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# Physician Burnout and the Marital Relationship: Spouse Perspective

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Abstract

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Proposal Submitted in Partial Fulfillment

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## Abstract

Physician burnout rates have consistently been higher than the general working population; however, recent literature suggested that after a steady decline in physician burnout rates, the COVID-19 global pandemic and additional organizational factors have caused physician burnout to reach an all-time high. Substantial research is available on physician burnout; however, little is known about how a physician's burnout is experienced in the marital relationship through the spouse's perspective. This basic qualitative study used purposive, convenience, and snowball sampling methods to recruit 10 female spouses of male physicians to participate in semi-structured interviews. The research question investigated the participants' perceptions of physician burnout on their marital relationships using the theoretical framework of Bolger's crossover theory. Data were analyzed using Saldaña's first and second-cycle descriptive and in-vivo coding method. This process allowed the identification of 10 common themes: sacrifice/loss, loneliness, solo parenting, anger, helplessness, misunderstood, health challenges, self-care, pride in his service, and relationships. The most relevant discovery was that the women felt like single parents and often experienced loneliness, feelings of isolation, and "walking on eggshells" as a result of their husbands' work-related burnout. Potential implications for positive social change include expanding the conversation on how physician burnout affects the spouse and their families. As a result, programs intended to support medical families can be introduced early in medical training programs and extend throughout the physician's career to adequately prepare couples for the challenges ahead.

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# Dedication

This study is dedicated to the medical families who support our physicians as they follow their calling to provide high-quality healthcare to those they serve. Your efforts do not go unnoticed! You are the true unsung heroes of the medical community. I thank each spouse who took the time to share their experience with me. Thank you for being open, honest, and vulnerable as you shared the inner workings of your personal lives with me. I intend to take what you have shared and use it to improve the lives of other medical families. I wish you all good health, prosperity, and many years of a happy "medical marriage."

# Acknowledgments

It is said that Sir Isaac Newton drafted a letter to scientist Robert Hooke in 1675 in which he expanded upon an earlier quote by Bernard of Chartres, stating, “If I have seen a little further it is by standing on the shoulders of Giants.” This quote speaks to me as I reflect upon the journey of conducting this study and completing this dissertation. The previous works on burnout from Freudenberger and Maslach and Leiter, and the studies on physician families from Gabbard and Menninger, and the Sotiles were foundational cornerstones in my work. The scholarly research on physician wellness contributed by Drs. Dyrbye, Shanafelt, Sinsky, Trockel, and West was pivotal in my process. I thank you for your work and truly being the shoulders I stand on.

Special thanks to the AMAA and FMAA for sharing my study, and to the amazing women who participated, making this all possible.

I have immense gratitude for my committee, Dr. Silvia Bigatti and Dr. Sandra Rasmussen. Their suggestions, guidance, and support were indispensable. To my peers, Kelsey and Ruth, walking the path to a Ph.D. with you both has been an excellent adventure!

Finally, I must acknowledge my husband and my inspiration for this dissertation, Dr. Stephen J. Muehlenbein. Being by your side in a “medical marriage” for the last 25 years has been a rollercoaster of ups and downs. This ride provided insight into the necessity of this study. Thank you for supporting me in every “wild card” idea I’ve ever had and for keeping me grounded. I appreciate everything you have done for me and our family. Being your wife and partner has been an honor and a gift.

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# Chapter 1: Introduction to the Study

## Introduction

The World Health Organization (2019) describes burnout syndrome as stress one experiences as a direct effect of their profession; it is especially prevalent among those in the human services field (Freudenberger, 1974). This proposal focuses on burnout among physicians. The societal burdens placed upon the physician are fueled by the expectations of long work hours, stressful work conditions, life-and-death scenarios, lack of sleep, and still having the ability to function at high capacity as par for the course for this profession (UCSF Department of Medicine, 2023). These working conditions lead to higher rates of work-related burnout, characterized by emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach & Jackson, 1981). Further, physician burnout is directly correlated to greater incidences of substance use and abuse, medical errors, decreased patient satisfaction, and decreased physician health (American Medical Association, 2023; UCSF Department of Medicine, 2023; Ryan et al., 2023; Trockel et al., 2020). The profession carries a higher suicide risk and completion rates when compared to the general population (Duarte et al., 2020; Williams et al., 2020). Finally, when a physician is suffering from the effects of work-related burnout, the ramifications can also carry over to the spouse, creating secondary trauma (Grimmer & Jacquin, 2023).

Chapter 1 provides a background on physician burnout, the problem statement, and the purpose of the study. The research question driving the study and conceptual framework to support the study are also detailed in this chapter. Further, the nature of the study and the rationale for utilizing a basic qualitative design are explained. Chapter 1

also includes operational definitions, assumptions, scope, and delimitations, as well as the study's anticipated limitations and significance this study will provide.

## Background

Prior to the COVID-19 pandemic, physician burnout rates had been on a steady decline despite being impacted at a higher rate than the general employed population (Aalto et al., 2022; Dyrbye et al., 2013; West et al., 2020). Rates of physician burnout rose sharply as the global pandemic spread and affected the entire medical community in an unprecedented way. The pandemic saw rates of physician burnout increase from 38.2% at the beginning of 2020 to 62.8% by 2021 (Berg, 2022; Shanfelt et al., 2022b). In addition to the stress caused by the pandemic, approximately 80% of physician burnout can be attributed to organizational issues such as long work hours, administrative burdens, and organizational contributors, while only 20% of physician burnout is because of factors specific to the physician (American Medical Association, 2023; UCSF Department of Medicine, 2023).

Burnout impacts physician health, decreases patient care, and contributes to high physician turnover and medical errors (American Medical Association, 2023; UCSF Department of Medicine, 2023). Physician burnout also burdens the healthcare system by increasing costs due to physician replacement, litigation costs from medical errors, and decreased revenue from lower productivity (Aalto et al., 2018; Berg, 2018; Patel et al., 2018; Weissman et al., 2023). The burnout experienced by the physician does not stop with them. When a physician experiences work-related burnout, the effects can carry over into the marital relationship, affecting the quality of life (QOL) of their spouse and family

and resulting in disruption of work-life balance (WLB), work-life integration (WLI), and work-home conflict (WHC) (Lee et al., 2021; Shanafelt et al., 2022a). Much research exists on the effect of burnout on physicians and the organizations they work for; however, there is a paucity of research on how physician burnout presents itself in the marital relationship from their spouse's perspective.

## Problem Statement

The organizational and societal demands and expectations placed on physicians create a high-pressure, high stress working environment that leads to physician burnout. In addition to having a negative influence on work performance, physician satisfaction, patient care, medical errors, anxiety, depression, and mental health, burnout can impact physicians' intimate relationships, which was the focus of this study. The research problem addressed through this study was how physician burnout influences medical marriages from the spouse's perspective.

## Purpose of the Study

This basic qualitative study investigated how physicians' spouses experience the physician's work-related burnout in their marital relationship. Examining the spouse's experiences and how the physician's burnout shows up in their marital relationship may provide insight to the physician, their spouse, and the organizations that depend on physicians on how to address the issue better and reduce the effects on all parties involved. Doing so may improve QOL, WLB, WLI, and decrease WFC for the physicians and their families, while also reducing costs and increasing revenue for the organization.

## Research Question

The research question guiding this study was as follows: How do male physicians' female spouses experience the physician's burnout in their marital relationship?

## Conceptual Framework of the Study

Bolger's (1989) crossover theory is the conceptual framework that grounds this study. Bolger's framework can help explain how the professional stress, strain, and burnout experienced by the physician in the workplace not only affects the physician but can be taken home and directly affect the spouse. As a result, the marital relationship can be affected by the burnout experienced by the physician.

## Nature of the Study

To address the main research question in this study, the specific research design included a basic qualitative study with data analysis following Saldaña's (2021) descriptive coding process and utilizing first and second-cycle coding. Applying a basic qualitative design to this study was appropriate as it allowed me to explore the spousal perspective of how physician burnout plays into the marital relationship. This study applied a purposive and convenience sampling approach to gather data from approximately 10 women who belong to groups of physician spouses. Additional participants were acquired through snowball sampling via word of mouth from friends who choose to participate.

## Operational Definitions

*Alliance:* Medical Alliances are groups typically comprised of spouses or partners of physicians. These organizations exist on the local county, state, and national levels and are focused on supporting physician families and advocating for the medical communities (American Medical Association Alliance, 2023)

*Burnout:* A syndrome relating to one's work that is characterized by three dimensions: emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Maslach & Leiter, 1981).

*Depersonalization:* One of the three dimensions of burnout. Persons experiencing depersonalization often appear callous and develop a cynical attitude towards others. When this involves the human services field, interactions with patients or clients can feel more transactional and less personal (Maslach & Jackson, 1981).

*Emotional Exhaustion:* One of the three dimensions of burnout. A feeling of being depleted, psychologically drained, and as though one has nothing left to give. (Maslach & Jackson, 1981).

*Maslach Burnout Inventory (MBI):* A measurement tool created by Christina Maslach and Susan E. Jackson in 1981 that is considered the "gold standard" for measuring the three dimensions of burnout. Many variations of this tool exist to address burnout in different professions. For example, the MBI-HSS is designed for those in human services, whereas the MBI-ES is designed for educators (Maslach et al., 2018)

*Medical marriage:* A "medical marriage" is a legal marriage where at least one spouse is a physician. Medical marriages differ from traditional marriages due to the

additional professional demands and stress placed upon the physician, which can create discord between work and family life (Gabbard & Menninger, 1988; Sotile & Sotile, 2000). For this study, a medical marriage includes a female (i.e., the spouse) who is not a physician, and a male who is a physician.

*Pandemic:* The U.S. Department of Homeland Security (2022) defines a pandemic as occurring when an infectious disease (typically viral) spreads across multiple countries and causes a large number of the population to become ill. For the purposes of this study, the term pandemic refers to COVID-19. The WHO declared COVID-19 a global pandemic on March 11, 2020 (WHO, n.d.).

*Personal accomplishment:* The sense of pride one feels from their work; a feeling that they are making a difference and what they do matters. When a person suffers from burnout, they often feel a reduced sense of personal accomplishment, one of the three dimensions of burnout. In this dimension, people develop a negative view of their work, believing that what they do does not make a difference. Lack of personal accomplishment often leads to employees developing negative feelings about themselves, resulting in lower job satisfaction (Maslach & Leiter, 2018).

*Physician:* A person who has successfully graduated from an accredited institution with the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) and, thus, is eligible for a residency approved by the Accreditation Council for Graduate Medical Education (ACGME; American Medical Association, 2023a).

*Quality of life (QOL):* QOL refers to the positive and negative components of one's well-being at a specific time. Multiple life factors comprise well-being, such as professional working environment, financial security, education, socio-economic status, and physician health (Teoli & Bhardwaj, 2023).

*Spouse:* Two individuals who are legally married to each other (Cornell Law School, n.d.). For this study, spouse refers to a non-physician female married to a male physician.

*Work-family conflict (WFC):* A WHC occurs when an individual struggles to complete the tasks required to fulfill their job duties and domestic responsibilities. This fight for the person's attention creates a conflict between the work and home environments (Dyrbye et al., 2013).

*Work-life balance (WLB):* A WLB occurs when an individual can create symmetry between the demands their workplaces upon them and the requirements of their daily life outside of work. When homeostasis is achieved between work and home, the responsibilities and commitments of one realm do not infiltrate the other (Iyer, 2022).

*Work-life integration (WLI):* WLI occurs when one's professional and domestic responsibilities align, and the individual is not forced to prioritize one area over the other (Tawfik et al., 2021). When a WFC occurs, the WLI is maligned.

## Assumptions

For the purposes of this study, I assumed that the inclusion criteria were appropriate for the population I wanted to learn from and that the experiences of the wives would be similar. It was also believed that I would be able to establish and hold a

space where participants felt they could speak freely while answering the interview questions regarding their experience with physician burnout and their marital relationship openly and honestly. Further, the assumption was that a physician's burnout carries over into the marital relationship. Understanding how spouses experience physician burnout would provide valuable insight to medical couples and organizations employing physicians. It was also assumed that the knowledge gained from this study would inform the couples and organizations of the pain points experienced in a medical marriage and that both parties would want to support the physicians and their families to reduce or eliminate these issues. Additionally, the initial questions and further probing questions to the participants were assumed to provide a deeper understanding of the wives' experience, allowing saturation to be achieved. Finally, the potential risk for bias would be reduced by following the methodological strategy, question formulation, and procedures to establish trustworthiness and ethical standards explained in Chapter 3.

## Scope and Delimitations

The scope of this study was limited to female spouses (who are not also physicians) of male physicians who have been practicing in the United States for at least 5 years. The delimitation of 5 years indicates that the physician would have had the opportunity to have practiced medicine before, during, and after the COVID-19 pandemic. This is important due to the previous decline in physician burnout seen pre-pandemic, and the height of physician burnout seen during the pandemic.

I considered including all spouses of physicians regardless of gender identity; however, I believe that the best way my study can contribute to social change is to

generalize the results to the greatest number of people who may be affected. As discussed in Chapter 2, the ratio of female physicians is growing, but the profession is still male dominated. Additionally, female physicians tend to marry male physicians; however, due to the ratio of male physicians to female physicians, most male physicians do not tend to marry female physicians. For this reason, the data indicate that the majority of physicians are male, while the majority of their spouses are females who are not physicians. This delimitation also excludes medical marriages where the female spouse is the physician, and the husband is not a physician, and dual physician marriages due to the additional complexities included in those types of marriages that are beyond the scope of this study.

LGBTQ+ marriages and domestic partnerships were also a consideration for this study; however, these relationships were excluded due to the lack of demographic data on physicians who identify themselves as LGBTQ+. The LGBTQ+ community faces social and political issues that place additional burdens and complexities on its members that are not typically experienced in a traditional male/female marriage. The LGBTQ+ community, as well as the aforementioned types of non-traditional medical marriages, deserve studies dedicated to addressing the unique needs related to their types of relationships.

## Limitations

When conducting a qualitative research study, researchers are often focused on constructing meaning from a participant's experience, which can be subjective. In contrast, a quantitative study relates more to information obtained through surveys and experiments, which can easily be distilled into numbers to determine how the

independent and dependent variables contribute to the results (Creswell & Creswell, 2017; Merriam & Tisdell, 2016). When information is subjective and not numeric, like an experience or perspective, it may be skewed by the participant's personal opinion or bias, which can be a limitation of qualitative research. Anderson (2010) explains that an additional limitation to qualitative research can be attributed to the researcher's ability to conduct interviews, not lead the participant, and refrain from bias. Further, she also recognizes the high volume of work involved in conducting and transcribing qualitative interviews. Finally, coding and analyzing the data from qualitative interviews can be time-consuming for the researcher (Anderson, 2010).

In this study, a potential barrier when collecting primary data included difficulty recruiting participants for interviews due to being a member of a local Medical Society Alliance. Ensuring a clear separation of my role as a member of the group and my role as the researcher was a potential challenge. To reduce this limitation and to focus on my role as researcher, I only interviewed people from the FMAA and AMAA (state and national levels) with whom I had no prior personal relationship with. Additionally, I did not solicit members of my local/county organization with whom I have previously met or had an existing personal relationship with. Additionally, reiterating my high regard for the privacy and confidentiality of participants was emphasized to ease any discomfort they may feel about speaking openly, honestly, and authentically about their experience.

