Understanding the Medical Marriage: Physicians and Their Partners Share Strategies for Success
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Abstract

Purpose
Physicians and their spouses experience challenges to their relationships, some of which are shared with the general population and others of which are unique to the field of medicine. Trainees and junior faculty members remain curious about how they will balance their careers alongside marriage and family obligations. This study explores the challenges and strengths of dual- and single-physician relationships.

Method
In 2009, using appreciative inquiry as a theoretical framework, the authors conducted in-depth qualitative interviews with 25 individuals: 12 women and 13 men; 10 from dual-physician and 15 from single-physician relationships. A phenomenological analytic approach was used to arrive at the final themes.

Results
Four themes emerged during the interviews: “We rely on mutual support in our relationships,” “We recognize the important roles of each family member,” “We have shared values,” and “We acknowledge the benefit of being a physician to our relationships.”

Conclusions
These findings illustrate that physicians identify strategies to navigate the difficult aspects of their lives. Learning from others’ best practices can assist in managing personal relationships and work–life balance. These data can also be useful when counseling physicians on successful relationship strategies. As systems are developed that improve wellness and focus on role models for work–life balance, it will be important for this topic to be integrated into formal curricula across the continuum of medical education.

Physicians, like others in demanding professions, face challenges of time and attention in their long-term relationships. Medical trainees and junior physician–educators often look to more senior attending physicians as role models as they begin to question how they will balance the competing demands of a career in medicine alongside marriage and family obligations. Thus, physicians in academic medicine play a significant role as mentors not only in medical training but also in the “informal curriculum” of work–life balance.

Understanding the potentially unique aspects of physicians’ relationships is necessary to the well-being of both students and physicians. The Liaison Committee on Medical Education requires medical schools to have “an effective system of personal counseling for its medical students that includes programs to promote the well-being of medical students and facilitate their adjustment to the physical and emotional demands of medical education.” Such a system might include a focus on physician relationships.

Physicians grapple with the demands of marriage and parenting during training and long after graduation. Nonetheless, physicians’ long-term relationships tend to last longer and be more resistant to divorce than those of other groups in society. Physicians tend to marry later in life and are better educated than average Americans, characteristics which may serve to protect them from divorce. Some of the resiliency found in medical marriages has been attributed to maintaining flexibility, successfully managing conflict, as well as making time for communication and intimacy amid demanding careers. Although interspousal differences in marital satisfaction and divorce rates exist, one large survey found that dual-physician marriages are associated with high levels of satisfaction from shared professional interests and high engagement in child rearing for both partners. A similar study examining marital satisfaction, this one from the partners’ perspective, found that minutes spent awake with their physician partner per week and number of nights their partner was on call per week also influenced spouses’ satisfaction. Among physicians, the conflict between personal and professional roles has been found to originate in call hours, professional obligations encroaching into personal time, and a sense of obligation to medicine. Role conflict has been found to lead to job stress, burnout, and changes in career change, particularly in dual-physician relationships, as well as younger and female physicians. Despite these studies, literature on physicians’ long-term relationships is sparse. It is unclear whether there are specific characteristics of long-term relationships that help physicians and their partners navigate the complex demands of balancing a career in medicine with intimate relationships. Using appreciative inquiry (AI) to ensure a focus on the positive aspects of physician relationships, we investigated these characteristics through narratives. In this report, we use the term domestic partner as a gender-neutral term for the partners in a long-term
relationship, whether or not they are legally married. The purpose of this project was to explore the challenges of dual- and single-physician relationships, particularly within the context of academic medicine.

**Method**

All aspects of this study received approval from the University of Michigan Medical School institutional review board. To protect confidentiality, we removed identifying information (e.g., names of individuals and departments) from transcripts prior to analysis and assigned all participants a pseudonym.

**Theoretical framework**

To highlight “best practices” in a relationship, we used AI as the theoretical framework for this study.13,14 AI promotes acknowledging and appreciating positive qualities in individuals and organizations, and using these qualities as a point of departure for continued growth and development. Since David Cooperrider and Suresh Srivastva first published “Appreciative Inquiry in Organizational Life” (in Research in Organizational Change and Development [1987]), this framework has been widely used to create new practices in professionalism,15,16 empathy,17–20 health care organizations,21–22 and relationship-centered care.23 We used AI to explore physician relationships because it prompts exploration of positive aspects rather than focusing on difficulties and deficits. Although participants were given the opportunity to discuss struggles, discord, and frustrations in their relationships, the focus of this study was on identifying strengths and finding techniques or best practices that enable individuals to be full participants in medical marriages.

