The psychosexual health of doctors and the “medical marriage” has been scrutinized since the dawn of doctors’ health science in the late 1980s. However, the traditional prototype of hard-working physician-husband and self-sacrificing, stay at home wife, with the latter “waiting for someday” has evolved into a plethora of relationship and role configurations amongst heterosexual and same sex partnerships at various stages of the medical life cycle. A range of social and systemic changes within and external to the medical profession—including but not limited to the “feminization” of the profession and the rise in dual physician households—have influenced the norms and frames of reference among male and female doctors alike. These diverse personal, relational, and cultural aspects means that stereotypes and broad assumptions regarding doctors’ relationships are no longer applicable.

Notwithstanding these variations, established links between well-being, job satisfaction, and marital satisfaction and ultimately, patient care mandates understanding the unique aspects of doctors’ relationships for the benefit of doctors and patients alike. In this article, we explore medical relationships from a contemporary lens, recognizing this diversity as well as examining the effects of the COVID pandemic. We also posit potential solutions.

The Good, the Bad, and the Ugly of Doctors’ Relationships

This diversity has meant that a true understanding of doctors’ relationships remains elusive, or certainly not captured in research to date, the results of which have been skewed by who were sampled and how. Most studies to date, based on responses to cross-sectional surveys, have emanated from the United States, have sampled predominantly married doctors in heterosexual relationships, and conflated findings from dual doctor and single doctor marriages and couples with and without children. Accordingly, rates of reported marital satisfaction amongst US doctors have ranged from around 50% to as high as 87% of doctors sampled.

In unpacking marital satisfaction, very pragmatic aspects of spousal support and clarity of role in the household emerge most frequently, although this is often based on experiences of couples with children. For example, in a cross-sectional survey of 415 US doctors from both dual physician and single physician relationships with children, marital satisfaction was associated with having a spouse who is supportive of one’s career and with lower role conflict between the couple. Male doctors were more likely to receive higher levels of support than female doctors, who were also more likely to report role conflict (frustration from the competing demands of career, marriage, and family).

Similarly, a small qualitative study of 25 US doctors from both dual and single doctor relationships explored the positive aspects of these relationships. Emergent themes included: (a) role clarity and knowing each other’s duties around the house; (b) having shared values; (c) showing mutual emotional (eg, acting as a sounding board) and occupational support; and (d) acknowledging the benefits of being a doctor (eg, such as financial and occupational security and knowing what to do when someone is ill).

Role conflict and partner support are particularly salient for dual doctor relationships, found amongst 25% of female and 16% of male doctors in the United States. Although unsurprisingly when women alone are sampled they report the benefits of having a supportive and understanding person at home, this issue is relevant to both partners. Noting both the rewards and challenges of dual doctor marriages, high levels of marital satisfaction are gained simultaneously from shared professional interests and high engagement in child rearing for both partners.
Looking at marital satisfaction from another perspective of doctors’ partners, a US study of doctor spouses/partners found that doctors often come home irritable, preoccupied with work, and too fatigued to engage. The strongest predictor of relationship satisfaction was minutes spent awake with the partner each day, although number of nights on call per week also correlated with relationship satisfaction, while other professional characteristics such as practice setting, specialty, or hours worked per week did not. In an earlier study, Sotile and Sotile similarly found that from the perspective of doctors’ wives, the greater the number of hours worked by the spouse, the lower the scores on objective and subjective measures of marital satisfaction. However, relatively small changes in work hours made significant differences in marital satisfaction, with the partners of nondistressed wives working only 7.5 h less. Moreover, despite large workloads of the husbands, 46% of the sample still spent on average 90 to 120 min or more each day with each other as a couple. Levels of marital satisfaction for doctors’ wives were affected by their perception that their husbands made “work sacrifices for the sake of their family.” Although this perception may have held in 2004 in a traditional medical marriage may have expired in its utility, the authors’ conclusion that “regardless of medical specialty or stage of career, more than...” (p. 30) still has relevance. From the perspective of male spouses of female doctors, the all-consuming and inflexible nature of doctors’ time and the cost of support is illustrated by emergent themes of “Hers is a career, mine is a job”; “A time for us? Really?” and “Supporting and protecting her, sometimes at my expense.”