## Significance

This study is significant in that it will fill a gap in the literature by improving the understanding of how physician burnout affects a marriage from the perspective of the

physician's spouse. The results of this study should inform the scholarly communities that have direct relationships with physicians how the burnout they experience due to the stress and strain of their profession can carry over into the marital relationship, possibly their families, and can also have a bidirectional effect on their work performance, patient care, and medical errors. Additionally, understanding how the spouse experiences burnout can help to determine additional support measures needed to address the psychological distress experienced in medical families (Grimmer & Jacquin, 2023). Most individuals in our society interact with their local healthcare, hoping they have a positive experience and outcome; therefore, reducing physician burnout, its effect on the marital relationship, and thus improving patient care can create positive social change.

## Summary

There has been significant research on general physician burnout but limited data on how the spouse experiences physician burnout in the marital relationship. This basic qualitative study focused on learning how (male) physician burnout was experienced in the marital relationship by their (female) spouse. Physician burnout poses significant burdens to the physician; however, the effects extend to their patients, the healthcare organizations that employ them, and their families (Aalto et al., 2018; American Medical Association, 2023; Berg, 2018; Grimmer & Jacquin, 2023; Patel et al., 2018; UCSF Department of Medicine, 2023; Weissman et al., 2023). The spouses and families are often the most significant support network for physicians; therefore, exploring how the spouse perceives the physician's burnout has carried over into their marital relationship is necessary as proper resources can be determined, support systems can be created, and a

healthier medical community can be promoted (Grimmer & Jacquin, 2023; Sotile & Sotile, 2004).

In Chapter 1, the study was introduced. This content included identifying the problem, declaring the purpose, identifying the research question, and defining the conceptual framework used to navigate the study. Chapter 1 also included the nature of the study, allowed for key operational terms to be defined, and identified assumptions made in the study's design. Further, this study's limitations, delimitations, scope, and significance were also included in Chapter 1. In Chapter 2, prior and current literature is reviewed on general physician burnout, as well as the causes, effects, and solutions. Additionally, Chapter 2 includes a description of the search strategy used and provided a detailed account of the applied theoretical framework.

# Chapter 2: Literature Review

## Introduction

Burnout syndrome is directly related to stress experienced in the workplace and is specifically associated with one's occupation (WHO, 2019). Herbert J. Freudenberger, a pioneer in the study of burnout, cited that burnout was frequently experienced by individuals working in the human services field (Freudenberger, 1974). He noted that physical and behavioral symptoms often characterize burnout syndrome. He further identified that the physical symptoms of burnout syndrome may include headaches, exhaustion, fatigue, recurring illnesses, and sleep dysregulation. He noted that behavioral manifestations of burnout may include being easily angered, having a cynical attitude, taking more risks than usual, exhibiting erratic behavior, and reclusiveness or becoming withdrawn (Freudenberger, 1974).

Leading up to the COVID-19 pandemic, physician burnout rates had been steadily declining; however, when compared to the general employed population, physicians experience burnout at higher rates (Aalto et al., 2022; Berg, 2022; Dyrbye et al., 2013; West et al., 2020). Generally, physicians are at a 40% greater risk for work-related burnout than the general population (Shanafelt et al., 2022b). Shanafelt et al. (2022b) and Berg (2022) shared that in 2014, the estimated physician burnout rate was 54.4%, and the general population was 28.4%. In 2017, the physician burnout rate dropped to 43.9%. In contrast, the general population lowered to 28.1%. The year 2020 began with the physician burnout rate as low as 38.2%, and the general population was 25.2% (Berg,

2022; Shanafelt et al., 2022b). By 2021, the physician burnout rate had climbed to 62.8%; general population rates were unavailable (Berg, 2022).

For physicians specifically, burnout results in decreased patient care and patient satisfaction, increased medical errors, decreased job satisfaction, reduced productivity, increased costs for the healthcare system, and increased physician turnover (West et al., 2018). With such a large percentage of a profession that is directly responsible for the health of the population experiencing burnout, the issues of increased medical errors, decreased quality of patient care and patient satisfaction, and extended recovery times, physician burnout becomes a significant social issue (Doolittle, 2020; West et al., 2018)

The effects of burnout can also carry over into the marital and family relationship (Bolger, 1989; Maslach et al., 2018; Yucel & Latshaw, 2020). Grimmer and Jacquin (2023) reported that when a physician is experiencing burnout, their spouse can experience higher anxiety and greater incidences of depression (Grimmer & Jacquin, 2023). The effects of burnout can also disrupt the physician's WLB and WLI and subsequently create work-home conflicts (WHC), which carry over into their marital relationship and cause decreased quality of life (QOL) for both the physician and their partner (Dyrbye et al., 2013; Shanafelt et al., 2022b).

A "medical marriage" is different from a traditional marriage due to the unique circumstances, stressors, burdens, professional demands, and situations experienced by couples where one (or both) of the spouses is a physician (Gabbard & Menninger, 1988; Sotile & Sotile, 2004). Previous research on physicians and spouses has focused on work-home conflicts relating to burnout and quality of life from the physician's perspective and

not the physician's spouse (Dyrbye et al., 2013). Understanding the spouse's perspective on physician burnout serves a significant purpose, as having a supportive spouse and social support is a valuable protection against burnout (Gabbe et al., 2002; Song et al., 2021; Warde et al., 1999). Spousal support can act as a moderator of the stressful work environment that physicians experience. As a result, when a physician feels emotionally supported by their spouse, they feel better equipped to manage their work-related stress (Jovanovic & Wallace, 2013; Peisah & Lele, 2022).

Researchers have investigated the issue of physician burnout in great depth. Studies have also examined the importance of physician relationships on burnout reduction. Recently, Grimmer and Jacquin (2023) conducted a quantitative study that examined how the spouse's perception of the physician's burnout created secondary trauma in the spouse; however, the topic of physician burnout and its influence on the marital relationship has not been explored from the perspective of the physician's spouse using a qualitative methodology.

The present study focused on the female (non-physician) spouses of male physicians, as 62% of physicians in the United States are male (Federation of State Medical Boards, 2023). Additionally, female physicians have a greater tendency to marry other physicians whereas, most male physicians do not tend to marry female physicians (Hu & Dill, 2021). A dual physician marriage and a marriage where the wife is the physician present unique challenges and circumstances that extend beyond the scope of the present study. Additionally, currently, little to no published data exist on the presence of LGBTQ+ physicians, their marital statuses, and issues specific to their unique

relationships (Peisah & Lee, 2022). This qualitative study aimed to explore how the female spouses of male physicians view the effects of their husband's work-related burnout on their marital relationship. The following sections discuss strategies used to research the literature, a background on generalized burnout, including causes, effects, and solutions, how physician burnout influences job satisfaction, WLB, the marital relationship, and a concluding summary.

## Literature Search Strategy

The strategy for researching the current literature on burnout and the marital relationship focused on literature published within the last 5 years. Research published before 2018 was reviewed and included when considered relevant to the topic of physician burnout and the marital relationship. Literature was sourced primarily from the Walden University online library using numerous psychology databases, which included APA PsychInfo, SAGE Journals, and EBSCO. The topic of this dissertation relates directly to the medical field; thus, the CINAHL, MEDLINE, and ProQuest Health & Medical Collection databases were also accessed. Additional resources were obtained through the Google Scholar search engine. Since no articles explicitly related to how a physician's spouse experiences the physician's burnout, all databases and resources examined were directly associated with exploring physician burnout, its influence on WLB and the physician's relationships, and how the spouse may experience these factors. Initial searches were limited to the last 5 years with references to earlier relevant works specific to the Maslach Burnout Inventory (MBI) and the marital relationship from the perspective of the physician's spouse. Keyword searches included *physician burnout,*

*spouse, partner, wife, wives, husband, spouse perspective, spouse as proxy, spouse perception, spouse support, physician and work-life balance, physician burnout and spouse support, physician burnout and divorce or separation, physician burnout and family relationships, physician burnout and suicide rates, physician burnout and Covid-19, coronavirus, 2019-ncov, sars-cov2, cov-19, physician spouse, physician marriage, doctors wives, physician work-life balance, burnout and crossover theory, physicians and crossover theory, marriage and crossover theory, stress and spouse well-being,* and *job satisfaction and crossover theory*. Five books were used regarding physician burnout and/or relating to physician relationships and the "medical marriage." Five online lectures were reviewed from the American Medical Association relating to physician burnout and the marital relationship. Research shared by presenters during lectures at the 2023 American Conference on Physician Health is also referenced.

## Theoretical Framework

The concept of burnout, as first described by Herbert J. Freudenberger (1974), is a syndrome widely experienced by those working in the helping professions. Christina Maslach expanded on Freudenberger's work by identifying burnout within three dimensions: emotional exhaustion, depersonalization, and personal accomplishment (Maslach & Jackson, 1981). She noted that burnout syndrome can cause those who are suffering from it to experience extreme exhaustion, feelings of extreme cynicism, and feeling ineffective in their job performance. These symptoms can lead to becoming withdrawn, increased doubt in the impact of their work, and feeling completely depleted. When not properly managed, the stressors that lead to burnout can create mismatches

between the worker and their places of work. These mismatches occur when the worker has one idea and expectation while the workplace has another vision, and the two are not aligned. Often, these misalignments can be due to overwork, not being able to control the work environment, imbalance of rewards for work rendered, lack of community support in the workplace, feelings of unfairness, and a discrepancy of values between the worker and the workplace (Maslach & Leiter, 2022).

For physicians, the experience of burnout is higher than that of the general population (Shanafelt et al., 2022b). Although rates of physician burnout had declined from 54.4% in 2014 to 38.2% in 2020, just before the COVID-19 pandemic, the post-COVID-19 pandemic rate of physician burnout has risen to 62.8% (Berg, 2022). Burnout can cause significant distress for the individual, which can, in turn, cross over into their relationships (Bolger et al., 1989).

**Crossover Theory**

Bolger's crossover theory can provide understanding on how burnout experienced by a physician carries over into the marital relationship. In the crossover theory, Bolger et al. (1989) explain how the professional stress, strain, and burnout experienced by the physician in the workplace not only affect the physician, but that these stresses can be taken home and directly affect the spouse. As a result, the spouse, and thus the marital relationship, can be affected by the burnout experienced by the physician. Yucel and Latshaw (2020) further define the crossover theory as an inter-individual transmission and dyadic nature, suggesting the burnout experienced by the physician is transferred to the spouse or partner. In the case of the present study, the burnout experienced by the

physician because of the stress and distress encountered through their profession can also be experienced by their spouse when the physician shares aspects of their work experience. Additionally, the depersonalization and withdrawn characteristics identified in burnout can cause decreased communication among spouses and work-family conflict.

WFC can occur when the experiences one has at work affect their life at home. Additionally, conflict can occur bidirectionally when family conflicts arising at home can affect one's work life, creating a family-work conflict (FWC); however, work conflicts tend to have a more significant impact on one's home life than home conflicts affecting work life (Bolger et al., 1989; Yucel & Latshaw, 2020). WFC tends to impact men more than women due to socio-cultural expectations of the male being the breadwinner of a traditional male/female relationship; however, when the male is experiencing work-related burnout and the adverse effects of burnout crossover into their marital relationship, it creates a WFC. Additionally, the effect of their burnout and stress can have a negative impact on the mental health of their female spouse (Yucel & Latshaw, 2020). The negative impact on the female spouse often occurs due to the greater empathy women express and the increased awareness women have when others around them experience conflict, which is attributable to gender socialization. As a result, when people they care about are experiencing greater distress, women are more affected than men (Yucel & Latshaw, 2020). Thus, the crossover theory implies that when a physician experiences physical and emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment in the workplace as a result of burnout, their experience can transmit to their spouse (Brough et al., 2018; Muhamad Nasharudin et al., 2020; Wang et

al., 2022; Westman & Etzion, 1995). Literature from Yucel and Latshaw (2020) suggested the interindividual transmission effect is greater on the female spouse, whereas Brough et al. (2018) cited the gender of the spouse as not significant. Despite gender, professional stress, strain, and burnout experienced by the physician can carry over into their home, creating WFC and impacting their spouse's well-being (Bakker et al., 2009). The effects of burnout carry a negative implication; however, Westman (2001) suggests that similar to adverse work events, positive experiences can also carry over into the home life and positively impact the spouse, thus suggesting that the crossover theory does not only carry a negative connotation.

Previous research has applied the crossover theory to the burnout and stress of the spouses of police officers, firefighters, Naval couples, and CPAs. These studies showed the female spouses of these men working in high-stress jobs were impacted by their partner's work-related stress and burnout. The female spouses experienced their husband's stress, decreased mood, physical and psychological symptoms, and overall, they experienced a decrease in their well-being (Beehr et al., 1995; Bolger et al., 1989; Buck & Neff, 2012; Jackson et al., 1985; Long & Voges, 1987; Morrison & Clements, 1997; Pavett, 1986). Current research has also applied the crossover theory to assess how one spouse's professional experience can carry over from work to home, consequently affecting their spouse and marital relationship. The latest research on employee and supervisor interactions shows that when an employee has a negative experience in the workplace, the effects on the employee can extend into the employee's home life and affect the spouse's perception of their marital well-being. Current studies of military

couples and first responders have shown that the stressful events experienced in these lines of work can affect the individual but also crossover into the marital relationship, subsequently affecting the spouse and the family. As a result, these studies showed a correlation between higher stress and lower marital quality, along with a disequilibrium in their work-life balance (Beltràn Ponce et al., 2023; Morman et al., 2020; Sharp et al., 2022; Wang et al., 2019; Wang et al., 2022; Woodall et al., 2020). Additionally, a recent quantitative study by Grimmer and Jacquin (2023) studied the secondary trauma experienced by physicians' spouses when they perceive the physician to be experiencing burnout. Their findings suggested that spouses' perceptions of when the physician is experiencing burnout are accurate, and that the spouse also experiences increased emotional exhaustion and depersonalization, as well as greater instances of anxiety and depression.

Like physicians, the non-physician professionals in the previous studies perform job duties in high-stress professions, work long hours (or are possibly deployed), and have an unequal distribution of family demands. While some of these previous studies looked at the effect of stress, distress, or burnout on the spouse, none looked explicitly at the employee's burnout from the spouse's perspective and how burnout was experienced in the marital relationship. For these reasons, the crossover theory was appropriate for this study to examine physician burnout and the marital relationship from the spouse's viewpoint.

## Literature Review Related to Key Concepts

### Burnout

Burnout syndrome occurs when a person encounters extreme and continuous stress due to their profession or in their workplace (Freudenberger, 1974). When individuals are unable to manage their chronic stress productively, burnout syndrome may ensue (WHO, 2019). A physician experiencing burnout syndrome may feel depleted and emotionally exhausted, become cynical, distant, and detached from their patients, and experience negative health outcomes (Patel et al., 2018).