**Recruitment**

Using theoretical sampling, we recruited practicing physicians and house officers who had expressed interest in similar topics through faculty e-mail lists, interest groups, and faculty participants of an M2 elective on domestic partnerships.25 We also used snowball sampling to generate additional referrals by asking participants to provide names of other members of the targeted population who might be interested in participating.26 Physicians and physicians’ domestic partners were eligible to participate in this study. We offered interviews to participants’ partners, regardless of whether that partner was affiliated with University of Michigan Health System—both members of a couple were welcome to participate, but this was not a requirement.

**Data collection**

One of the authors (P.T.R.) conducted in-person interviews between May and December 2009, each lasting 45 to 90 minutes. The interviewer reviewed the informed consent document, answered any questions, and, with the participant’s written and verbal consent, proceeded with the interview. Interviews were held in locations most convenient for the participants. All participants were given a $25 gift card for their participation. Interview questions were devised using an AI framework; thus, participants were specifically asked to focus on the strengths of their relationship and to reflect on how to build on these strengths and focus on the positive aspects of their relationship (see Appendix 1). Each interview was audio-taped and transcribed verbatim.

**Data analysis**

Using a phenomenological analysis approach, two of us (R.L.P. and P.T.R.) independently read each transcript to extract significant statements.27 Phenomenological analysis uses thick description and close analysis of the lived experiences to understand how meaning is created through embodied perception and to capture meaning and common features.25 The final themes were reached through several lengthy discussions and repeated comparison until consensus was obtained. We each read each transcript independently to become familiar with the data and extract phrases or significant statements that pertained to the phenomenon under investigation. All transcripts were placed into a qualitative software program, NVivo (QSR International, Doncaster, Victoria, Australia), to help with data management. This allowed us to further analyze the data units within each code and to organize codes by participant, specifically on the topic of medical marriage. An initial list of concepts and themes was then generated by reading the data and creating as many relevant codes as possible. This phase of the analysis was conducted to extrapolate key elements that described unique experiences. In accordance with principles of phenomenological analysis, a continual and conscious effort was made to “bracket” preconceived beliefs, assumptions, and biases and avoid allowing personal perspectives, interests, or backgrounds from having an undue influence on the interpretation of the participants’ stories.28 As a validation method, one of us (M.L.L.) independently read each transcript and confirmed the themes, and as a form of member checking, these themes were shared with three participants in the study, who all agreed that they reflected their perspectives.25

**Results**

A total of 25 physicians and spouses—12 women (48%) and 13 men (52%)—participated in this study; 19 (72%) were attending physicians, 3 (12%) were house officers/fellows, and 3 (12%) were nonphysician spouses (Table 1). Relationships were categorized as either single physician (n = 15; 60%) or dual physician (n = 10; 40%) (Table 2). Through the thematic analysis, four themes emerged from our data (Table 3). It is worth noting that although individual participants described having negative experiences in their relationships or their work–life balance, these comments were diverse and infrequent and thus not represented in the themes. We formulated the themes as “We …” statements. Throughout the Results, quotations are attributed to participants’ pseudonyms.

**We rely on mutual support in our relationships**

Many participants emphasized both the support they provided to and received from their domestic partner. For example, one participant in a dual-physician relationship described the emotional support he offered to his partner for her career.

> She's in a position of leadership and leadership can be lonely. So I give her sort of a sounding board that she can go over issues and get my ideas about things so I think I am helpful that way. (Dr. Xie)

Another physician described the support she provided to her domestic partner to encourage his participation in recreational activities.
Any time he wants to go do something, he can do it. If he ever said to me, “I want to go to Italy for a week by myself” I would say, “Yes, I want him to do something that makes him happy… He is supportive of me in that he has hung in there, like all of my work trips and huge amounts of time at work and lack of being an interesting person. He’s really hung in there. (Dr. Gupta)

Participants also recognized how the support they received from their domestic partners helped them in achieving their career goals.

I’m doing a lot more work at evenings,…. I’ve just started this new role at my job a few weeks ago. I was already, like two weeks into it, saying, “Maybe this was not the right decision (laughter) for our family.” And he’s very supportive. He’s like, “No, don’t be stupid. You have to give it a few months. You know this is what you wanted.” He’s just really, really supportive. (Dr. Foster)

He is very supportive…. If he wasn’t willing to shoulder a large burden of the primary childcare, picking up, dropping off, taking care of them if I go out of town, I couldn’t do my job. And when I took the promotion [which involves] traveling and doing all that stuff, he was very supportive. (Dr. Valdez)

Table 1
Characteristics of 25 Participants (Physicians and Their Partners) in Qualitative Interviews About the Challenges and Strengths of Their Relationships, 2009

