The doctor's family: some problems and solutions*

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SUMMARY. Some sources of stress in the doctor's family are described and a number of solutions are offered. Problems which are common to all doctors' families are identified and others which relate to specific groups. Solutions are classified according to those which require self-help and those which are offered from outside. The practical possibility of groups for trainee wives is suggested as a means of prevention rather than cure.

Introduction

IN 1978 I was fortunate to chair a session on 'The Doctor's Wife' at the WONCA conference on family medicine at Montreux (*Journal of the Royal College of General Practitioners,* 1978). The session uncovered some deep anxieties not only among the doctors' wives but among the doctors themselves, and led those of us who were there to ask two questions:

1. What are the stresses that have led to such anxieties?
2. What can be done about them?

I should therefore like to discuss some of the sources of stress I have identified which are common to all doctors' families, and some which are specific to certain groups, and then try to offer some solutions.

My approach is necessarily anecdotal but no statement is made which cannot be substantiated either by my own experience or that of other doctors' wives to whom I have talked. My constraints are the difficulties of generalizing about doctors as a group, the fact that my own experience is predominantly of general practice, and that little yet has been written on the subject in this country. In addition, although I refer throughout to doctors and their wives, I hope my remarks will be taken to apply to women doctors and their husbands as well. Furthermore, although I relate the problems I describe to doctors' families alone, this should not be taken to mean that I think they are problems which belong exclusively to the medical profession. Many would strike a note of recognition in other families both in the professions and in other jobs.

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Common problems

One of the chief sources of stress is to be found in aspects of the doctor/patient relationship, which may be seen as a threat to the family.

Aspects of the doctor/patient relationship

One aspect which affects the family considerably is confidentiality. There is an inherent conflict between the desire of a doctor to maintain the confidentiality of his patients and the desire of his wife to lighten his burden of knowledge by sharing it. A young doctor almost certainly needs to talk to someone as he starts on his professional life, but probably less as he grows in confidence, and this creates a corresponding feeling of exclusion in his wife and therefore of loneliness. An unnatural barrier is formed between a couple who may otherwise believe in sharing all problems. A wife may also feel the irony that, through the nature of their jobs, the practice staff know many of the problems which are causing her husband worry while she, the one who is in a position to offer help and comfort, must not know.

This is not such a problem for the children, who are used to the fact that their parents withhold from them knowledge about all sorts of matters, and they usually accept that their father cannot talk about his work, as so many of their friends are his patients.

Friends as patients pose greater difficulties for wives. While a woman patient may feel on the one hand that her innermost secrets are safe with the doctor, on the other she may be quite hurt to find when she meets his wife socially that he has not told her about something which she regards as 'public' knowledge, for example

that she went in to have her varicose veins done last week or that her father has just had a stroke. It is interesting that in a seminar of doctors and their wives in Boston, one group felt that wives should be 'told all' and that it was in the friends' and relatives' best interests, whereas the other group took the opposite view (Savory, 1978). It is a problem which has never been clarified by the profession.

Another aspect of the doctor/patient relationship which is seldom talked about is physical. I wonder how many doctors realize how threatened a young wife can feel by her husband's physical relationship with his patients? It is not a question of trust or of understanding professional relationships, but a matter of the patient requiring a special kind of contact—taking something of her husband apart from his time and understanding and compassion. Nobody who remembers Recordon's (1972) sensitive article in this journal a few years ago will deny that this physical component is there, to a greater or lesser extent, in all doctor/patient relationships, although it may not be something of which all wives are conscious. The threat may be greater for non-medical wives and those who live 'over the shop'.

One source of stress that is deeply felt by all medical wives is the way the doctor divides his time between patients and family. However good a rota system, whether in hospital or in general practice, there is bound to be some conflict between the needs of the patients and the needs of the family. Patients cannot always be neatly buttoned into units of time, however efficient the doctor. There will always be the worrying case that spills from patient time into family time, and this encroachment into what they feel to be 'their' time inevitably leads to resentment in the family. The result is sometimes an 'us and them' attitude which may be reflected in the wife's behaviour to the patients.

Illness in the family

Medical families appear to attract more illness than other families, and while this may or may not be true, it certainly is true that illness in the doctor's family presents a far wider problem than the mere sum of complaints and diseases.