At the extreme end of dissatisfaction, a study of 1,118 married doctors found that choice of specialty was significantly associated with the risk of divorce, which was highest among psychiatrists (cumulative incidence 50%), followed by surgeons (33%), and internists, pediatricians, and pathologists (22-24%). Risk of divorce was also associated with female gender, marrying before graduation from medical school, and scoring in the highest quartile for the Anger Scale.

Domestic violence (DV) can mar the relationships of doctors with the problem magnified by geographical isolation from other supports and self-stigma, perpetrated by the myth: “As a doctor, I should have known better.” Despite the limited literature, visibility of the problem is growing as understanding of DV in the community grows. An independent DV advice line for doctors, intended to support doctors in assisting patients who were experiencing DV, found that many doctors were using the service to discuss their own relationships. Although without evidence specific to male doctor victims, this population may also face the help-seeking barriers identified for male DV victims including challenges to traditional conceptions of masculinity, fear of disclosure, and a relative lack of available services.

Fertility problems impact 25% of female doctors in the United States, well above the rate (9-18%) in the general population. Training requirements, geographic dislocation, and relative late achievement of financial security in doctors graduating with large debts are known contributors. Less well known are the psychological impacts of infertility, miscarriage, and birth defects and their impact on doctors’ relationships. With the feminization of the workforce, it is likely that a higher proportion of doctors and their partners are facing this stress which has been linked to relatively high rates of burnout in the profession. The significant barriers faced by female surgeons in particular have been well documented, and it is possible that fertility issues might be more pronounced in this group.

LGTBQI Relationships

Not surprisingly given the invisibility and neglect of medical LGTBQI relationships, a literature search yielded abundant studies about patients but nothing about doctors themselves. While issues of competing commitments with erosion of companionship and intimacy remain ubiquitous regardless of sexual orientation, LGTBQI doctors face a plethora of additional challenges emanating from implicit and explicit bias against sexual minorities in medical cultures which compound societal prohibitions, which often threaten the very existence of the relationship. Such challenges were articulated by a dual male physician couple:

Every time I have a conversation with someone about my family, I’m having a “coming out” type of moment if someone didn’t see me in that light. That can be difficult because I have to guess if that person is going to be supportive. Are they going to turn away? Are they going to think of me in a negative fashion?

Gender Issues

Gender issues clearly emerge from the aforementioned studies of traditional heterosexual relationships in which the solutions to life-work life imbalance manifestly disfavor female doctors, who make more personal and professional accommodations and compromises within relationships with resultant inequity in productivity, income, advancement, and career satisfaction. In a 2014 survey of 1,049 research doctors, women more commonly than men (85.6% vs 44.9%); had spouses or domestic partners who were employed full time; spent 8.5 more h per week on domestic activities; and took time off during disruptions of usual childcare.

These findings have been echoed across cultures where traditional gender roles prevail, as evidenced by a study of Japanese cardiologists but not shared in more gender-equitable cultures. For example, drawing comparison with their United States and Spanish counterparts, a study of life satisfaction amongst Norwegian medical students and doctors found few differences between male and female doctors with respect to levels of overall well-being and emotional distress,
attributed to more equitable gender roles and regulated work life in Scandinavian medical systems.6