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age in years</td>
<td>43.5</td>
</tr>
<tr>
<td>Gender, no. (%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12 (48)</td>
</tr>
<tr>
<td>Male</td>
<td>13 (52)</td>
</tr>
<tr>
<td>Couple type, no. (%)</td>
<td></td>
</tr>
<tr>
<td>Single physician</td>
<td>15 (60)</td>
</tr>
<tr>
<td>Dual physician</td>
<td>10 (40)</td>
</tr>
<tr>
<td>Physician specialty, no. (%)</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>13 (52)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4 (16)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4 (16)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Surgery*</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Nonphysician spouse</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Stage of career, no. (%)</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>19 (72)</td>
</tr>
<tr>
<td>Resident/fellow</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Spouse</td>
<td>3 (12)</td>
</tr>
<tr>
<td>Timing of marriage, no. (%)</td>
<td></td>
</tr>
<tr>
<td>Premedical school</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Medical school</td>
<td>10 (40)</td>
</tr>
<tr>
<td>Residency</td>
<td>10 (40)</td>
</tr>
<tr>
<td>Practice</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (8)</td>
</tr>
<tr>
<td>Mean no. of years married</td>
<td>15.8</td>
</tr>
<tr>
<td>Timing of first child, no. (%)</td>
<td></td>
</tr>
<tr>
<td>During medical school</td>
<td>1 (4)</td>
</tr>
<tr>
<td>During residency</td>
<td>10 (40)</td>
</tr>
<tr>
<td>During practice</td>
<td>13 (52)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (4)</td>
</tr>
</tbody>
</table>

*Emergency medicine, internal medicine, family medicine.
*General surgery, urology, otolaryngology.

Participating indicated how support from external family members helped their family to function more smoothly.

My [husband’s] mom lives with us and takes care of the kids. We asked her to [move in] when we had kids. She was willing to come and help us, which has been great. She will help keep you grounded and when you are working too much she’ll tell you. And if we have to go in in the middle of the night, she’s there. (Dr. Hamil)

Having defined roles within the family and the knowledge that others must fill in ensured the success of their relationships amid the context of a medical career with competing demands.

We have shared values
Participants clearly articulated that their relationships worked because they shared important values with their domestic partners. Having shared values is often the catalyst for drawing couples together.

We both value the importance of raising kids, that’s number one on the list. [Number] two is we both value each other’s careers. We value each other’s opinions and, believe me, we do not agree on many things and we have had issues with that. But I respect her opinions and I think she respects mine. And we both bring, I think, different things to the marriage that we like and respect. (Dr. Xie)

Another participant indicated,

We both value integrity and working hard and doing the right thing…. I think what we want for our kids is the same; we want them to be kind and work hard and understand that everything doesn’t just get handed to you. (Dr. Hamil)

These shared values helped many participants define the foundation of their relationship and offered a frame of reference when competing commitments arose or when they faced challenges and difficult issues.
We acknowledge the benefits of being a physician to our relationships

Another theme to emerge during the interviews was the benefits to their relationship associated with being a physician. Participants described how the knowledge physicians possess to care for a family member when ill or injured provides a direct and practical value to their relationships.

There is definitely a benefit to having someone who is not scared at the sight of blood. My son cracked open his eyebrow on the playground and clearly needed stitches. And rather than go sit in the ER for three hours and wait to get this thing stitched up [my physician husband] was able to leave whatever he was doing and meet me at the school. (Mrs. Daniels)

As an emergency physician, at least I’m able to care for a lot of stuff that might otherwise require us to go to the hospital. My kid cut his hand so I stitched it up. (Dr. Brooks)

Participants also noted the benefits of financial and occupational security associated with being a physician. One physician, Dr. Sims, noted, “There is more financial security than you would get in other settings. " Others spoke to the same issue.

We had money … security … you know, I always I could always have sitters, it wasn’t an issue of being able to afford it. I could always have somebody to clean my house. (Dr. O’Reilly—wife)

There are clearly some benefits for financial security. Financial security aside—it’s sort of related, but it’s just occupational security. I mean, there is large unemployment in Michigan right now [but] neither of us really feels threatened that we are going to lose our jobs and are going to have to depend on the other. (Dr. Young)

These physicians recognized that through being a physician they are often shielded from the economic downturn of larger society, which allows them to avoid relationship problems fueled by a lack of finances.