Maslach and Jackson (1981) classified burnout syndrome in three dimensions: emotional exhaustion, depersonalization or cynicism, and a decreased sense of personal accomplishment or professional efficacy. They explain that when an individual is experiencing emotional exhaustion, they feel depleted and like they have nothing left to give or are mentally drained. Further, a physician may become depersonalized and cynical, causing them to be resentful of their patients. Additionally, this experience may cause the physician to dehumanize their interaction with their patients by viewing it as more transactional than personal. Finally, when experiencing burnout syndrome, physicians may feel like their work is not doing the good they set out to do and are not making a difference. This feeling of a lack of personal accomplishment leads to job dissatisfaction. When workers suffer from a lack of personal accomplishment, they may miss work, leave their jobs, suffer from low morale, or use alcohol or drugs to cope. To determine an individual's level of burnout, Maslach & Jackson (1981) devised the Maslach Burnout Inventory (MBI) as a tool to assess and measure these three

dimensions. The MBI is now considered the "gold standard" measurement for burnout (Maslach & Jackson, 1981; Maslach et al., 2018; WHO, 2019).

## Causes of Physician Burnout

### *Long work hours*

On average, physicians work 50.8 hours per week vs. the general population, which works 40.7 hours per week (Shanafelt et al., 2022b). Many physicians feel that long work hours are necessary to address the substantial debt they have accrued during medical school. In 2020, the Association of American Medical Colleges reported that 73% of medical students have debt upon completion of medical school. This debt can range from $250,000 for a public school to $330,000 for a private school, with a median debt load of $200,000 (Budd, 2020).

A higher clinical workload, seeing more patients, and more evenings on-call often accompany the longer work hours. An increased workload has been positively associated with a physician's increased risk for burnout (Shanafelt et al., 2022b). When physicians experience an increased workload, they experience emotional exhaustion (Watson et al., 2018). Recognizing workload as a contributing factor to physician burnout is vital, as emotional exhaustion and problems at work have been linked to an increased risk for attempted suicide (Williams et al., 2020). Additionally, increased workload can be directly associated with decreased patient care, inability to spend quality time with patients, and negative patient outcomes, which cause the physician to experience a lack of personal accomplishment (Watson et al., 2018).

### *Administrative Burdens*

Advancements in medical technology, such as the introduction and application of electronic health records (EHR), have added to the physician's workload. EHR has provided a technological advancement and secure patient access to their medical records; however, it has also resulted in organizational inefficiencies, as much of this work had previously been done by other office staff. As a result, the doctor is forced to spend more time on the computer, less time with the patient, and less time working at the top of their license and performing actual "doctoring," which makes the doctor-patient interaction more transactional and less personal (American Medical Association, 2023; Doolittle, 2021; Patel et al., 2018; UCSF Department of Medicine, 2023). A physician will spend, on average, 2 hours per day completing administrative duties for each hour they spend providing direct patient care (American Medical Association, 2023; U.S. Department of Health and Human Services, 2022).

### *Organizational Contributors*

The roots of burnout stem from within an organization or system, while the manifestation of burnout occurs within the physician (American Medical Association, 2023b). The responsibility for physician burnout is 20% on the individual, while 80% of the responsibility belongs to the organization or healthcare system and its leadership team (UCSF Department of Medicine, 2023). The healthcare system expects its physicians to provide high-quality healthcare for its patients, but the organization does not reciprocate by providing an environment that supports the health and wellness of its physicians. Instead, the organization creates an environment that contributes to physician burnout

through a lack of leadership, making decisions to increase the organization's bottom line without communicating with the physician staff, without considering the perspective of the physician, and without recognizing the burden their decision puts on the medical staff (UCSF Department of Medicine, 2023). Further, many physicians are expected to take their work home with them and complete EHR and other administrative tasks after already completing their full workday (which is by nature already more extended than the general population), or what is known as "pajama time" (American Medical Association, 2023b). Increased work after hours is also a major contributor to physician burnout. These actions display a lack of understanding of the root causes of physician burnout. As a result, organizational decisions that put profits ahead of people place more stress on the physician and decrease morale, leading to higher incidences of physician burnout (UCSF Department of Medicine, 2023). In contrast, when physicians have a favorable perception of their organization and administration and they feel communication with the entities is good, physician burnout is lower, and physician well-being and job satisfaction are both higher (Beltràn Ponce et al., 2023; Dyrbye et al., 2021; Maslach & Leiter, 2022; Parikh & Cavanaugh, 2023).

## Effects of Physician Burnout

### *Physician Health*

The effects of burnout carry adverse risks to physician health. One such health concern of burnout for the physician is the increased risk of heart attack and ischemic stroke (UCSF Department of Medicine, 2023). Another way burnout can impact physician health is by creating sleep dysregulation from the long work hours and

increased demands of being on-call. It is estimated that 1 in 3 physicians experience sleep disturbances in conjunction with higher rates of burnout and lower job satisfaction (American Medical Association, 2023b). Lack of sleep can lead to increased medical errors, decreased empathy toward patients, and reduced cognitive ability (Trockel et al., 2020). Increased alcohol and drug use is also a consequence of burnout, as these substances are used as coping mechanisms to manage the stress the physician is experiencing (Williams et al., 2020). Further, physicians who were previously diagnosed with a major depressive disorder may notice their depression is amplified while experiencing burnout (Messias & Flynn, 2018). As a result of increased depression, suicide rates increase. When comparing completed suicides relating to job issues, the outcome is higher for physicians than for the general population or other professions (Williams et al., 2020; Ryan et al., 2023). Many physicians fear seeking treatment for mental health issues, such as depression and anxiety, due to fear of licensure issues and the cultural stigma surrounding a physician seeking mental health care (American Medical Association, 2023; Arnhart et al., 2019; Favre et al., 2023; Lele et al., 2023)

***Decreased Patient Care***

Adverse patient outcomes and poorer patient care are additional consequences of physician burnout (Aalto et al., 2018; Parikh & Cavanaugh, 2023; Weissman et al., 2023). Lack of sleep can increase medical errors, resulting in a patient's negative outcome or mortality (Messias & Flynn, 2018; Trockel et al., 2020). The psychological effects of burnout can cause physicians to become cynical and show lower empathy toward patients. This display of reduced empathy can impair the physician-patient

relationship by causing the interaction to become depersonalized and more transactional (Beltràn Ponce et al., 2023; Patel et al., 2018; Watson et al., 2018). Additional factors contributing to negative patient outcomes include less face time with patients, which can result from physicians feeling rushed to get through appointments because they also have to complete EHR. It is estimated that for each hour of patient care a physician completes, they spend 2 hours completing medical records, ordering prescriptions, and completing patient notes (Patel et al., 2018). This time spent completing other tasks can delay hospital admission, reduce patient satisfaction, decrease patient trust, and result in patient attrition (Song et al., 2021; Watson et al., 2018; Williams et al., 2020).

### *High Turnover/Physician Shortage*

Physician burnout has led to many clinicians leaving the practice of medicine. The main reason physicians are choosing to leave medicine is due to job dissatisfaction, a key contributor associated with burnout (Beltràn Ponce et al., 2023). It is expected that by the end of 2024, 1 in 5 physicians intends to discontinue practicing medicine, while 1 in 3 plan to cut hours. By 2034, this exodus of physicians is expected to create a shortage of between 37,800 and 124,000 practitioners (Association of American Medical Colleges, 2021; Shanafelt et al., 2022b; U.S. Department of Health and Human Services, 2022). The Association of American Medical Colleges (2021) reports the largest deficit of physicians in the primary care modalities, including family medicine, pediatrics, and geriatrics. With a growing number of "Baby Boomers" and people living longer and needing medical care, this physician shortage poses a detrimental threat to the healthcare system (Watson et al., 2019)

## Financial Consequences of Physician Burnout

### *Increased Costs*

The issue of burnout has resulted in higher physician turnover rates and increased absenteeism, which have placed an increased cost burden on the current healthcare system (Favre et al., 2023). Alternatively, Sara Berg (2018) of the AMA reported organizational costs of between $500,000 to over $1 million when having to replace a physician who has left. She further notes these costs can be two to three times the salary of the exiting physician. Berg attributed these costs to recruiting a replacement physician, payout for signing bonuses of the replacement, revenue lost in the interim of hiring a new replacement, and costs associated with onboarding a new physician and getting them working at their optimal capacity and generating revenue for the organization. Additionally, when physicians experience burnout due to long work hours and increased workload, they are more susceptible to making medical errors, which can incur costly malpractice judgments and increase stress for the physician, their practice, and the hospital or medical organization (Patel et al., 2018).

### *Decreased Revenue*

When physicians experience burnout, particularly emotional exhaustion, they can become dissatisfied with work, experience low morale, and put forth a lower effort, resulting in decreased revenue for the organization (Aalto et al., 2018; Patel et al., 2018; Weissman et al., 2023).) In the U.S., turnover, lower effort, and reduced clinical hours attributed to physician burnout have resulted in a $4.6 billion annual loss. This loss equates to approximately $7,600 per physician overall (Beltràn Ponce et al., 2023; Ryan

et al., 2023). An organization may try to "fix" the physician's low morale and decreased effort by increasing incentives or pay, which cost the organization money, further decreasing its revenue. These perks intend to engage the physician to work harder and be more productive and do not address the fact that physician burnout is primarily an organizational issue (Maslach & Leiter, 2022).

## Solutions for Physician Burnout

Maslach and Leiter (2022) noted that burnout often occurs when there is a mismatch between the organization and the employee. When considering solutions to address physician burnout, consideration must be given to the division of responsibilities. The American Medical Association (2023) and UCSF Department of Medicine (2023) noted the bulk of physician burnout (80%) to be caused by the medical organization and 20% the responsibility of the physician. For this reason, successful solutions for physician burnout should focus mainly on organizational change, which would positively affect both parties.

### *Administrative*

The organizational system that employs physicians is responsible for 80% of physician burnout. For this reason, the root of physician burnout stems from the physician's experience with their administration and the organization's leadership team; therefore, the most effective solution for reducing physician burnout (or avoiding it in the first place) begins with effective leadership and enhancing the qualities they exhibit (American Medical Association, 2023; Dyrbye et al., 2021; UCSF Department of Medicine, 2023). An initial step is for leaders within the healthcare system to recognize

that a problem exists and address it rather than ignore it and pretend it doesn't exist (Lexa & Parikh, 2023). Reducing work hours, decreasing workload, and creating efficient organizational solutions would also reduce physician burnout (Lexa & Parikh, 2023). Maslach and Leiter (2022) explain that when an organization decides to make a change, they often do so without considering how it will impact the physicians or asking them for their thoughts or input. They further state that when an organization does ask its workers what they want or need, the requests often go unmet or without an explanation of why a change cannot be made or a suggestion of a feasible alternative change that can be made. Further, they explain that successful burnout reduction stems from a leadership team that asks questions, listens to the answers, makes changes where they are feasible, and communicates effectively with the physicians, helping to build trust, rapport, and a cohesive relationship between the organization's leadership and the physicians (Maslach & Leiter, 2022). Together, these items help to increase job satisfaction and contribute to burnout remediation (Weissman et al., 2023).

***Physician Well-being Services***

The physician is responsible for 20% of their experience with burnout (UCSF Department of Medicine, 2023). Physician well-being services can help the physician increase their awareness so they may create personal strategies that will prepare them for successfully managing the stress and pressure associated with their medical profession (Lexa & Parikh, 2023). One key element critical to fostering an environment that allows physicians to manage their stress and reduce their potential for burnout is to promote positive social relationships between the physician, their colleagues, and the organization,

as well as social support (Weissman et al., 2023). This task can be achieved by providing opportunities for physicians to connect with others of similar professional backgrounds in medicine or healthcare and changing the current culture (Aalto et al., 2018; Song et al., 2021). Additionally, working in an environment where the physician feels supported, appreciated, valued, and retains autonomy in medical decisions can also reduce physician burnout (Doolittle, 2021). A deeper facet of social support comes from an individual's spouse and marital relationship. Being married and having spousal support may reduce burnout experienced by the physician (Beltràn Ponce et al., 2023).

The ratio of burnout that the physician can take responsibility for can be addressed in several ways. Bernard and Cohen (2018) state the importance of cognitive distortion and cognitive reframing. They describe cognitive distortion as having illogical thoughts. The authors suggest the psychological process of cognitive reframing or replacing a false, negative thought with a positive one to counter cognitive distortion. Additionally, incorporating mindfulness and meditation techniques and a gratitude practice can help physicians stay in the present moment and avoid catastrophizing situations that extend beyond their control. Further, setting aside adequate time for completing EHR right after seeing a patient vs. procrastinating will help physicians stay on track with time management and avoid the stress of falling behind in administrative tasks. Another way a physician can control their circumstances is to fully take advantage of their time off by stepping away from work entirely and taking an actual vacation where they can relax and unwind or by taking up a hobby. The authors suggest physicians set boundaries on what they are or are not willing to do. For example, if an organization

asks a physician to do something that may jeopardize their medical license or subject them to a lawsuit. In that case, the physician may choose to practice elsewhere and avoid this stress. Finally, seeking professional support through psychologists or psychiatrists for extreme burnout, anxiety, depression, or suicidal ideations is strongly encouraged (Bernard & Cohen, 2018).

For the general population, focusing on building resilience is helpful. Resiliency training can help individuals manage stress, cope with traumatic experiences, and manage chronic health conditions (Cleveland Clinic, 2019; West et al., 2020). Resiliency training has been suggested as a method for helping physicians manage burnout; however, compared to the general population, physicians already exhibit naturally higher resiliency due to the rigorous study, perseverance, and dedication required to become a practicing doctor (American Medical Association, 2023b). When a person with high natural resiliency, such as a physician, experiences burnout, burnout is identified as a systemic issue, not an issue of individual resiliency (American Medical Association, 2023b).

### *Chief Wellness Officer*

Creating and incorporating a Chief Wellness Officer (CWO) can help an organization lay the foundation to support and foster professional well-being. According to the American Medical Association (2020), the CWO position is a C-level executive role that helps the organization focus on the "quadruple aim" of improving patient care and promoting better health outcomes while supporting clinician well-being and reducing costs. The AMA further explains that the CWO role may create a Well-Being Task Force to help implement organizational change by following the Stanford WellMD Model. This

model combines a Culture of Wellness, Efficiency of Practice, and components of Personal Resilience to foster Professional Fulfillment. The CWO acts as an advocate, collaborator, and liaison between the organization, stakeholders, and healthcare professionals (AMA, 2020). The role of CWO is a relatively new position in the medical and healthcare industry. Dr. Tait Shanafelt was the first to hold this position at Stanford University Medical Center in 2017 (Richter, 2017).

### *Physician Coaching*

Wellness coaching for physicians has become an effective tool in helping physicians manage their burnout. Fainstad and Mann (2023) shared the details of their program titled Better Together. In this longitudinal study, physician trainees took part in 4 months of coaching to address such topics as emotions, growth mindset, imposter syndrome, and transitioning into practice. Group coaching was provided weekly via online Zoom sessions, while participants also had the option to submit their questions anonymously in writing. Self-directed video modules were also available for participants to watch asynchronously. The researchers found a decrease in imposter syndrome and the emotional exhaustion component of burnout while self-compassion increased. Similarly, Boet et al. (2023) found that physician coaching contributed to improving participants' overall well-being while reducing stress and decreasing emotional exhaustion.

