Duwors RE. Work demands on administrators and spouse well-being. *Hum Relations* 1980; **33:** 253–278.
8. Sekaran U. Factors affecting the quality of life in dual career families. *J Occup Psychol* 1983; **56:** 161–174.
9. Cooke RA, Rousseau DM. Stress and strain from family role and work — role expectations. *J Appl Psychol* 1984; **67:** 361–369.
10. Myerson S. Under stress? *Practitioner* 1990; **234:** 973-976.
11. Vaillant GE, Sobowale NC, McArthur C. Some psychological vulnerabilities of physicians. *N Engl J Med* 1972; **287:** 372–375
12. Garvey M, Tuason VB. Physician marriages. *J Clin Psychiatry* 1979; **40:** 129–131.
13. Gerber A. *Married to their career: career and family dilemmas in doctors' lives.* New York: Tavistock, 1983.
14. Gabbard GB, Menninger MD, Coyne L. Sources of conflict in the medical marriage. *Am J Psychiatry* 1987; **144:** 567–72.

15. Sakinofsky I. Suicide in doctors and their wives. *BMJ* 1980; **281:** 386–387.
16. Nelson S. Some dynamics of medical marriages. *J R Coll Gen Pract* 1978; **28:** 585–587.
17. Bennet G. *Patients and their doctors.* London: Baillière Tindall, 1979.
18. Barker MG. The doctor's family. Rendle short lecture 1980. *Service of Medicine* Suppl., April.
19. Heins M, Smock S, Martindale L, *et al.* Comparison of the productivity of women and men physicians. *JAMA* 1977; **237:** 2514–2517.
20. Horder E. Stress in the general practitioner's family. In: *Royal College of Practitioners 1982 members' reference book.* London: RCGP.
21. Gray JP. The doctor's family: some problems and solutions. *J R Coll Gen Pract* 1982; **32:** 75-79.
22. Dewe P. Measuring work stressors: the role of frequency, duration, and demand. *Work and Stress* 1991; **5:** 77–91.
23. Newton T. Occupational stress and coping with stress: a critique. *Hum Relations* 1989; **42:** 441–461.
24. Ducker DG. The effects of two sources of role strain on women physicians. *Sex Roles* 1980; **6:** 549–559.
25. Hall DT. A model of coping with role conflict: the role behaviour of college educate women. *Admin Sci Quarterly* 1972; **17:** 472–486.
26. Hollway W. *Subjectivity and meaning in psychology.* London: Sage, 1980.

Acknowledgements

The author thanks Dr J K Rout and Dr S Lewis for their helpful comments. I am grateful to the general practitioners and their spouses for cooperating in this study.

Address for correspondence

Dr Usha Rout, Department of Psychology and Speech Pathology, Manchester Metropolitan University, Elizabeth Gaskell, Heathersage Road, Manchester M13 0AJ.

Doctors as patients

Health promotion for doctors

Much concern has been expressed about doctors' health[1] and O'Donnell's comments are striking: 'Doctors use their power and status to distance themselves not just from their patients' feelings — and their own — but from the dreaded implications of mortality.'[2]

It is known that cirrhosis of the liver is three times more common in doctors than in the general population.[3] It is also known that general practitioners can influence their patients' behaviour in relation to smoking[4] and alcohol intake,[5] and there is emerging evidence that health checks can lead to some sustained changes in behaviour.[6] Thus, some health promotion approaches by primary health care workers are known to be effective while doctors are not without health promotion needs. Therefore, there is an opportunity for general practitioners to promote good health of their doctor patients.

Concerns about doctors' health, their attitudes to their own health and their ambivalence towards health promotion initiatives raise the suspicion that general practitioners may take health promotion for themselves less seriously than for their patients. I explored this hypothesis by examining the medical records of the 41 doctor patients on my practice's list who were aged under 75 years. I also examined the medical records of 41 controls who were the closest matches for age, sex and social class (according to the registrar general's classification).

Subjects' medical records were examined for the presence or absence of recordings of each of the criteria in the general practitioner health promotion contract. In my practice, health promotion recording is either opportunistic or as a result of health promotion clinic attendance. Recordings of the health promotion criteria in the subjects' records were as follows: blood pressure, 49 of the 41 doctors and 80% of the 41 controls; smoking status, 61 and 88%, respectively; alcohol intake, 41 and 66%, respectively; body mass index, 37 and 59%, respectively; family history of stroke or coronary heart disease, 22 and 39%, respectively; exercise advice, 10 and 29%, respectively; and dietary advice, 10 and 29%, respectively.

These results appear to compare favourably with the results of Richards' study.[1] His doctor respondents reported discussing preventive health measures with a general practitioner as follows: blood pressure, 23%; smoking habits, 10%; drinking habits, 4%; stress and lifestyle, 14%; and weight and diet, 9%. However, his survey was carried out before health promotion was incorporated into the 1990 contract for general practitioners; since then there has been a financial incentive for general practitioners to ensure that health promotion activity data are recorded.

At face value, the results of my study suggest that there were substantial differences between the group of doctors and the control group, but when the paired *t*-test was applied, the differences were not statistically significant at the 95% level.

While a larger sample would clarify whether doctors differ significantly from the average, these results should act as a reminder to doctors to pay attention to promoting their own health and that of their doctor patients.

M G Dornan

Holywell House Medical Centre,
Holywell Street, Chesterfield S41 7SD

References

1. Richards C. *The health of doctors.* London: King's Fund, 1989.
2. O'Donnell MA. A remedy for doctors' disease. *The Times* 1987; 10 April: 11.
3. Royal College of General Practitioners. *Alcohol — a balanced view. Report from general practice 24.* London: RCGP, 1986.
4. Russell MAH, Wilson C, Taylor C, Baker CD. Effect of general practitioner's advice against smoking. *BMJ* 1979; **2:** 231-235.
5. Wallis P, Cutler S, Haynes A. Randomised controlled trial of general practitioner intervention in patients with excessive alcohol consumption. *BMJ* 1988; **297:** 663-668.
6. Imperial Cancer Research Fund Oxcheck study group. Effectiveness of health checks conducted by nurses in primary care: final results of the Oxcheck study. *BMJ* 1995; **310:** 1099-1104.