Editorials

Marital distress among resident physicians

Michael F. Myers, MD, FRCPC

Residency training has long been known to constitute a stressful time in the professional development of physicians.\(^1\)-\(^4\) Considerable literature has documented problems in work performance,\(^5\) anxiety states,\(^6\) alcohol and drug abuse,\(^6\) depression\(^7,\)\(^8\) and suicide\(^9\) among residents, but marital issues\(^10\) have been discussed less often. In 1984 Dr. Terry Isomura, Department of Psychiatry, Shaughnessy Hospital, Vancouver, and I administered a questionnaire to all women physicians who were enrolled in the various residency programs at the University of British Columbia. A large proportion of the women said that they and their partners had communication difficulties, did not have enough time together, had arguments over finances, work and sharing of domestic responsibilities, and were concerned about their sexual relationship (unpublished data, 1984).

What are the problems that commonly beset married resident physicians? Long work days and frequent on-call assignments rapidly lead to insufficient time with their spouses. Subsequent lack of sleep results in diminished mental alertness, irritability, loss of pleasure in light-hearted activities and decreased interest in sex. The stage is set for increasing tension at home and frequent arguments that, if unresolved, lead to eroded intimacy and feelings of loneliness in one or both individuals.

Junior trainees struggle with conflicts about their chosen specialty. Self-doubts, lack of professional confidence, a sense of dysequilibrium, second thoughts about career choice and conflicts with authority figures may contribute to marital tension and estrangement in residents who do not disclose their concerns to their spouses or who play down their internal distress. Also, as physicians progress through residency many changes occur: the acquisition of a professional identity, increased autonomy and greater self-esteem, a larger amount of separation and independence from the family, a more secure sexual identity, an increasing ability to form and maintain intimate relationships, and an attentiveness to community and social responsibilities. Spousal fears of abandonment toward the end of training are not unusual, especially among individuals who were married before or during medical school.

Role strain — "the felt difficulty in fulfilling role obligations"\(^11\) — has long been known to be a problem for professional women\(^12,\)\(^13\) and is especially common in married women residents with children.\(^14\) In addition to their clinical and academic responsibilities in the hospital setting, many of these women not only perform more than their share of home and child care but also organize and manage most of it. This often results in exhaustion, resentment and guilt. One woman's statement says it all: "I'm never guilt-free: when I'm home with my daughter I feel I should be with my patients, when I'm at the hospital on call I feel I should be with my daughter and my husband, when my mother visits I feel the house is a mess, when I'm at a movie, I feel I should be studying."

Role strain in male physicians has not been studied extensively.\(^15\) Historically, the male physician has been able to devote all or most of his energies to his medical career because he has had a wife at home to do everything else. Nowadays many physicians' wives are working outside the home, and the trend is toward an attempted sharing of domestic and child care responsibilities. Increasingly, men are feeling the tension and exhaustion of conflicts about their work, marriage and children. The common lament of many contemporary physician couples is "We need a wife!"

Other problems for married residents may include one or more of the following: loneliness and longing for family and established friends may occur in couples who have relocated for residency training; financial worries secondary to a backlog of education debts may create personal and interpersonal tension; anxiety in senior residents about fellowship examinations (including time away from their spouses and children for individual and group study) may upset marital stability; and,
finally, primary psychiatric illness (e.g., affective, anxiety and substance use disorders) in the resident or spouse not only may produce marital distress but also may be aggravated by marital conflict.

In sum, residency is a stressful time for many physicians, particularly married residents. For too many years marital distress among residents has been denied, ignored or camouflaged under a cloak of silence, embarrassment or sense of failure. The following suggestions may remedy this situation.

* Directors of postgraduate education in medical schools and coordinators of residency training in teaching hospitals must develop and cultivate a heightened sensitivity to the dynamic interplay in a resident’s professional and personal life. This is especially important in this era of economic constraint and reduced numbers of residency positions in various specialties. The now decreased number of residents should not be expected to perform all the duties of the original complement of residents in any clinical setting. Increasingly, paid staff and sessional physicians will have to share time on call with residents. This does not detract from the importance of night call as a learning experience for all residents; on the contrary, it gives night call legitimacy and respectability and attacks the drudgery.

* Regular formal and informal dialogue between residents and training directors must continue. Much of the impetus for this will come from house officers 17 (e.g., the Canadian Association of Internes and Residents and the Professional Association of Residents and Interns). There are many subjects that require discussion: part-time and shared residencies, policies regarding pregnancy during training, maternity and paternity leave, unpaid leave, ethical issues in the doctor–patient relationship, alcohol and drug abuse among residents, physician well-being, and marriage and medicine. An annual day-long forum, called, for example, “Residency and marriage: how to survive both,” that is open to clinical teachers, residents, spouses and children is one possibility. I feel that spouses and children can make an enormous contribution toward updating and humanizing the residency training years.

* Training directors and clinical supervisors must strive to understand that the expectations of residency trainees are now different. In short, most contemporary residents are more clearly aware of what they expect of teachers, tend to speak up more often, may challenge authority, do not expect to give up their lives to medicine and are attempting to strike a healthy balance between work and home. Indeed, many are issuing an overdue and refreshing challenge to the traditional male standard of the teaching and practice of medicine. 18 It distresses me to hear such residents dismissed pejoratively as cheeky, not dedicated, “not like they used to be” or “home again with a sick child.” Until we see more women doctors heading departments and directing training programs and until we have a greater understanding of the many gender issues in medicine, all of us, male and female, must guard against unconscious sexism toward our residents.

* Finally, I caution residents to pay close attention to the health of their marriages and to listen carefully to the perceptions of their spouses. Most spouses of residents, especially wives, are better able to describe the mood and behavioural changes than the residents themselves. It helps to understand that all marriages require time, energy, creativity, honesty and humour. It is ridiculous and ill advised to try to put issues on hold until the residency is over. Support groups for married residents 19 can be helpful as a means of identifying common problems, sharing solutions and breaking down the sense of isolation so prevalent in newly situated or newly married residents. Marital therapy may be beneficial for couples that are having more persistent problems.

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References

17. Kutcher SP: Coping with the stresses of medical education. Can Med Assoc J 1984; 130: 373–374, 381