## Physician Burnout and Job Satisfaction

Liselotte Dyrbye and colleagues (2013b) explained that physicians' job satisfaction may be decreased when they are experiencing burnout. They stated that this issue could result in physicians reducing their work hours, deciding to retire earlier than

expected, or influencing a physician's decision to relocate to a different practice. Further, Dyrbye et al. (2013b) stated the results of decreased job satisfaction can contribute to the potential physician shortage and reduce patient's access to quality healthcare.

The effectiveness of organizational leadership is a contributor to physician burnout (American Medical Association, 2023b). Similarly, organizational leadership can also contribute to a physician's job satisfaction and well-being. When physicians feel decreased job satisfaction due to ineffective leadership, the physician may experience reduced personal accomplishment, which is one of the three dimensions of burnout (Mete et al., 2022). Shanafelt et al. (2022b) noted that decreased personal accomplishment has also been linked to greater incidences of imposter phenomenon (IP) in physicians. Additionally, they stated that higher IP can also be attributed to greater suicidal ideations (SI). Further, they recognize that the rate of IP is greater among physicians than among the general population.

**Effects of Physician Burnout on Relationships**

The negative consequences of burnout and decreased job satisfaction can also disrupt a physician's personal life by affecting their work-life integration (WLI) (Shanafelt et al., 2022a). For an individual to have a balanced WLI, their work and home life must coexist harmoniously (Fallon-O'Leary, 2021). Berg (2022) stated that in 2021, WLI for physicians fell to 30.2% from 46.1% the previous year. Shanafelt et al., (2022a). Shanafelt et al. (2022a) recognized the COVID-19 global pandemic as an exacerbating factor to the high levels of burnout physicians were already experiencing in their profession. The researchers noted the lack of personal protective equipment (PPE), risk of

contracting COVID-19 and becoming ill themselves or taking the disease home to their families, increased patient load, longer work hours than pre-pandemic, lack of adequate staffing, and increased loss of life compounded physician burnout. Additionally, these factors contribute to a reduced WLI and greater disruption of the physician's WLB.

The concept of a WLB suggests that one's work life and home life are kept separate and do not commingle (Fallon-O'Leary, 2021). The introduction of the COVID-19 pandemic and the concerns it brought with it added to the distress and burnout that already existed for physicians and their families. Lee et al. (2021) explained that when the needs and expectations of one's work become incompatible with the demands of home and family life, a WFC can occur. Additionally, physicians experience a greater incidence of WFC due to long work hours, which causes them to miss events and important family occasions. The researchers further describe greater WLC as a contributor to a higher stress level, lower job satisfaction, higher rate of burnout, and lower QOL (Lee et al., 2021). The concepts of physician burnout and its influence on WLB, WLI, and WLC will be covered in greater detail when discussing the medical marriage and the marital relationship.

## Physician Relationships

### *Marital Relationships*

Jovanovic and Wallace (2013) explained that the marital relationship plays a crucial role in supporting a physician's professional goals and how they manage the stress that is generated from their position. They recognized that support from spouses can be provided emotionally, informationally, and instrumentally. They explain

emotional support as listening, being a sounding board, and expressing concern for the physician when they encounter stress at work. Informational support was often provided to the physician when the wife worked in a medical job or within their medical practice and could relate professionally to what the physician was experiencing. The researchers further described instrumental support as duties performed within the couple's home, carrying out household responsibilities, child-rearing, or "invisible labor," which takes the pressure off of the physician. Additionally, they recognized that dual-physician marriages often exhibit greater spousal support and have a lower divorce rate than single-physician marriages due to both spouses understanding the professional demands. Finally, their research suggested that gender role socialization has contributed to a support gap where the female spouse provides more empathy and emotional support for their male counterparts (Jovanovic & Wallace, 2013).

Chen et al. (2022) reported marriage as generating support for physicians during the COVID-19 pandemic as well as a source of stress. The researchers indicated that the support received through the marital relationship could reduce the stress experienced in the workplace and add to the stress due to the physician's concern for their family's health and well-being during an unprecedented time in the modern healthcare industry.

***The "Medical Marriage"***

In a "medical marriage," at least one spouse is a physician as their profession. Perlman et al. (2015) explained that when compared to a traditional marriage, a medical marriage presents unique challenges and stressors. They noted contributing factors as longer than average work hours, being on-call, and medicine taking a front seat. The

researchers further describe that each family member takes on additional roles and responsibilities to compensate for the physician's absence. For example, the male physician may be the breadwinner, but the wife pays the bills, does most of the child-rearing, and takes on the majority of the domestic responsibilities. The lack of the physician's presence becomes a way of life for the family as they support the career that provides them financial stability. Finally, the colleagues noted that physicians who feel they have a supportive spouse tend to report a higher marital satisfaction rate and a lower divorce rate despite the unique challenges presented by a medical marriage (Perlman et al., 2015).

Postponement is another unique concept present in a medical marriage. Gabbard and Menninger (1989) explained postponement as the couple living in the future rather than the present. They noted that the couple may constantly delay gratification due to the current demands of the physician's career, causing the couple to adopt the view that things will be better when certain milestones are achieved. For example, they may feel they aren't spending enough time together, but when residency is over, when fellowship is finished, and when the first job is landed, everything will finally be worth the sacrifice. Finally, they identified that postponement can cause different issues at various stages of the marriage (Gabbard & Menninger, 1989). When postponement occurs in the early years of a marriage, the spouse takes on most of the responsibilities at home, which is often recognized as a necessary step to launching a new physician's career. In this stage, the couple feels confident that the sacrifice will be worth it, and that life will improve. In the mid-years of marriage, the physician may have found their niche at work and can

come to prefer work as a method of avoiding home responsibilities. This avoidance can lead to a breakdown in communication and diminish intimacy. In the later stages, when the children are older and the physician's job is established, they may experience guilt as they recognize that they have missed many family events and realize that they have neglected their spouse. During this revelation, the physician may try to compensate by trying to spend more time with their spouse or children; however, by this time, their spouse has established themselves in different activities and created a new role for themselves, and the children are more independent and have their own interests (Gabbard & Menninger, 1989).

***Spouse Perspective***

In their book *The Medical Marriage: Sustaining Healthy Relationships for Physicians and Their Families,* Sotile and Sotile (2000) explained that wives often feel judged by others' misperceptions of what it is like to be married to a physician. They describe the lack of awareness that the physician works long hours, leaving the wife to bear the brunt of domestic responsibilities. These extended hours often lead to the physician experiencing fatigue, which affects their family time. Additionally, the writers noted financial stability as a benefit to the long work hours and years of education; however, the salary is often accompanied by increased debt load due to costs associated with attaining the necessary education to hold such a position (Sotile & Sotile, 2000).

Iyer (2022) explained that in a medical marriage where the professional demands supersede the familial responsibilities and commitments, the WLB and WLI become disrupted. Iyer described how physicians often have difficulty separating their work and

home lives. Additionally, the physician sees the practice of medicine as their "calling" and frequently places their job ahead of their family (Iyer, 2022). When the physician's job takes precedence, WFC can result. Physicians who are experiencing WFC can experience increased fatigue, depression, and decreased QOL (Dyrbye et al., 2013). When the physician experiences a WFC, the ramifications cross over to the spouse, furthering the discord experienced in the home (Bolger et al., 1989; Yucel & Latshaw, 2020). When a WFC occurs and impacts the spouse's well-being, a cyclical effect can result in the physician experiencing greater burnout at work, which, in turn, continues to affect the spouse at home (Paul et al., 2021). Further, when the perception of a WFC is present, there is a higher probability of the physician experiencing burnout (Sagalowsky et al., 2019).

In their book *Medical Marriages,* researchers Gabbard and Menninger (1988) described the spouse losing their sense of self as an additional issue that may accompany a medical marriage. They explained that the wife may feel she has lost her identity and is now known only as the doctor's wife or their children's mother. They noted that as the children get older and the physician still focuses their energy on their career, the spouse typically reinvents herself by returning to work or taking on a new hobby.

Sotile and Sotile (2004) noted that spouses correlate higher marital satisfaction with the greater amount of quality time the couple spends together despite the physician's long work hours, especially when the conversations are regular. The researchers also stated that when the physician shared their work experience with their spouses, the spouses felt included and involved, making them feel like the sacrifices the family made

for the physician's career were worth it. Additionally, regular engagement in meaningful conversations allowed the couple to nurture their relationship (Mayo Proceedings, 2013; Peisah & Lele, 2022; Sotile & Sotile, 2004).).

***Children, Childcare, and Family***

Having children poses additional stressors for a physician and their spouses. Due to the physician's job demands and the mother/spouse taking on the majority of domestic tasks and child-rearing responsibilities, the children tend to have a stronger bond with the mother. The closeness of the mother-child(ren) may result in the physician feeling left out of the equation and the family unit forming without them. The children come to feel like the mom is in charge, and the physician simply assists or helps out periodically (Sotile & Sotile, 2004).

Before the COVID-19 pandemic, Chen et al. (2022) noted that physicians who were married with children experienced greater work burnout and lower personal burnout. The colleagues stated that during the pandemic, these physicians experienced a higher level of work-related burnout and a greater level of personal burnout. They identified the increased work-related burnout as the stressors exacerbated by the pandemic. They attributed the personal burnout to the physician's fear of bringing the virus home to their families, increased time away from their families due to extended work hours, sleep dysregulation, and disruption to the family dynamic due to children being home from school and quarantine. Overall, they identified high marital satisfaction as a mitigator of work-related burnout (Chen et al., 2022).

## Summary

Burnout syndrome is related to one's profession and includes three dimensions: emotional exhaustion, depersonalization, and decreased sense of personal accomplishment (Freudenberger, 1974; Maslach & Jackson, 1981). Evidence indicated that physicians have a higher rate of burnout when compared to the general population, which increased significantly with the COVID-19 pandemic (Berg, 2022; Shanafelt et al., 2022b). Chapter 2 included a detailed examination of scholarly, peer-reviewed research on physician burnout and the marital relationship published in the last five years. The literature review identified the current gap in research related to physician burnout, the causes, effects, and solutions to physician burnout, the marital relationship, and the spousal perspective on the subject. Researchers have identified long work hours, administrative burdens, and organizational issues as contributors to burnout. Additionally, the effects of physician burnout were cited as decreased physician health and patient care, high physician turnover, and increased costs and reduced revenue for the institutions. The literature suggested solutions for physician burnout as administrative adjustments, inclusion of physician well-being services, appointing a Chief Wellness Officer, and implementing a physician coaching program. The research also suggested that physician burnout extends beyond the physician and can also affect the spouse and family by causing a disruption to the WLB, causing an imbalance in WLI, which can create a WFC and impact QOL (Dyrbye et al., 2013; Shanafelt et al., 2022b). Current literature suggested future research was needed on the spousal perspective. This study

sought to further understand the nuances of physician burnout and the medical marriage to address this gap in the literature.

Chapter 3 includes a description of the research design of this study and the rationale behind this choice. Methodology, procedures, research questions, data collection, data analysis, and anticipated results of this study are also covered. Chapter 3 concludes with a discussion of trustworthiness, data security, and ethical considerations.

# Chapter 3: Research Method

## Introduction

A basic qualitative methodology was applied to explore physician burnout and the marital relationship from the spouse's perspective. A basic qualitative study allows researchers to gather participant data based on the participant's experience, perception, and reality (Merriam & Tisdell, 2016). Since this study focused on exploring data on how a physician's burnout carries over into the marital relationship from the spousal perspective, a basic qualitative approach was appropriate for this study.

The research method is the focal point of Chapter 3. This chapter begins with a description of the research design, rationale, and main research question. The role of the researcher will be discussed to address issues of researcher bias, conflicts of interest, and ethical concerns. Next, I present the methodological approach to the study, including participant selection, population, sampling strategy, size, the recruitment process, instrumentation, and the procedure followed to collect and analyze data. Finally, Chapter 3 closes by addressing issues of trustworthiness and ethical procedures, including a detailed description of how data and participants will be honored and preserved.

## Research Design and Rationale

### Research Question

The research question that guided this study was as follows: How do male physician's female spouses experience the physician's burnout in their marital relationship?

## Design and Rationale

Merriam and Tisdell (2016) categorize qualitative research into six types: basic qualitative, phenomenology, ethnography, grounded theory, narrative inquiry, and qualitative case studies. The authors explain that a basic qualitative approach allows the researcher to understand the issue from the participant's perspective and understand their point of view and experience. A phenomenological approach focuses on participants' lived experiences and how they place meaning on those experiences. An ethnographic approach has anthropological roots and typically focuses on conducting fieldwork to understand the culture of a specific group of people. Grounded theory stems from constructivist and postmodern perspectives and uses the researcher as the instrument to collect data and extricate meaning from the data to build a theory further. A narrative inquiry uses stories as the primary data source to understand one's experience. Finally, a qualitative case study describes and analyzes a bound system (one specific group) through investigative interviews and observations (Merriam & Tisdell, 2016).

This study sought to understand the spouse's perspective and how they experience the physician's burnout in the marital relationship. Since the goal was to understand the issue of physician burnout and how the spouse experiences its carry-over into the marital relationship, a basic qualitative design was an ideal approach (Merriam & Tisdell, 2016).

## Role of the Researcher

As the wife of a physician for more than 24 years, the seed to conduct this study was planted after witnessing my husband experience work-related burnout and then suffering burnout myself. The impetus was established during the COVID-19 global

pandemic when the world saw the medical community experience unprecedented burnout. As a physician's spouse, I witnessed first-hand the stress and unique marital experiences these medical professionals and their spouses encountered daily. Local medical societies support physicians, while their counterparts, the medical alliances, support the physician's spouse. My involvement with various medical society alliances, such as the Collier County Medical Society Alliance (CCMSA), the Florida Medical Association Alliance (FMAA), and the American Medical Association Alliance (AMAA) afforded me access to other couples in similar circumstances.

Burkholder et al. (2020) describe the researcher as the primary data collection instrument in qualitative research. In this study, my role as the researcher using a basic qualitative approach was to conduct semistructured interviews with physician's wives to learn more about how they experience their spouse's burnout in their marital relationship. In addition, my role includes categorizing, analyzing, coding, and reporting the data acquired in this study. As a physician's wife and member of the organizations that were asked to participate in this study, it was critical for me to withhold bias and to ask open-ended questions without leading the participant to a specific response. To reduce researcher or participant bias and maintain impartiality, the goal was to access members of the FMAA and AMAA (larger state and national organizations), whose members I did not know or have an existing personal relationship with.

## Methodology

This study's premise was to understand how approximately 10 physicians' wives experience their spouse's burnout in their marital relationship. For this study, I conducted semistructured interviews utilizing open-ended questions and apply Appreciative Inquiry (Ai) and active listening techniques to better understand the spouse's experience of how the physician's burnout carried over into their marital relationship. Ai is rooted in positive psychology and empowers the interviewee to examine an issue or topic concerning them through a conversation and in their own words (Moore, 2023). Active listening includes the interviewer displaying such gestures as physically leaning into the conversation, responding with "Mmhmm," and nodding their head as a supportive indicator of understanding. These mannerisms encourage the interviewee to expand upon their statements and allow the interviewer to gain a deeper understanding of the participant's perspective (Louw et al., 2018).