The chief problem is that the illness produces a role conflict in the doctor/father or doctor/mother, even if the family does have its own general practitioner. If the doctor/father stands back to give the family doctor a free rein, he can appear callous to his children, who cannot understand why their father does not seem to care. On the other hand, over-involvement can also produce tension. If the medical views of the two doctors conflict, his wife and children are caught between two loyalties just when they need to have absolute trust in both doctors. Even a happy and natural event such as the birth of a baby can be difficult. In a situation where the mother needs her husband to be wholly husband and father, he may not be able to forget his professional role—one part of him may be checking the actions of doctor and nurses and he may look first at his baby with a professional rather than a father's eye.

Illness may produce other stresses for the children. Some are sent to school in a state of health in which no ordinary family would send them—temperatures, tummy aches and tears—which causes comment at school. Others may be wrapped in cotton wool and always away from school—an over-reaction on the part of the parents where the worst is read into every symptom. Both situations are bad for the children, who feel they are being penalized for having doctors as parents.

Telephone

The telephone is taken so much for granted as an irritation that a doctor may not think about it seriously enough as a cause of stress for the family. Does he fully appreciate the anxiety of his medically unqualified wife when she is rung by a patient in real distress and she is unable to get hold of him—the constant ringing at the worst possible moments, the problems she has when she is tired and cannot 'give' to the patient?

A related problem not often discussed is whether children should be allowed to answer the telephone when the doctor is on call. It is obviously not a good idea, yet many do it. It can be tremendously stressful, even for the competent teenager left to hold the fort for half an hour. It is not enough to be able to take the name, address and problem. If there is a potential suicide at the other end, or a woman with a threatened abortion, what is the child to do? If the mother feels stressed by such calls, how much more so will her child? Yet many doctors' families are guilty of burdening their children in this way.

Doctors as achievers

Another problem stems from the fact that doctors as a group are achievers. Although they may not enjoy the status they once had, they still have a certain standing in society as professional people who have had to pass endless examinations and endure years of higher training. This can place considerable stress on their children, who may feel they have to follow in father's or mother's footsteps, if not by becoming doctors, at least by going to university or following a profession.

Problems of specific groups

Hospital doctors

Of all the different groups of doctors, junior hospital doctors probably suffer most from unsocial hours. General practitioners are much better organized than they used to be, with rota systems and deputizing services, so that on the whole they are able to plan their time off reasonably well. The hospital doctor's rota may be such that he is never on call on the same night of the week so that planning social engagements and regular evening activities becomes a nightmare.

In a study of married registrars in Edinburgh, Elliot (1978) found that the doctors' heavy work-load meant that their wives were taking on the role of father/husband as well as their own wife/mother role, and were exhausted and overwhelmed by the dual responsibility. Several wives felt their children had become overdependent on them and put down behaviour difficulties such as aggression, sleep problems, schooling difficulties and fear of men to the constant absences of their fathers. Seventy-one per cent of the wives felt deprived of the companionship of their husbands and were intensely lonely; periods of examination study and weekend absences were felt particularly keenly. Feelings of injustice and resentment were rife.

The necessity for young hospital doctors to move every six months or so in order to be promoted is another obvious source of difficulty for their families.

General practitioners

General practitioners' families also have their problems, however. The wife of a single-handed rural practitioner, for instance, inevitably bears added responsibilities and may envy the lot of the wife whose husband has gone into group practice. She, however, may have problems of her own. For all the stresses and strains she may have endured when working in the practice, she may have enjoyed her involvement, her contact with patients and working with her husband, and losing this role may require considerable adjustment. For those who have not been trained to do other work, the feelings of isolation will be particularly intense. The wife of a new, young principal may also feel isolated. She may find herself with a new house, a new baby or a new job—and suddenly she finds that her husband is involved in a new kind of partnership with problems of adjustment which neither of them was expecting.

Wives of doctors in private practice have also told me that, contrary to what other medical families imagine, they, too, are subject to special pressures; being outside the health service carries burdens as well as benefits.

Other groups

Women doctors have special problems as they cope with their conflicting roles of doctor, wife and mother, and these increase if their husbands are doctors as well. Conflicting careers make it extremely difficult for them to find time for each other and time for the children (*Journal of the Royal College of General Practitioners,* 1979; Ronalds *et al.,* 1981).

Overseas doctors, too, have particular problems, both in hospital and general practice (Ronalds *et al.,* 1981), which often arise from cultural and language difficulties.