Impact of COVID-19

Women in dual physician marriages, women in management, and women doctors generally appear to have fared worse in the COVID-pandemic.36,37 Women doctors are more likely to report increased anxiety and worry about their finances, job security, contagion, and the health of their partner and children as well as their own health.36 Notably, “report” is the operative word here; it remains unclear if these findings represent artefactual reporting differences or real differences. For example, in a US cross-sectional survey of burden in dual doctor marriages distributed via e-mail and social media which found disproportionate burden amongst women, 81% of the 1,799 doctors who completed the survey were women.36 However, supporting these findings was a cross-sectional study of Canadian doctors, amongst which men comprised 51% of the sample, similarly showed higher burnout in female doctors.37 Interpreting these findings resonates with the examination of the gender differences in depression. Similarly though, the findings of disproportionate burden amongst women conferred by COVID remain robust and echoed across cultures with likely origin in the gender role differences described earlier. For example, Covid-exacerbated gender inequality in child-care and domestic obligations amongst female doctors have been demonstrated across Canada and Australia,38 United States,5 and Japan.39

Strategies

On a hopeful and optimistic note, Brubaker5 has pointed to the potential for the COVID-19 pandemic, in its horrific professional, interpersonal, and psychological effects, to act as the very catalyst for change. Certainly, change is desperately needed, with an entrenched status quo persistent in medicine for decades prior to the pandemic. The observation that medicine lagged behind the sociocultural gender role revolution elsewhere was noted back in 1997:

“He” is no longer regarded, implicitly, as a sexless, childless, work-driven automaton. Except perhaps in medicine, where expectations persist that “dedicated” doctors will be infinitely available to their patients and immune to fatigue.40 (p. 8)

Twenty-five years on, similar observations have been made of: “unhealthful work environments, with expectations of 24/7 availability and a persistent life-work imbalance” with “far too few physicians have effectively prioritized commitments to the personal roles they value.”39 (p. 835). Perhaps, the most significant difference now is that women are now equally “privileged” to become “work-driven automatons.” This privilege in the face of persistent gender role differences is only likely to fuel anger-inducing intergroup social comparisons41 between male and female doctors in relationships, and, given Rollman et al’’s48 findings, likely destructive of such relationships.

How can we galvanize the earthquake effects of the pandemic on our lives and relationships? Based on insights gleaned from the literature, augmented by our own experience in promoting doctors’ well-being and relationships, we posit some systemic solutions that may foster relational health in doctors:

1. Create work environments that reject expectations of unhealthful personal sacrifice5 and workplace interventions that decrease role conflict10 and that also respect sexual diversity.
2. Normalize attention to relationship health, akin to other health priorities. Recognize that medicine is an all-enveloping career24 and “like a third party” or “a jealous lover”42 that gets in the way, while at the same time, “triangulation” (use of a third party or issue to avoid facing a confronting or threatening conflict) allows this to be used to avoid inevitable anger and conflict that can be hidden or overt.24
3. Normalize a nongender stratified workforce with more flexible options such as job-sharing and part-time work available to men and women alike,40 and more flexible training options including multiple sittings and submission dates for exams in college training programs.
4. Capitalize on social modelling, learn from others’ best practices in relationships, and sound role models7 who prioritize relationships. Relegate personal and relationship sacrifice and martyrdom to the “old-fashioned and out-of-date” pile.
5. Shed light on DV and increase access to dedicated services, for example, social work for DV, specialized services which may increase sense of safety.33
6. Normalize and encourage help-seeking with couples counseling5 while recognizing the myriad of help-seeking avoidance maneuvers adopted by doctors. Despite advice from professional bodies and conventional wisdom, doctors often continue to diagnose and treat their families and partners, while also displacing the problem by blaming the partner, or seeing the partner’s problems as the source of dysfunction. Psychiatric symptoms, addictive behaviors, or overworking also may be understood as triangulated manifestations of relationship difficulties that are less threatening than addressing relationship problems directly. Finally, biomedical expertise may encourage doctors to view relationship problems, especially those that manifest as sexual dysfunction, as biomedical, which is far less threatening than addressing psychosocial and interpersonal contributors.

On a final note, as far as intimate relationships go, doctors are as diverse and vulnerable as the rest of the community, perhaps...
more so. Attending to relational health in doctors is likely to have pay-off for doctors, their families, and patients alike.

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