### Participant Selection Logic

The concept of a "medical marriage" presents unique circumstances and dynamics that are not as prevalent in other types of traditional marriages. These issues include physician burnout, excessive work hours, higher stress levels, increased debt, and higher suicide risk and success rates (Aalto et al., 2022; Berg, 2022; Duarte et al., 2020; Dyrbye et al., 2013; Ryan et al., 2023; Shanafelt, 2022b; West et al., 2020; Williams et al., 2020). According to the Federation of State Medical Boards (2023), the percentage of female physicians is growing; however, at present, the larger majority (62%) of physicians in the

U.S. are male, providing a larger pool of participants who are female, and who may experience a more significant impact of this topic.

Sotile and Sotile (2000) identified differences in types of medical marriages, noting that a dual physician marriage invites a more complex relationship dynamic beyond the scope of this dissertation; therefore, female spouses who are also physicians will be excluded. Additionally, work by Yucel and Latshaw (2020) shows how women partners may be more likely to be impacted by the crossover of their spouse's work stress and strain due to cultural gender socialization. These researchers also cite previous work by Symoens and Bracke (2015) that states the female spouse's mental health is affected by their husband. In contrast, the husband's mental health was not affected by the work-family conflict experienced by the female spouse. Further, present information regarding the LGBTQ+ physician population, their marital status, and relationship issues specifically related to their unique dynamic is non-existent; therefore, including non-binary couples may include more complex experiences that are not being explored in this study (Peisah & Lee, 2022). For this reason, learning the perspective of the female spouse would provide clear and valuable information to the scholarly community.

Interviewing participants whose spouse has been practicing medicine for at least 5 years was one of the inclusion criteria. Physicians who have been practicing for at least 5 years have been practicing medicine before, during, and after the COVID-19 global pandemic, which, according to the American Medical Association (2022), demonstrated the highest rates (63%) of physician burnout in history.

### *Population*

Criteria for participation in this study were based on heterosexual couples and revolved around the following factors: (a) over age 18, (b) being fluent in English, (c) spouses who are not also physicians, (d) spouses that identify as female, (e) married to a male physician who is currently practicing in the United States and has been practicing for more than 5 years, (f) believes their spouse has experienced burnout, and (g) is willing to participate in a recoded interview lasting approximately 45-60 minutes via phone, in-person, or Zoom.

### *Sampling Strategy*

The primary sampling strategy I employed was purposive sampling, as I sought a specific demographic with a similar experience of being physicians' wives. Secondarily, these samples were also considered convenient as the organizations targeted for participation were groups to which I have general access. Finally, participants in the study suggested another wife to participate, or shared on their own social media platforms, creating a snowball sample.

Following approval by the Walden University Institutional Review Board (IRB), I contacted the FMAA and AMAA Alliance groups and asked them to send my study information and flyer to their membership asking for participation. Another strategy was to seek approval from Facebook page administrators to post my study information on relevant Facebook groups whose members are physicians or their wives. (Appendix A).

### *Sample Size*

The sample size for this study was based on Mason's (2010) recommendation of 10 initial interviewees for general qualitative research. Participant recruitment and interviews began at approximately 10 participants and continued until saturation. Saturation is reached once the data collected begin to repeat and common themes evolve. The themes were categorized using Saldaña's (2021) first and second-cycle coding process.

## Procedures for Recruitment, Participation, and Data Collection

### *Recruitment Procedures*

Initially, an e-mail was drafted and sent to the appropriate contacts at the AMAA and the FMAA that described my study's details, the purpose of the study, and the need this study would fill in the medical community. This e-mail also requested their assistance with distributing a flyer advertising my study and my contact information to their membership via their e-mail or newsletter database. The organizations' databases remained their property, and I had no personal access to them. The e-mail (Appendix A) and flyer (Appendix B) are included in the Appendix of this document.

As an additional means of participant solicitation, I considered seeking permission from private Facebook groups whose members are physicians and/or physician spouses to post the flyer for my study on their Facebook page. The members of these Facebook groups would have been asked to contact me directly via the information in the advertisement (Appendix B). Following distribution by the FMAA and AMAA, enough participants were recruited and soliciting additional pages was not necessary.

***Participation Procedure***

All flyers, advertising, correspondence, and consent forms associated with this study were provided to potential participants in English. The advertising material included eligibility criteria and asked participants who believed they met the requirements and were willing to participate to email me with their contact information. Once a participant emailed me their information, I responded to their email and attached two documents: 1) the informed consent, and 2) the Eligibility Screening Questionnaire (Appendix C). They were asked to complete the questionnaire and told that if they were able to answer "yes" to all questions except question five, they were eligible to participate. Question five asked if they are also a physician, which was a delimiter for participation in this study. I asked them to let me know their preferred contact method to schedule the interview. If participants met the eligibility requirements and were willing to participate, they were asked to respond to the e-mail with "I consent."

At that next contact, a method of interview (in-person, by phone, or via Zoom) was agreed upon by the participant and me, as well as time and day of interview. No participants were local to me, and all opted to conduct their interviews via Zoom. After agreeing upon a date and time to conduct the interview, a Zoom link was sent to the participants via e-mail. A reminder e-mail was sent to participants 24 hours prior to the scheduled date and time.

Upon commencement of the interview, participants were reminded that the interviews would be recorded, their names would be deidentified, and their responses would be confidential. A brief explanation of the study, its purpose, and its significance

to the medical community was provided to the participants, allowing them to ask any questions before beginning the interview. A review of the informed consent, the demographic questions (Appendix D), and finally the Interview Questions (Appendix E) followed. At the end of the interview, participants were thanked for their contribution and asked to share information about the study with anyone they believe meets the eligibility criteria and may be interested in participating.

## Instrumentation

### *Researcher*

In this study, I, as the researcher conducting the semistructured interviews, was the primary instrument used. Additionally, tools such as the interview questions asked were also a primary instrument (see Appendix E). Eligibility screening questions and demographics questions (Appendices C and D) were used as secondary instruments to the primary interview questions. Primary interview questions were followed by additional probing questions to allow participants to expand on their experiences and to elicit a more detailed response. The interviews were all conducted via Zoom and recorded for review. The Zoom transcription feature was used for additional review and analysis of the data obtained from the interview.

### *Maslach Burnout Inventory- Human Services Survey for Medical Personnel*

The Maslach-Burnout Inventory- Human Services Survey for Medical Personnel (MBI-HSS MP) was used to guide the development of the interview questions for female spouses regarding the symptoms of burnout demonstrated by their (physician) spouse (Maslach et al., 2018). This tool has been identified as a widely used instrument to

measure burnout among medical personnel (Dyrbye et al., 2018). The MBI-HSS [MP] considers three domains to measure burnout. These domains include emotional exhaustion, depersonalization, and a low sense of personal accomplishment (Maslach et al., 2018). These questions identified which domains of burnout the participant's physician-spouse was experiencing and were important for the interpretation of data.

**Data Collection**

The primary method for data collection was semistructured interviews with open-ended questions (Creswell & Creswell, 2017). The open-ended questions were worded to coincide with active inquiry recommendations to allow for a rich and detailed response from participants (Moore, 2023). Additional probing questions were asked to encourage the participant to elaborate on their answer or to provoke a more in-depth and descriptive discussion. Active listening skills were used to encourage and support the participant throughout the interview process (Louw et al., 2018).

A potential barrier when collecting primary data included difficulty recruiting participants for interviews due to being a local Medical Society Alliance member. Ensuring a clear separation of my role as a member of the group and my role as the researcher was a potential challenge; however, participants were willing to share their experiences openly and honestly as ensuring their privacy and confidentiality was emphasized.

## Data Analysis Plan

Data obtained during participant interviews were analyzed simultaneously during the collection process. This process was duplicated as each subsequent interview was

conducted and continued until saturation was achieved and no further data is required. The data analysis in this study included the use of first and second-cycle coding in accordance with Saldaña's (2021) descriptive coding process. Descriptive coding allowed me to identify common words or phrases in the data and assign coordinating labels. When using first and second-cycle coding, the data are examined more than once, and one or more types of coding are applied. After data were analyzed, the codes presented were categorized, synthesized, and consolidated by meaning. Finally, the categories were streamlined into pertinent themes. These themes were common words, sentences, or phrases present in each category. Transcripts from each interview were reviewed more than once to allow for similarities and patterns to be identified. Following each review, the categories and themes were reassessed to organize the data further and identify developing themes.

In this study, the use of in vivo coding as the first cycle coding method allowed codes to be applied by the actual word used by the participant and allowed me to become more attuned to the participant's perspective and their experience with physician burnout (Saldaña, 2021). The continuous presence of a specific word or phrase by subsequent participants was coded and suggested a common theme. During the second-cycle coding process, pattern coding allowed me to distill each theme's commonalities further until a pattern was identified. A pattern code allowed me to consider the participants' experiences in this study with those in previous studies.

## Issues of Trustworthiness

When conducting a qualitative research study, trustworthiness is proven when the research is valid, reliable, and conducted ethically. Merriam and Tisdell (2016) explain that validity and reliability in qualitative research studies can be achieved when a mindful focus is placed on collecting, interpreting, and analyzing data. They further recognize that designing a study carefully and using standards set forth and accepted by the scientific community further contribute to its validity and reliability. In qualitative research, credibility, transferability, dependability, and confirmability aid in establishing trustworthiness (Merriam & Tisdell, 2016).

### Credibility

Credibility in a study contributes to the study's trustworthiness by assuring readers that the data are correct (Stadtlander, 2015). Additionally, when the findings from a study match reality, and the data accurately measures what it intends to measure, internal validity is established, furthering the study's credibility (Merriam & Tisdell, 2016). Merriam and Tisdell (2016) explain that member checking is another method to establish credibility in qualitative research. Member checking allows participants to read and review the researcher's notes, verifying their accuracy. They further describe triangulation as another factor in establishing credibility in qualitative research. Triangulation involves cross-checking data collected from multiple sources at different times and comparing the results. Investigator triangulation uses multiple researchers to review the data collected independently and then compare their findings. This study

established credibility by reaching saturation during the data collection process (Stadtlander, 2015).

**Transferability**

Transferability is the qualitative counterpart for assuring external validity in quantitative research (Merriam & Tisdell, 2016). Transferability occurs when the data are collected in a way that allows for a thick or very detailed description of the interviews and the environment or circumstances in which the interview took place (Stadtlander, 2018). When the qualitative researcher is able to gather a detailed and thick description of the interview process, transferability is enhanced (Merriam & Tisdell, 2016). Additionally, the data can be generalized to other groups in similar circumstances. In the case of this study, the results were generalizable to the medical community, specifically physicians' wives. Further, the results provided important information for physicians, the organizations that support physicians, or those whose revenue streams revolve around the work that physicians do by giving insight into how to support the physicians better and reduce burnout.

**Dependability**

In quantitative research, reliability suggests that the instruments used to collect data are doing so in a statistically accurate way. In qualitative research, statistic reliability is not present; thus, the equivalent concept is dependability (Merriam & Tisdell, 2016). Dependability in a study is a way to support the accuracy of the data collected and ensure collection and analysis occur consistently (Merriam & Tisdell, 2016; Stadtlander, 2018). In qualitative research, audit trails and triangulation are common ways to achieve

dependability. In this study, dependability was achieved by triangulation or asking all participants the same set of general, open-ended questions. Additionally, audit trails further supported the dependability of this study as detailed records of all correspondence with organizations and participants kept, as well as audio and video recordings and transcriptions of interviews.

### Confirmability

In qualitative research, there is a strong focus on objectivity and separating the researcher from the data to reduce researcher bias as much as possible. Qualitative research studies are more subjective, but the methods employed must still be verifiable to achieve confirmability (Merriam & Tisdell, 2016). Confirmability is an additional element of dependability in a study. Confirmability ensures that the results obtained in this study could be replicated and confirmed by additional researchers at another time through a confirmability audit (Merriam & Tisdell, 2016; Patton, 2015). In addition to contributing to a study's dependability, an audit trail also supports a study's confirmability by assuring the data collected was not due to researcher bias but rather due to the concentration of the study (Stadtlander, 2018).

## Ethical Procedures

### Ethical Concerns

Before engaging in this study, potential participants completed an informed consent form approved by the IRB. The participants were ensured that their identity would be coded, and their responses would be confidential. At the time of interview scheduling, a location and method (phone, Zoom, in-person) were selected that were

conducive to both the interviewer and the participant. Participants were instructed to choose a setting that would assure privacy, confidentiality, and that would allow them to focus on the interview without distractions. In the case of this study, all interviews were conducted via Zoom. At the outset of the interview, participants were informed of their right to discontinue participation in the study at any time. Participants were also notified that I may reach out for a follow-up interview to provide further clarification or to ask additional questions after the original interview had been completed and the information reviewed. Participants in this study were all consenting adults over the age of 18. Additionally, this study did not target any participants who were considered a vulnerable population according to the APA's Code of Ethics (APA, 2017). The Walden University IRB considered participation in this study to be of minimal risk to its participants and granted approval for this study to be conducted (IRB # 12-08-23-1155451, expiration December 7, 2024).

**Treatment of Data**

Data collected in this study was acquired and stored in compliance with the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct (APA, 2017). Interviews were considered confidential, and all participant's identifying information was coded to protect their identity and respect their privacy. Data collected was stored on a password-protected hard drive on my personal computer and a password-protected external hard drive as an additional safeguard. All interviews were transcribed using the transcription feature on Zoom, printed for review,

and stored in individual folders in a locked file cabinet. All data collected during this study will be destroyed five years after publication (APA, 2017).

## Summary

Chapter 3 provided a detailed description of how this study used a basic qualitative research design to explore how approximately 10 male physician's female spouses experience the physician's burnout in their marital relationship. Participants were recruited through purposive, convenient, and snowball sampling by requesting the AMAA and FMAA to e-mail the study flyer to their mailing lists. This study aimed to explore how female spouses experience their (male) physician husband's burnout in their marriage. Semi-structured interviews were conducted to obtain the wives' responses to questions guided by the MBI-HSS-MP. Chapter 3 also addressed the data coding and analysis using Saldaña's (2021) first and second-cycle coding and theming, as well as how issues of trustworthiness and ethical considerations were handled. Chapter 4 details how the study was carried out, how data were collected and analyzed, and the results obtained.

# Chapter 4: Results

## Introduction

This qualitative study sought to gain an understanding of how work-related burnout of male physicians carried over into the marital relationship by exploring the perspective of the physician's female spouse. The information obtained from this study may provide valuable insight to the families involved by improving the understanding of how physician burnout affects a marriage from the perspective of the spouse, who has been identified as a vital component in the physician's primary support network. Scholarly communities and organizations that have direct relationships with physicians would benefit from this knowledge by understanding their roles as contributors to physician burnout, grasping the concept that a physician's work performance, patient care, productivity, and medical errors have a bidirectional effect on their home life. As explained by Grimmer and Jacquin (2023), looking at physician burnout through the eyes of the spouse can be a catalyst for creating tools and programs that can provide support for the psychological distress unique to medical families.