Then there are the activists, whose energies are such that other interests compete for time with patients and family. Whatever these interests are, if they take up too much time, the family will feel resentful. However, I suspect that it is more difficult for the medical wife whose husband is following professional interests to accept the out-of-hours commitment than for the wife whose husband is always on the golf course. Society accepts the need for leisure and recreation, whereas professional interests may be seen only as an extension of work, and an unnecessary extension at that. Wives and children who understand the needs of patients and the need for doctors to relax may not be so tolerant of the needs of a committee!

Some of the worst stress, however, must surely come from those doctors who lack professional satisfaction, whatever the reason. Morale cannot be high for the inner city doctor who has bricks thrown through his surgery windows every week, who has to move from premises to premises as each comes under a demolition order, and who scarcely has room for himself and his patients, let alone attached ancillary staff (Bolden, 1981). Then there are the doctors with impossible workloads who can see no way of reducing them, the doctors living in areas of high unemployment whose children go to school with those whose fathers are out of work ("It's all right for you—your dad'll never be out of work!"), and the consultant frustrated by hospital politics. Or there is the doctor trapped in the wrong job—the general practitioner who should have been an anaesthetist, the psychiatrist who should have been a general practitioner. And there is always the doctor who has made a mistake and must live with it. The strain of receiving such doctors home at the end of the day, weary, depressed, dissatisfied, must surely tell on wives and children, the wives constantly playing piggy-in-the-middle between father and children, trying to protect each from the other.

Worst of all, perhaps, is the stress for the family where the doctor is the victim of alcohol, drugs or depression—or any serious illness. It is as hard for the family as for his patients to accept that the doctor, too, is fallible as far as health is concerned, and there may be a conflict between wanting to get him treated quickly and wanting to help him 'cover up'.

Solutions

Those are some of the problems. What are the solutions?

One way of coping with stress is for individuals to find their own solutions; another is to look for help from outside.

Self-help

Time

As a lay person, I feel particularly hesitant about haranguing a profession which relies on the art of communication for part of its skill—but it must be said: talk to your families and allow them to talk to you. If there is no time, make time. Sally Nelson (1978) said at Montreux: "The time spent with those we love is the really important time in our lives."

The danger lies in a doctor thinking that these problems do not apply to him. But I would urge all doctors to ask themselves about the problems I have described and accord the same courtesy to their families that they give to their patients: time to talk, time to listen, time to understand and time for compassion.

Involving wives

Doctors whose wives feel lonely and excluded might look for ways of involving them, even if actual work in the practice is barred. For instance, patient participation groups are becoming increasingly popular (Pritchard, 1981) and there may be tremendous scope for wives to help husbands and patients alike. Some doctors interested in research have been able to involve their wives in this aspect of their work. College members could well respond to Mrs Horder's call for greater involvement of their wives in College activities.

Of course it is not a one-way affair. In return, families must try to understand the doctor's problems in order to meet him half-way, as in any family.

Practice organization

General practitioners may be able to help themselves and their families in a more practical way by taking a close look at their practice organization. For example, the general practitioner who is never on time for his meals should ask himself why his colleague down the road, who has a comparable practice and list size, usually is. They may both be caring doctors, but one is causing his family a great deal more upset and irritation. The other is simply more organized. He has probably found the right balance between the number of surgery consultations he offers and patient demand, checked whether all his home visits are really necessary, and shared his work appropriately with other members of the practice team. If his work-load is really too great, he might consider reducing his list size or look at the advantages of personal lists (Pereira Gray, 1979). A reduction in income or temporary upheaval are small prices to pay for a happy family. I am not, of course, talking about doctors who are fighting factors beyond their control such as arise in inner cities.

Health

As far as health is concerned, it is essential that all doctors' families should have a family doctor. The arguments for this are well set out in two editorials in this journal (1978 and 1980) and need not be repeated here. There are still far too many doctors' families not registered with a general practitioner, and even those who are do not always use him properly. It is a temptation to which too many general practitioners and hospital doctors succumb—to make a quick, provisional diagnosis, bypass the family doctor and go straight to the consultant friend in the relevant specialty. To me it is particularly extraordinary that general practitioners, who subscribe to the view that their role is to care for the 'whole person', should err in this way. As far as the sick doctor is concerned, wives can help by watching for danger signs in their husbands, whether physical or mental, which might lead to serious problems, and persuade them to see a doctor. Unfortunately doctors as a group tend to present late rather than early; this is one way in which their families can help.