Discussion and Conclusions

There have been several surveys exploring physicians’ marital satisfaction; however, our study extends this research by providing insight on how this is navigated within the relationship. We found that having shared values with their partners is a source of relationship satisfaction and can provide a useful framework for physicians and their domestic partners who are beginning to confront the challenge of navigating a “medical marriage.” Participants also appreciated having role definition. In its simplest sense, this enables knowing what they needed to do around the house and knowing what duties their partner would perform. Warde and colleagues found that physicians’ increased marital satisfaction was associated with lower levels of role conflict, defined as “the perceived frustration resulting from the competing demands of career, marriage, and family.” It is possible that the exact nature of individual contributions to household management is less significant than knowing your...
Physicians in this study valued their intimate relationships as well as the time they spent with their patients. In this report, physicians and their domestic partners described what makes the “love” portion work for them. This study is strengthened by the use of the AI approach and the rigorous standards of phenomenological analysis. Using the AI framework, our results represent an exploration of what individuals in dual- and single-physician relationships value in their relationships. Although the interviews were not conducted with the goal of being personally useful to the participants, AI encourages a “vocabulary of hope.” By focusing on positive aspects of a business, a situation, or a relationship, one learns to build on these strengths. Using an AI approach may be well suited to young physicians who want to focus on a positive approach to their relationships, rather than on the shortcomings. In addition, AI has been used to explicitly teach students about professionalism. AI can be a useful educational tool to discuss positive impacts on students and trainees.

In a study of marital satisfaction in physicians, Wardle et al10 noted that having a supportive spouse was associated with high levels of marital satisfaction. Nearly half of all physicians in our study reported being either extremely or very satisfied with their relationships and strategies to ensure work–life balance. Others have found common interests, understanding and empathy, and financial benefits to be positive aspects of medical marriages; they have found time, workload, and career compromise to be negative aspects of medical marriages. In our study we were able to identify key strategies for making physician relationships work regarding the use of role clarity and the benefits of the job.

There are several limitations to this study. All participants were associated with a single academic medical center and thus not representative of all physicians in the United States. However, despite this limitation, roughly one in eight physicians in the United States are affiliated with an academic medical center. Although academic physicians may not be representative of all physicians, as medical school faculty members they are in the position to have an influential role in the lives of students and other trainees during their formative years. We did not explore the ways in which the role of physician may have conflicted with the role of being a spouse; similarly, participants were not asked about any potential disadvantages of having a physician as a domestic partner. We also did not address specific markers of stress, burnout, or depression—all of which could reasonably impact the perceived quality of long-term relationships. The insights gained from this study have a broad relevance to many couples connected to academic medicine; however, these findings cannot be generalized to all medical marriages.

Intimate relationships are an important aspect of physicians’ well-being. A focus on physician relationships is an important part to ensuring a healthy academic workforce that is able to provide sound role models for trainees. Study participants noted concrete examples and strategies to navigate their relationships and their careers. Their ability to articulate lessons learned and best practices in physician relationships may provide trainees and junior faculty with a path forward and insight into physician work–life balance.

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Ethical approval: All aspects of this study received approval from the University of Michigan Medical School institutional review board.

Previous presentations: These data have been previously presented at the 2013 University of Michigan Medical School, Medical Education Day, the Departments of Internal Medicine and Pediatrics Grand Rounds, and LakeLace Grand Rounds in St Joseph, Missouri.

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Appendix 1
Interview Questions From a 2009 Qualitative Study of 25 Individuals Examining Strengths of Dual- and Single-Physician Relationships

1. What kind of work do you do, and what is your day like?
2. Is your spouse employed? If yes, in what occupation?
3. How demanding is their career?
5. What is it like to be in a dual-academic-career family?
6. What does your spouse’s career mean for yours?
7. What is it like to support a significant other not in medicine?
8. What does your relationship mean for potential career options?
9. What is it like to have a spouse in private practice?
10. How often do you work evenings and/or weekends?
11. How much traveling do you do for work?
12. When did you begin to realize the time demands of the life of a physician?
13. What are some of the benefits for your relationship as a consequence of the demands of your occupation?
14. What is the best part about being in a medical marriage?
15. What do you value most about your medical marriage?
16. Do you have children?
17. How do you make time for your spouse and children? What makes the time you spend together worthwhile?
18. How do you share in the child care responsibilities? What makes that work?
19. How did you balance pregnancy, career, and early child care?
20. How do you ensure longevity in your relationship?
21. What are the challenges of having small children?
22. Do you see any difference between your male and female colleagues and their approach to family?
23. Any similarities between your relationship and your parents’ relationship?
24. What have you found to be the most important aspect of maintaining your relationship despite your career demands?
25. What does your spouse like most about you?
26. What can other medical students or other faculty learn from you?
27. How do you serve as a source of support?
28. How do you share household responsibilities, chores, financial responsibilities, child care? Do you hire additional assistance?
29. What other support does your family have (e.g., housekeeper, outside family, nanny, etc.)?
30. What are the core values that make your relationship work?
31. What time do you devote to personal interests?