This basic qualitative study included semistructured interviews of 10 female spouses of male physicians. This study included a base of 25 open-ended questions (Appendix E) as well as additional follow-up questions to probe further and gain a thicker description of the wife's experience when necessary. All questions centered around the main research question: How do male physicians' female spouses experience the physician's burnout in their marital relationship?

Chapter 4 recounts a detailed description of the interviews, including the setting, participant demographics, and their experiences relative to the research questions. Additionally, evidence of trustworthiness is discussed based on criteria described in Chapter 3. Finally, Chapter 4 concludes with an explanation of the process used for collecting and analyzing data and a summary of the results chronicling how male physicians' female spouses experience the physician's burnout in their marital relationship.

## Setting

The participants in this study were female spouses of male physicians who had been practicing medicine in the United States for at least the last 5 years. All participants were over the age of 18, fluent in English, and were not physicians themselves. Lastly, all participants believed that their spouse has experienced burnout due to their profession as a physician.

Once a participant provided consent via e-mail in per the requirements set forth by the Walden University Institutional Review Board, they were offered the choice to meet in person, over the phone, or via Zoom. All participants opted to conduct the meetings over Zoom. Once a mutually agreed-upon time was determined, a Zoom link was sent to the participants via e-mail. A follow-up e-mail was sent to the participants at least 24 hours prior to the scheduled interview time as a courtesy reminder as well as to potentially increase interview follow-through by reducing the possibility of a participant forgetting that the interview was scheduled.

The interview process commenced on January 8, 2024, and continued through January 23, 2024. I conducted all interviews via Zoom while in a private, secluded area of my home with no other individuals present to ensure privacy. All participants appeared to be in their own homes with no other individuals present.

## Demographics

This study included the participation of 10 female spouses of male physicians who agreed to share their perspective as the spouse of a physician who has experienced burnout related to their profession. Eligibility requirements for participation in this study included the following criteria: (a) over age 18, (b) being fluent in English, (c) spouses who are not also physicians, (d) spouses that identify as female, (e) married to a male physician who is currently practicing in the United States and has been practicing for more than five years, and (f) believe their spouse has experienced burnout.

To ensure confidentiality and to preserve privacy, all participants were assigned a pseudonym based on the order that they provided consent to participate in the study. For example, the first spouse to provide their consent to participate was further identified as "Mrs.Med1." The second participant who provided their consent is referred to as "Mrs. Med2," and so on. Participants ages ranged from 34 to 60 years old, with a mean age of 48.6 years. The physician husbands in this study ranged in age from 38 years old to 64 years old, with a mean age of 50.3 years. The length of each marriage ranged from 8 years to 37 years, with a mean length of 18.6 years. The range of household income for each couple varied from $200,000 to $800,000, with a mean income of $463,000. All the couples live in single-family homes that they own. Nine participants were Caucasian, and

one was Latina. The number of years the physicians had been practicing medicine ranged from 5.5 years to 30 years, with a mean of 17.1 years in practice. The education of the participants ranged from some college to master's degrees. The participants reported their employment statuses as not employed/stay-at-home moms, employed full-time, and retired. Eight of the participants reported having children. The average number of children per family was 2.3, with a mean age of children of 14.3 years.

## Data Collection

Following receipt of approval from the Walden University IRB, a copy of the sample e-mail in Appendix A was sent to the Presidents of the FMAA and AMAA requesting their assistance with participant recruitment on December 12, 2023. Each president then sought approval from each of their respective boards before sharing the study with their memberships. Each organization requested an additional brief description to be included with the flyer explaining who I was and my connection to the group (Appendix F). The boards of each organization approved the advertisement of my study to their membership and inclusion in their next member newsletters. Due to the close proximity to the holidays, both groups decided it would be best to wait until they sent out their January 2024 newsletters for the best exposure. In the interim, each organization posted the flyer and description on their social media platforms (Facebook and Instagram) immediately upon receiving board approval on December 14, 2023. Additionally, I posted the study on my personal social media pages (Facebook and Instagram), and several individual members of each organization shared the study on

their personal social media pages (Facebook and Instagram) garnering more attention and creating a snowball effect.

Recruiting began on December 14, 2023, and continued until I completed the final interview on January 23, 2024. During this period, 20 female spouses of male physicians contacted me via e-mail or social media, stating they met the eligibility criteria on the flyer and expressed their interest in participating in the study. Six of the women were ineligible for the study for one, or more, of the following reasons: they were located outside of the U.S., their husband has not experienced work-related burnout, their husband's position is now in administration and no longer actively practicing/seeing patients, they responded after the study had been completed, and their husband not practicing at least 5 years. Consent forms were sent to the remaining 14 volunteers. After receiving a return e-mail stating "I consent" or a scanned signed copy of the consent form, an e-mail was sent asking for their preferred method to conduct the interview, days, times, and time zone. Eleven of the 14 volunteers scheduled times and days to be interviewed. I made three attempts to follow-up with the remaining three volunteers to schedule interviews; however, they did not respond to my e-mails. All participants opted to have their interviews conducted via Zoom. After identifying a mutually agreed upon day and time, a Zoom link for the scheduled interview was created and e-mailed to the participant. A reminder e-mail was sent to each participant at least 24 hours prior to the scheduled appointment to reduce the possibility of missed interviews. Interviews began on January 8, 2024, and finished on January 23, 2024.

At the beginning of each interview, the participants were reminded that the interview was being recorded using the Zoom recording option. After all participants agreed to being recorded, eligibility requirements were reviewed again. Upon confirmation that they met the eligibility requirements, the interview began by asking the basic demographic questions from Appendix D. Each participant's responses were recorded by hand on individual printed copies of Appendix D. These copies were also used to record additional notes during the interview of any information that stood out as being important. To hold space for the participant and to be present and exhibit Ai techniques, I made a concerted effort to maintain eye contact and avoid writing, opting to rely on the transcript for coding and theming purposes.

The eligibility requirements were shared with potential participants on the recruitment flyer, confirmed via e-mail before sending the interested parties the consent form, restated on the consent form, and confirmed at the outset of recording the interview. While asking the demographic questions, an additional participant was deemed ineligible.

After asking the demographic questions from Appendix D, I asked participants 25 open-ended interview questions from Appendix E. All questions were guided by the MBI and revolved around the main research question of how the women perceived the physician's burnout in their marital relationship. The interview began with me asking questions about the physician, their job, and the spouse's perception of the physician's burnout. This line of questioning created a foundation of understanding of what the physician's work environment was like from the spouse's perspective. The next line of

questioning centered on her perspective of how the physician's burnout affected her and their marital relationship. Follow-up questions and additional probing questions were asked to provide a thicker and richer response and to allow the participant to elaborate on her perception and experiences. Interviews lasted between 26 and 98 minutes, with an average interview lasting 58.7 minutes, not including initial introductions that occurred prior to recording, debriefing of the next steps in the study, and non-study-related conversations that took place after the interview. Each interview was transcribed immediately following completion using the Zoom transcription feature. A copy of the interview transcriptions, an audio recording, and a video recording of each interview are stored on the Zoom cloud feature as well as in a password-protected file on my computer and an additional password-protected external hard drive. A printed transcription of each interview and the printed copy of Appendix D used for each participant were stored in individual folders for each person and stored in a locked filing cabinet. All files were labeled with pseudonyms (Mrs.Med1-Mrs.Med11) to protect participant identity. All interviews and data collection methods were conducted and stored in accordance with the methods outlined in Chapter 3.

## Data Analysis

During the first phase of coding, Saldaña's (2021) descriptive coding process was used to describe topics or statements made by the participants in each interview while the use of in vivo coding allowed for actual words and quotes used by the participant to be identified. Recurring common words and phrases were highlighted and notated, allowing categories to be identified as they developed. In the second-cycle coding process, each

evolving theme was further emphasized through pattern coding which allowed consistent consideration of the perspective of the spouse and how they experienced their husband's work-related burnout throughout the study. Quotes, statements, and recurrent words or phrases were written on sticky notes. These notes were arranged on a wall based on their similarities. The placement of these notes enabled me to step back and identify recurring patterns seen within the interviews. Recognition of these patterns allowed for further evidence of emerging common themes. The crossover theory (Bolger et al., 1989) provided a framework for recognizing themes that demonstrated how the physician's burnout impacts their spouse and the marital relationship. After reviewing the interview transcripts multiple times and completing two cycles of coding, I reflected upon the initial research question to eliminate codes that did not address the question. Codes that directly addressed how male physicians' female spouses experience the physician's burnout in their marital relationship were streamlined into 20 categories and further distilled into 10 themes. The themes, categories, and examples of codes that were identified during the analysis of data are depicted in Table 1.

**Table 1**

*Summary of Themes, Categories, and Codes from Data Analysis*

| Themes | Categories | Examples of codes |
|---|---|---|
| Sacrifice/loss | Personal identity<br>Sense of self<br>Career | "You totally lose your sense of self.<br>"A lot of our life has been dictated by his career. I gave up so much. I moved and did all of those things to get him through training and he's not happy. It's hard."<br>"I just became a totally different person than before I met him. That person is totally gone. "I feel like a 'silent quitting wife.'" |
| Loneliness | Feeling lonely/isolated<br>Long work hours (his) | "We are not near any family."<br>"He misses holidays and family events. It's difficult living far away from family." |
| Solo parenting | Inconsistent schedule<br>Domestic duties | "Whenever decisions had to be made, or things didn't go right, it was on me. I have to keep all the balls in the air at all times, and if something falls, that's my fault because I am the one in charge of all of those things."<br>"I do everything around here. He does nothing."<br>"His schedule is different all the time; therein itself is a source of stress (for her)." |
| Anger | Systemic issues<br>His coping mechanisms | Feels "angry when he has been treated poorly at work."<br>"It makes me so angry because it is demoralizing the way they are treating the physicians. It's sickening. They ride on their backs making money."<br>"I'm really angry. What I say never matters. Nothing ever changes." |
| Helplessness | Inability to "fit it" for him | "It gets old, tiring, same old complaints, and I can't fix it."<br>Seeing him suffer from burnout made her "very sad." "I'm a fixer. I just wanted to help him." |
| Misunderstood | Outside judgments | "I thought it (a medical marriage) would be easier." "I didn't realize it (medicine) would consume so much of our lives."<br>"Everyone thinks it's the Cleaver family here. You go inside and you have your heels on and start vacuuming, and then go out to dinner, go to a country club, and all your kids are really smart and never get into trouble." "We have just as many problems as you do in your house. That (problems) cuts across to all socioeconomic groups."<br>"The biggest misconception of a medical marriage is that you make a ton of money, and it makes life very easy. And I think the reality of it is a lot of medical marriages can get pretty lonely." A medical marriage "it's way different than I think either one of us signed up for or thought it was going to be." |
| Health challenges | Physical health<br>Mental health | "I got sick." "Breast cancer," "stomach issues," "weight gain," "high stress," "low vitamins," "zero cortisol." "I'm exhausted." "By the end of the day, I'm tired. To be honest, I'm to the point where I barely even want to hear about his work."<br>"I struggle a lot with anxiety. "His burnout is one of the number one contributors to my mental health issues."<br>"I have felt suicidal many, many times, and I have been to a psychiatrist. I've gotten on antidepressants. I had this recent treatment called TMS. It was supposed to help with anxiety and depression." "I hate my life." |

**Table 1 cont.**

*Summary of Themes, Categories, and Codes from Data Analysis*

| Themes | Categories | Examples of codes |
|---|---|---|
| Self-care | Support networks | "I have my own social outlets." "Volunteering, Alliances, PTO." "Turn my attention to other things that need to be done." |
| | Treatments | Walking, exercise, deep breathing. "I'll leave town if he's on nights if I can." |
| | Physical exercise | "It's important to have a support system." |
| | Occupying time | "I take on a lot of his emotions." "therapy," "coaching." "My mental health needs to matter just as much as his." Medications, TSM treatment |
| Pride in his service | Altruism | Hearing positive stories from patients about their husbands provides a sense of pride, "Your husband is the best doctor." |
| | | "It's a bittersweet life. You know how much he means to other people, and how much people appreciate him and are grateful for him and what he does." |
| | | "The guy I trust the most is also the guy they trust the most and that makes it all worth it." |
| | | "When we run into patients out and about and they're so happy and thankful for what your husband has done for them and how good he is to them. I like knowing he does a good job for people and takes good care of them, and they appreciate it." |
| Relationships | Marital | "His stress really impacted our marriage." |
| | Family | "I don't know if I would do it all over again. Marrying a doctor is really not easy." |
| | | "I think it (his burnout) impacts our children and me just in terms of sometimes him being a bit volatile. Not in explosive ways, just a bit unexpected. The kids are like, 'Who are you?'" |
| | | There is no intimacy. "We don't sleep in the same bed anymore because he would come to bed very late" (after staying up too late to complete charting). |
| | | "I've definitely thought about exiting the situation on more than one occasion." |

## Evidence of Trustworthiness

A semistructured interview approach was used in this basic qualitative study to understand how 10 female spouses of male physicians experience the physician's burnout in their marital relationship. Trustworthiness in a qualitative study is evident when steps are taken to ensure credibility, transferability, dependability, and confirmability (Merriam & Tisdell, 2016). To establish trustworthiness in this study, mindful focus was used when data were collected, interpreted, and analyzed by following the process outlined in Chapter 3 and guidelines established by the Walden University IRB.

## Credibility

To establish credibility, Merriam and Tisdell (2016) explained the importance of the findings matching reality and the data measuring what they were intended to measure. Stadtlander (2015) describes the process of achieving saturation in the data collection process as an additional method of establishing credibility. In this study, credibility was achieved by meeting both metrics. First, the interview questions centered around the main research question: How do male physician's female spouses experience the physician's burnout in their marital relationship? Second, saturation occurred very early in the interview process when similar statements or accounts were given by multiple participants; however, to further support credibility and to remain consistent with Mason's (2010) recommendation of conducting at least 10 interviews for a qualitative research study, I continued interviewing until 10 participants who met the eligibility criteria were interviewed.

## Transferability

Establishing transferability in a qualitative study is like achieving external validity in a quantitative study (Merriam & Tisdell, 2016). Transferability allows data acquired in one study to be generalized and applied to a different group in a similar circumstance. To attain transferability in this study, I asked open-ended questions to allow the participants to share their experiences. Follow-up questions allowed me to probe deeper into a comment or explanation and learn more about how the spouses were experiencing the physician's burnout in their marital relationship. These additional inquiries provided the

opportunity to gain a deeper and thicker description of their experience, which further enhanced transferability.

**Dependability**

The statistical reliability that is present in quantitative research is absent in a qualitative study. Alternatively, consistency in data collection promotes the accuracy of the data collected and ensures dependability in the qualitative research process (Merriam & Tisdell, 2016; Stadtlander, 2018). Dependability was achieved in this study by consistently asking the same set of open-ended questions to each participant during each interview. The dependability of this study was further supported as a detailed record of all correspondences with the AMAA, FMAA, and all participants was kept. Additionally, the Zoom recordings, videos, and transcripts of each interview further contributed to achieving dependability in this study.