Outside help

Obviously some of the problems I have mentioned can be solved only at government level and this is beyond the scope of my paper. However, I think there is much that the profession can do for itself.

Acknowledge the problem

The first thing it can do is quite simply acknowledge the problem. It is noticeable that the literature on the subject is far greater in the USA than in this country, which suggests either that the problems are greater there or that the profession there takes more notice of them. The WONCA session at Montreux was recognition on an international scale: the study day held by the Royal College of General Practitioners was an important step towards recognition in this country.

A way of thinking should be encouraged whereby the implications for the doctor's family are taken into account whenever broad issues are discussed. For instance, the National Trainee Questionnaire (Ronalds *et al.*, 1981) could well have taken the opportunity to ask about support for trainees' spouses in the different training schemes, and I wonder if the College working party on confidentiality has discussed the difficulties of confidentiality in relation to the family such as I have described?

The profession can also strive to promote those organizations which bring doctors and wives together such as the Local Medical Societies and the Royal Medical Benevolent Fund.

Groups for trainee wives

There is one further practical possibility, at least for the families of general practitioners.

General practitioners have discovered that one way of solving their professional problems is to meet in small groups in order to share them. They have, in fact, found a way to professional satisfaction which it is to be hoped is reflected in the home.

I suggest that a similar system is appropriate for wives, but at the training stage of their husband's career. Now, with the introduction of compulsory training for general practitioners, is the ideal time to tackle the problem. If general practitioners have been given time to learn, instead of being catapulted into practice as in the past, so now have their wives.

If wives can have their own sessions as part of a vocational training course, they can be helped to know what to expect, and what will be expected of them, when their husbands enter practice. They could work through

a curriculum which would include such topics as first aid, answering the telephone, what to expect in different types of practice, what to expect at interviews, the role of a partner's wife and what the problems are likely to be. In future, doctors' wives are not so likely to be involved in the practice and most expect to do other work when their children are old enough; for that very reason they may not realize just how great the pressures will be. To be forewarned, therefore, would be to be forearmed. But there should, of course, be no pressure on wives to attend such groups. Perhaps initial joint sessions with the doctors would be helpful, and I think trainees in any case should have sessions on 'The Doctor's Family' built into their course.

I am doubtful whether the same approach is wise for the wives of established principals, although I know such groups already exist. There are problems of being linked by partnerships, rotas, friendships or feuds. In other words, relationships between members of a local group are already established, and although they might be improved by group work, they might also be made very much worse (Savory, 1978). It is extremely difficult to maintain the boundaries between what is general and what is personal. Other wives have also told me that they think such groups can create more problems than they solve. If we do have them, it is essential that they should be led by someone professionally qualified or experienced in group leadership.

There is not quite the same problem for trainee groups. The doctors are not in partnership, nor in most cases in the town in which they will ultimately practise, so the wives do not feel they have to watch what they say to quite the same extent. They have individual problems, but these do not impinge on each other and there is a common bond of wanting to know what is in store. I think groups for trainee wives could be led by doctors' wives provided they had had several years' experience and were sensitive to people.

Conclusion

The problems are many, the solutions few. However, I think all doctors and organizations with responsibility for health care should now look at the problems facing doctors' families to see if there is any way they can offer help.

Prevention is a topical subject at the moment, as the profession, having decided that prevention is probably better than cure, is now looking for practical opportunities. I suggest that if it is not possible to find a 'cure' for the problems of the older generation of doctors' families, it may at least be possible to prevent them happening to a new generation.

I should like to see the Royal College of General Practitioners take the lead in encouraging groups for trainee wives. Although other countries such as the USA have been supporting their residents' wives for some time (Curry, 1978), we have been slow to see the need in the UK. Now is the time to start, so that with a new generation of vocationally trained practitioners we can at the same time produce a new generation of wives who have been helped in advance to meet the pressures of practice life and so contribute confidently to the happiness and well-being of their families.

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Incontinence

Fifty women with normal urinary control and 100 women with urinary incontinence wore a series of pre-weighed sanitary towels for 1 hour. The pads were weighed again after use. Mean pad weight increase was less than 1 g/h in normal women and 12·2 g/h in women with incontinence. In each case the pad-weighing test provided information about the severity and the pattern of incontinence which was not easy to obtain either from patient interview or from clinical examination.

Source: Sutherst, J., Brown, M. & Shawer, M. (1981). Assessing the severity of urinary incontinence in women by weighing perineal pads. *Lancet,* **1,** 1128-1130.