**Confirmability**

To establish confirmability and increase dependability, research studies that use a qualitative method must strive to reduce researcher bias and concentrate on objectivity, while at the same time remaining verifiable (Merriam & Tisdell, 2016). Confirmability in a study suggests that future researchers studying the same topic could successfully replicate the study and yield the same results, which would indicate the results obtained in the first study could be attributed to the concentration of the study and not to researcher bias (Merriam & Tisdell, 2016; Patton, 2015; Stadtlander, 2018).

## Results

Once the process of analyzing the data was completed, descriptive and in vivo coding were used to identify 10 themes and 20 categories represented in the interviews. The emerging themes represent the perspectives of the participants as they related to the main research question. To summarize and synthesize the perspectives of the participants, a descriptive report was created. This report includes a narrative and quotes from the 10 core themes extracted from the interview transcripts during the analysis of data. These themes accurately represent the perspectives of the women participants and how they experienced their husband's burnout in their marital relationship.

### Theme 1: Sacrifice/Loss

During the analysis of data, the first theme that emerged was that the women felt a sense of sacrifice and loss due to the demands their husbands' profession as a physician has placed on them. The women interviewed described sacrificing their careers and their desires to relocate to another city or state to support their husbands' career as depicted by Mrs. Med 3.

> I gave up my career to move where he was during residency. Now that the kids are older, I worry if this is "it." What do I do now with my life? What else can I do that is constructive and helpful to this community and help me grow as an individual?

Mrs. Med 5 stated, "I put a lot of what I wanted on hold so that our family could allow this career choice for him." She continued by mentioning, "His demanding schedule has prohibited me from exploring anything."

> A lot of our life has been dictated by his career and it's kind of like I feel like I gave up so much. I moved and I did all of those things to get him through training and he's not happy (with his job). It's hard. (Mrs. Med 6)

In addition to relocating and making family decisions that centered around the physician's career, a sense of loss was also experienced by the participants. These losses included the following: losing their personal identity, losing their sense of self, and loss of connections from multiple moves required at various stages of the physician's training and career. Mrs. Med 2 stated, "You totally lose your sense of self." This sentiment was also demonstrated by Mrs. Med 7 as she mentioned, "I think the biggest sacrifice I've made was not taking care of myself. I've taken on a lot of his stress. I think the second biggest sacrifice is just losing myself." Mrs. Med 7 explained in greater detail.

> If I had to do it over again, I'd pay more attention to myself and what was good for me. I ended up losing myself in the support role and making sure everybody was taken care of, including kids, including parents, including my husband, including everybody else, and I didn't take care of me in the process. I didn't think about what I would want long term.

Mrs. Med 9 recounted, "(I) just became a totally different person than before I met him. That person is totally gone."

**Theme 2: Loneliness**

Physicians work an average of 50.8 hours per week, compared to the general population logging 40.7 hours per week (Shanafelt et al., 2022b). These extended hours and unpredictable schedules kept by many of the physicians were noted as a primary

contributing factor to loneliness and isolation experienced by the spouses in the study. Mrs. Med 9 mentioned, "I feel very ignored and isolated and it's the most painful thing." Not being near family or a support system compounded the loneliness and isolation (Mrs. Med 2, Mrs. Med 4, Mrs. Med 6). Mrs. Med 3 stated she felt "isolated" and "very estranged." When discussing the physician's work schedule, Mrs. Med 4 recounted, "He misses holidays and family events. It's difficult living far away from family." Mrs. Med 7 acknowledged, "He's not around on holidays." Mrs. Med 6 moved to a new state where she didn't know anyone and described how this situation was very stressful for her and made her feel isolated.

**Theme 3: Solo parenting**

The physician's long work hours and their unpredictable schedule require the spouses to be self-reliant and independent. "His schedule is unpredictable" (Mrs. Med 5). "His schedule is different all the time; therein itself is a source of stress" (Mrs. Med 4). Mrs. Med 7 stated, "He doesn't have a regular schedule at all." "I never know when he's coming home from work," (Mrs. Med 9). "You have to be very independent."

The spouses described how they often felt like they were single parents and that they were doing everything alone.

> Whenever decisions had to be made, or things didn't go right, it was on me. I have to keep all the balls in the air at all times, and if something falls, that's my fault because I am the one in charge of all of those things. (Mrs. Med 4)

Mrs. Med 2 mentioned that her former career [being a nurse] "prepared by for being basically a single parent," and drew a parallel between her former career and solo

parenting by stating, “You can multitask and evaluate situations.” She added that she felt “jaded” when she saw other husbands at events, stating “It kind of made me very angry because I was like, why am I accountable for everything?” Mrs. Med 2 further described that her husband “missed holidays and family events” and that “the kids were used to him not being around.” Mrs. Med 3 explained, “I do a lot of things alone that some other (non-medical) couples might have chosen to do together.” She elaborated by describing attending school events or other social events by herself instead of her husband being by her side.

In addition to feeling like a single parent, the spouses stated that the majority of the domestic duties and responsibilities fell on their shoulders as demonstrated by Mrs. Med 5, “Everything at home falls on my shoulders.” Mrs. Med 6 explained, “I do everything around here. He does nothing.” Mrs. Med 7 stated, “I do all the housework. He’ll do the dishes every once in a while. I cook all the meals. He does the yard work. She added, “I ask him how I can help him, but he never asks how he can help me.”

Eight of the participants stated that they carried 90% or more of the domestic responsibilities, while two spouses (Mrs. Med 2, Mrs. Med 3) estimated their contribution as 80%. Jovanovic and Wallace (2013) described the domestic duties and child-rearing responsibilities carried out by the spouse as “invisible labor,” which takes the pressure off of the physician.

It should be noted that the COVID-19 global pandemic was reported as an extremely stressful time by several of the spouses (Mrs. Med 1, Mrs. Med 4, Mrs. Med 5, Mrs. Med 6, Mrs. Med 7, Mrs. Med 9); however, some spouses also reflected upon this

time as less stressful due to a decreased workload, more family time resulting from offices being closed and elective procedures canceled (Mrs. Med 2, Mrs. Med 3, Mrs. Med 11) Combining both experiences, Mrs. Med 8 explained, "At first, it was pretty great because he didn't have any cases and we got to stay home (together) for a few weeks. Then, when he had to go back in, it was pretty stressful."

**Theme 4: Anger**

Anger is the fourth theme represented by the spouses in this study. Mrs. Med 3 explained,

> I would feel underappreciated or just angry because he would come home in a bad mood and take it out on us. He was impatient and critical about me or the children. I would be angry, but we also didn't feel as close.

The female spouses often displayed feelings of anger when describing systemic issues their husbands faced in the workplace. For example, Mrs. Med 4 stated she "feels angry when he has been treated poorly at work." When other physicians "case dump" on her husband, leaving work for him to do instead of doing it themselves, Mrs. Med 1 experiences anger and frustration. She explained that the extra work coworkers leave causes her husband to have to stay late at work and "that is time he could be spending with us." Mrs. Med 9 stated, "It makes me so angry because it is demoralizing the way they are treating the physicians. It's sickening. They ride on their backs making money."

Four of the spouses reported the physician using "mindless scrolling" or video games as coping mechanisms for their stress and burnout (Mrs. Med 1, Mrs. Med 5, Mrs. Med 6, Mrs. Med 9). Mrs. Med 5 explained, "When he uses coping mechanisms that

aren't healthy, like scrolling on his phone or playing video games, I feel I get super short and irritated with him." Mrs. Med 9 also stated that the couple has had arguments that centered around his playing video games.

**Theme 5: Helplessness**

Seeing their husbands experience work-related stress and burnout created a sense of helplessness in the spouses as demonstrated by many of them referring to themselves as "fixers" who were not able to "fix it" for the physicians. Mrs. Med 1 described herself as "a fixer" and explained that she feels "Exhausted. Tired. A little helpless." She further explained that her husband's burnout is challenging for her because "I can't fix this for him. There's nothing I can do." Mrs. Med 4 remarked, "It gets old, tiring, same old complaints, and I can't fix it." Mrs. Med 6 stated, "I want for him to be happy at work and I don't know how to help him." Mrs. Med 7 shared that seeing her husband suffer from burnout made her "Very sad." She followed by sharing, "I'm a fixer. I just wanted to help him." When describing how she experienced her husband's burnout, Mrs. Med 9 explained, "I became so shut down because there was nothing I could do about it," and "I'm lost." Mrs. Med 11 remarked, "I feel powerless to help him. I feel frustrated. What can I do?"

The majority of the women noted their tendency to censor what they say or to calculate what type of information they share with their husbands and when they share it based on how they gauge his mood after work. This was often described as "walking on eggshells" around their husband. Mrs. Med 2 demonstrates this caution as she explains, "You decide what to share and when (carefully) when they're home, to preserve time."

She further explains, “You have to decide what information should be released. Is it really a decision you need input on? Or can you take care of it yourself?”

**Theme 6: Misunderstood**

Many of the participants in this study described experiences they had where they felt outsiders had misunderstood the complexities of a medical marriage. Additionally, the spouses shared circumstances in which they misunderstood what a “medical marriage” would entail.

> I think I thought, ok, once residency is done, we’re just gonna have this awesome life. We’re just gonna have this great life, like vacations. You know, we’re gonna go to the theater. We’re gonna do things that I did growing up and I’m going to work and I’m going to have my career. We’re just gonna have kids and just gonna be like this perfect life. And it’s just not, you know? It’s not been perfect. It’s just messy at times. It’s hard. Marriage has been really, really hard at times because we’re so different. Sometimes we just don’t communicate. We have to remember to communicate. (Mrs. Med 1)

Mrs. Med 1 further stated, “I thought it (a medical marriage) would be easier,” and “I didn’t realize it (medicine) would consume so much of our lives.”

> Everyone thinks it’s the Cleaver family here. You go inside and you have your heels on and start vacuuming, and then go out to dinner, go to a country club, and all your kids are really smart and never get into trouble. (Mrs. Med 2)

Mrs. Med. 2 also remarked, “We have just as many problems as you do in your house. That (problems) cuts across to all socioeconomic groups.

> People think everything is all roses. That all doctors make a lot of money, and they can afford for their families whatever the family needs. They just don't know that most physicians, no matter what their practice are not home as you think they would be. Things take them away that are work-related from their family. (Mrs. Med 3)

Mrs. Med 3 was not alone in her experience of being misunderstood as it relates to physician finances. Mrs. Med 6 commented, "The biggest misconception of a medical marriage is that you make a ton of money, and it makes life very easy. And I think the reality of it is a lot of medical marriages can get pretty lonely." She later added that her perception of a medical marriage "it's way different than I think either one of us signed up for or thought it was going to be."

> People just assume that because my husband is a doctor, he's rich and that we can afford everything we could ever want or need, and because we can afford those things, it makes life easy, and that is just not the case. I sacrifice so much for him to have his career. (Mrs. Med 5)

The long work hours of physicians garner judgment from onlookers as well as demonstrated by Mrs. Med 5's comment, "People judge when your spouse (the physician) is not present." Mrs. Med 5 continued, "People will occasionally make comments that are pretty hurtful like he's not involved, or he's choosing to work over being with family." When her husband was not home for Christmas, Mrs. Med 7 received a comment from a neighbor stating, "At least he's a doctor." Mrs. Med 3 contributed, "I

think that people probably don't realize that there's more stress involved in the family because of a physician's career than is realized by the general public."

Comments would extend beyond work hours and children into business and work for Mrs. Med 11. As a business owner, Mrs. Med explained that people would question why they should refer business to her because they assumed she didn't need the money because her husband is a physician. She stated, "People think we live this life of luxury and that we don't have any of the everyday stress that other people have and that couldn't be further from the truth." Mrs. Med 7 discussed the societal misconception that life is easy because you're married to a doctor; however, she noted that her husband's profession makes it difficult to talk about any negative experiences she may encounter out of fear that she may be judged. She noted it was difficult to "talk about any negative parts of how we feel or how it's impacting us because we should just be grateful."

**Theme 7: Health Challenges**

Health challenges were the seventh theme in this study. Data indicated that both mental and physical health challenges were present in the spouses. Grimmer and Jacquin (2023) reported that when a physician is experiencing burnout, their spouse can experience higher anxiety and greater incidences of depression. Mrs. Med 1 stated, "I definitely think it (his burnout) has affected by mentally and emotionally." She continues, "I think I've become desensitized. I've checked out." Mrs. Med 5 stated, "I struggle a lot with anxiety," and "His burnout is one of the contributors to my mental health issues." Mrs. Med 9 noted, "It's (husband's burnout) made my anxiety and depression worse." She continues to explain that the stress of her parents' passing was traumatic. She feels

that he ignores her and "is not paying attention" due to "looking at his computer all the time due to his work demands." "That made my grief, my depression, my self-worth worse. I have felt suicidal many, many times and I have been to a psychiatrist. I've gotten on antidepressants." (Mrs. Med 9). Additionally, Mrs. Med 9 noted, "I hate my life," "I have insomnia," and "I'm very nervous." Mrs. Med 11 shared, "The biggest sacrifice has been the mental stress, just the strain. The mental strain that it puts on me and my husband; how it's affected my own mental health."

Physical health issues were experienced by two of the spouses. Mrs. Med 1 and Mrs. Med 7 both stated they had experienced breast cancer. Additionally, Mrs. Med 7 noted "stomach issues," "weight gain," experiencing "high stress," "0 cortisol," and being "low in vitamins." She attributed her ailments to the stress she experienced from her husband's burnout.

**Theme 8: Self-Care**

Self-care is presented as the eighth theme in this study. The spouses shared a common trait of putting the family and the physician's needs ahead of her own, which had negative ramifications according to the spouses. To cope with the challenges facing a medical family, support networks, physical activity, and treatments including talk therapy and TSM treatment were utilized by the spouses. Mrs. Med 1 stated that "Getting plugged in (Alliances)," "making friends," "networking," and "playing tennis" was relevant to her self-care. Mrs. Med 2 also stated that "making friends with other doctor's wives," was important to her. Mrs. Med 3 recognized the importance of "Teaching myself not to react," and stated, "I have my own social outlets." Some additional outlets for Mrs. Med

3 included volunteering, joining Alliances, and being a member of the local PTO. She explained that she needed to "Turn my attention to other things that needed to be done, or that I wanted to do." Mrs. Med 4 remarked that she utilized walking, exercise, deep breathing, and the Headspace app to support her self-care. Additionally, when her husband's work gets too stressful for her, she tells him, "I need a break," and said, "I'll leave town if he's on nights, if I can." She also recognized, "It's important to have a support system," and that she finds value in "having other medical couples and medical families that you can rely on to help out and spend time with, because who understands the struggles better than them?"

Mrs. Med 5 shared that she has turned to therapy, coaching, medication, exercise, and TMS therapy to promote her self-care. She stated, "My mental health needs to matter just as much as his."

> Something I've worked on is allowing a space for him to vent without having it negatively affect me. It's really hard. I have to be really conscious of where my brain and my thoughts go. When I'm not able to control it, it affects us on so many levels. It affects what I'm able to get done. It affects my mood. It affects my mood with the kids. It affects my emotions for the day. (Mrs. Med)

Mrs. Med 6 shared, "I just find other things to do," "I have a lot of hobbies," "I go with friends," I distract myself."

> His level of stress makes me stressed out, and I don't want to get stressed out anymore. I'm trying to get myself healthy, too. I'm finally taking care of myself, and I don't want to go back over to the other side. (Mrs. Med 7)

To support her well-being, Mrs. Med 7 practices breathing techniques, "takes supplements," and focuses on "helping others" through her business. Mrs. Med 8 noted using meditation and breathing techniques found in a wellness program called Positive Intelligence (PQ) as methods to promote her well-being. Mrs. Med 11 commented that trips to the beach, eating a healthy diet, exercising, meditation, and prayer were her primary sources of self-care.

**Theme 9: Pride in his service**

Every participant shared the challenges they faced as a spouse in a medical marriage. Alternatively, they each shared positive experiences as well. Five spouses showed great pride in the physician's altruistic nature and dedication to the field of medicine. Mrs. Med 2 shared that hearing positive comments from patients, such as, "Your husband is the best doctor," provided a sense of satisfaction. Mrs. Med 4 remarked that it makes her happy when her husband comes home and says he has had a good day.

> It's a bittersweet life. You know how much he means to other people and how much people appreciate him and are grateful for him and what he does. The guy I trust the most is also the guy they trust the most and that makes it all worth it. (Mrs. Med 5)

Mrs. Med 5 elaborated on her "bittersweet" comment above by explaining that she appreciates that he is valued, but sad that it comes as a detriment to her family.

> When we run into patients out and about and they're so happy and thankful for what your husband has done for them and how good he is to them. I like knowing

> he does a good job for people and takes good care of them, and they appreciate it. (Mrs. Med 8)

"Some people aren't super kind to their patients so I'm thankful that he is, even if he's not kind when he comes home all the time. He's using good energy at work and that makes it ok" (Mrs. Med 8). Mrs. Med 9 shared, "He's really kind when he talks to people (patients) on the phone. And he's caring, and I love that about him." She added, "I think of some of the things he did that weren't so kind to me, then I remind myself that this (his kindness to her family and his patients) is more important."

**Theme 10: Relationships**

The tenth theme in this study was based on relationships, specifically marital and family relationships. Many of the participants explained that the physician brought work home with them after regularly scheduled hours. This extra work, described as "pajama time" by the AMA, lengthens the physician's workday and is a contributor to burnout (American Medical Association, 2023b). This additional work was required, unpaid, and took away from their family time, affecting the dynamic of the marital relationship. Mrs. Med 1 and Mrs. Med 6 explained that their husbands spend at least three hours per day working during "pajama time." Mrs. Med 9 recounted, "He brings it (work) here (home) so he's doing it all weekend." She further described, "He gets up early Saturday and Sunday and will get on the computer and work all day." In addition to "pajama time" work carrying over into family time, the physician's inconsistent schedule leads to a "lack of family time" (Mrs. Med 5). "Our family revolves around medicine. It consumes us a lot" (Mrs. Med 1).

Mrs. Med 5 shared her perception that the children experience stress when he's not home. She stated that her child says, "Don't go to work without me (without saying goodbye)." She further describes that their child sets an alarm on the family's Alexa device to know when daddy should be home and gets upset if he isn't back by the time the timer goes off (Mrs. Med 5).

> I worried about our children when they were young. I felt like I had to run interference because sometimes he would come home, and he'd just be really stressed out. He needed to calm down and just take time to unwind. I would feel like sometimes the children would maybe get yelled at when it wasn't necessary. I would be kind of on "pins and needles" trying to manage that situation. Sometimes, I think that would happen with me as well. (Mrs. Med 3)

"I think it impacts our children and me, just in terms of sometimes him being a bit volatile. Not in explosive ways, just a bit unexpected. The kids are like, 'Who are you?'" (Mrs. Med 8)

In terms of the marital relationship, participants had varied responses; however, a common statement of "walking on eggshells" or mindfully delivering information to protect or buffer the physician from experiencing more stress was present.

> (In therapy) I noticed that something I would do in an attempt to not add to his plate of all these stressors that he's already dealing with, I would just bottle up my own issues that I was dealing with so that I wasn't just another thing for him to worry about or take care of. (Mrs. Med 5)

"His stress really impacted our marriage" (Mrs. Med 6). "I don't want to tell him how I feel because I don't want anything to be worse" (Mrs. Med 7). She continued, "Sometimes I do tell him things because he's the person I want to be with and I want to work on things with him, so I will tell him things, but it's very strategic, and it's very thought out before I do" (Mrs. Med 7).

Mrs. Med 8 remarked that when her husband is stressed out, "I feel like walking on eggshells a bit because I'm wondering what will be the thing that triggers him to get upset." "I sort of try to manage the situation and do all the things around him to make life easier (for him), which can be stressful (for her)."

Mrs. Med 9 described a lack of intimacy in her marriage as demonstrated by her comment, "We don't sleep in the same bed anymore because he would come to be very late (after staying up late to complete his required charting)."

Mrs. Med 11 explains that when her husband has a bad day, "he gets short and snappy." For this reason, she "makes a deliberate choice not to ask him how his day was," and continued by stating, "I try to refrain from any of those kinds of questions because it can trigger him." She continued, "You can't even ask your spouse how their day is because it's so negative and so stressful that you might trigger them." She further added, "There's just kind of this underlying stress that is put on the relationship. An underlying current of stress that is pervasive." (Mrs. Med 11).

> I take on a lot of his emotions. If he texts me that he had a bad day or something bad is currently happening, it doesn't matter how good my day is going. I take that on 100%, and then it ruins the rest of my day. (Mrs. Med 5)

"I'm very sensitive to moods and energy and the people around me. When he's in a down, grumpy mood, I can have a tendency to personalize that" (Mrs. Med 6).

Several spouses described their concern for the longevity of their marriages. "We were on a downward spiral. I didn't know if I could handle this (marriage) in the long run. It was pretty rough until we found (a program through his work)" (Mrs. Med 8). Mrs. Med 11 shared, "I've definitely thought about exiting the situation (marriage) on more than one occasion." "I don't know if I would do it all over again. Marrying a doctor is really not easy" (Mrs. Med 7).

## Summary

Chapter 4 focused on the fundamental research question: How do male physicians' female spouses experience the physician's burnout in their marital relationship? This study explored the perspective of 10 female spouses of male physicians and how they felt personally affected by the physician's burnout and the role it played in their marital relationship by engaging participants in semi-structured interviews using the questions from Appendix E. The female spouses who participated in this study shared their experiences in great detail during the interview process. Through analyzing the interview transcripts multiple times, 10 themes and 20 categories surfaced suggesting that when male physicians experience work-related burnout, their female spouses are also deeply impacted.

This chapter included a detailed description of the data collection process, analysis of the data, and the results obtained from the interviews of 10 female spouses of male physicians who have experienced work-related burnout. Chapter 5 provides an in-

depth interpretation and synthesis of the findings based on Bolger's (1989) crossover theory as a conceptual framework. Additionally, Chapter 5 includes a description of the limitations of the study as well as recommendations for future research on this topic. Finally, Chapter 5 concludes with the implication of the results of this study to effect positive social change.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

This basic qualitative study explored physician burnout and the marital relationship from the perspective of the spouse. The research question was as follows: How do male physicians' female spouses experience the physician's burnout in their marital relationship? For this study, I recruited 11 female spouses of male physicians. One participant did not meet the eligibility criteria and was excluded, resulting in 10 valid interviews. Semistructured interviews using 25 open-ended questions were the primary method for data collection (Creswell & Creswell, 2017). To garner a rich, detailed response from the spouses, Moore's (2023) recommended method of active inquiry was applied during interviews. To support a more detailed response and further deeper discussions, additional probing questions were asked. Additionally, to provide a supportive experience to the participant throughout the interview process, active listening skills were used (Louw et al., 2018).

During the data analysis process, 20 categories were identified, leading to 10 key themes. These themes included sacrifice/loss, loneliness, solo parenting, anger, helplessness, misunderstood, health challenges, self-care, pride in his service, and relationships. These themes indicated that the female spouses were directly impacted by the work-related stress, strain, and burnout their husbands experienced by their profession as physicians, as explained in Bolger's (1989) crossover theory. As a result, the burnout experienced by the physician can affect the spouse and their marital relationship. An interpretation of the findings from this study detailing the spouse perspective is included

in this chapter. Additionally, limitations of the study, recommendations for future research, implications for social change, and a conclusion are also included.

## Interpretation of the Findings

In 2019, the World Health Organization (WHO) stated that burnout syndrome is attributable to work-related stress. Those persons whose professions are in the human services field often suffer from burnout, frequently exhibiting physical and behavioral manifestations such as illness, sleep dysregulation, cynicism, and erratic behavior as a result (Freudenberg, 1974). When compared to the general population, physicians are 40% more likely to experience burnout (Shanafelt et al., 2022b). In 2021, the physician burnout rate had reached a record high of 62.8% (Berg, 2022).

The effects of burnout extend beyond the physician and into the marital and family relationships (Bolger et al., 1989; Maslach et al., 2018; Yucel & Latshaw, 2020). Grimmer and Jacquin (2023) noted in their work that a physician's spouse may experience higher anxiety and depression when the physician is experiencing burnout. To examine how burnout can crossover from the physician to their spouse and the spouse's perception of this effect, 10 female spouses of male physicians, who met all eligibility criteria, participated in semistructured interviews. The data obtained were analyzed using Saldaña's (2021) first and second-cycle coding methods, descriptive and in vivo, to discover emerging themes. These themes centered around the research question: How do male physicians' female spouses experience the physician's burnout in their marital relationship? During the process of analyzing the data, each of the spouse's perspectives was examined using Bolger's (1989) crossover theory. During this process, 10 major

themes emerged, which reflected the perspectives of the spouses on physician burnout and their marital relationship. These themes included sacrifice/loss, loneliness, solo parenting, anger, helplessness, misunderstood, health challenges, self-care, pride in his service, and relationships.

**Theme 1: Sacrifice/loss**

The first theme, sacrifice/loss, was a common thread throughout each of the interviews. Each of the spouses described circumstances in their relationship that required them to sacrifice or give up certain things for their husband to pursue his career in medicine. Depending on when the couple's relationship began, they may have experienced several relocations. A physician may be in one location for medical school, a second location for their residency, a third location if they complete a fellowship, and a fourth location upon embarking on their first job as an attending physician. These moves may involve relocating to a different city, state, or possibly across the country. Relocation is a complex process involving timely coordination of the completion of one stage of the physician's career with the beginning of the next. Relocation stress syndrome, often associated with elderly persons moving into assisted living or long-term care, may also apply to physician families during this stage of life where they have moved frequently. Parallels between the stress experienced by military families and physician families were drawn in Chapter 2. This connection continues in new literature published by Ribeiro et al. (2023) with the concept of relocation stress syndrome. The authors explained how relocation stress syndrome can contribute to depression, stress, and psychological distress in military spouses due to frequent relocation as the support systems created in one area

are disrupted when the family relocates. These frequent relocations cause spouses and families to repeatedly leave existing support systems to create or find new ones.

When children are involved, and depending on their ages, school transcripts need to be transferred, as well as medical records. These tasks often fall on the spouse. A vital component to relocation is leaving a community they are familiar with and moving away from friends and family, for someplace new and starting all over again. All the participants stated that establishing a support network was crucial during this process. Many of the spouses reported being involved in social media groups for physician spouses and becoming members of their county, state, or national Alliances.

Another area the spouses felt they gave up was in their careers. Eight out of 10 of the women had children and stated that they gave up their careers to stay home with the children and raise the family. The spouses stated that they made this decision consciously and intentionally; however, the physician's unpredictable work schedule created a scenario where they felt like single parents, which will be expanded upon in Theme 3. When a spouse reported that she gave up her career to take care of the children, or that much of their life centered around the physicians' careers, they described feeling a sense of loss. They specifically described losing their identity, their sense of self, and the loss of previous connections they had due to multiple moves throughout the physician's career. This feeling of losing their sense of self is consistent with earlier research by Gabbard and Menninger (1988). Often, the spouses reported that they didn't take care of themselves due to the overwhelming obligations of taking care of everyone else in the family and putting those needs above the spouse's own. Sotile and Sotile (2000)

described frequent moves, the non-physician partner sacrificing their career and goals, and feeling like a single parent. This information was present in 2000 when the Sotiles published their book *The medical marriage: Sustaining healthy relationships for physicians and their families*. Knowledge learned from this study shows these issues still exist for medical families.

**Theme 2: Loneliness**

Loneliness was the second theme to emerge in this study. The spouses anticipated their marriages to be partnerships with their soul mates; however, the physicians' extended work hours and unpredictable schedules often left the spouses feeling lonely. Additionally, these circumstances created uncertainty for the spouse and the family as not knowing when the physician would be home from work made planning difficult and often resulted in missed family events and holidays. Park et al. (2020) cited that feelings of loneliness, though subjective, can lead to adverse health outcomes for the individual. For example, increased stress can lead to hypothalamic-pituitary-adrenal (HPA) axis dysfunction and higher levels of pro-inflammatory health markers. Literature on loneliness and marriage and older adults exists in abundance; however, current research is limited on how loneliness may affect the marriages of younger individuals, specifically those in a medical marriage.

**Theme 3: Solo Parenting**

An additional effect of the physicians working long hours was the spouses feeling like they were solo parents, which surfaced as Theme 3 in this study. Decisions involving the children or the household fell onto the shoulders of the spouse, causing them

additional stress because if something went wrong, the accountability was on them. This perspective of doing everything alone and being a solo parent (even when there are two parents) led to the spouses describing the importance of being very self-reliant, independent, and a great multitasker; this resulted in the children being more reliant on and closer with the mother, which is consistent with Sotile and Sotile (2004). Additionally, the missed events and holidays, bearing the brunt of the domestic responsibilities, and "invisible labor" often left the spouses feeling "jaded" (Jovanovic & Wallace, 2013). All the spouses in this study (who had children) chose with their husbands to be stay-at-home moms. Current research by Doan and Quadlin (2019) suggests that socially defined gender norms often dictate that in heterosexual couples, more women will take on the responsibility of housework than males. Additionally, the authors stated that lower earners (in this case, the female spouses) generally tend to be assigned childcare and domestic responsibilities than the higher-earning partner.

**Theme 4: Anger**

The fourth theme to evolve in this study was anger. The spouses shared that they experienced a feeling of anger when they perceived their husbands were being mistreated by the hospital or organization where they were employed. Additionally, the participants described scenarios where the physicians worked extended hours during "pajama time" to get caught up on case notes, explaining that the extra work takes away from the time that the physician could have been spending with their family. Further, the participants who shared that their husbands used "mindless scrolling" or video games described this behavior as the physicians' way to cope with their work-related stress. The spouses

perceived this behavior as the physicians' way to "check out" or to focus on something menial when they (the physician) have been dealing with life and death all day at work. The spouses explained that they knew this was an outlet or stress reliever for the physician; however, this behavior also led to arguments and discord between the couples. The anger described by the spouses is directly related to their husband's profession. The spouse's perceived mistreatment of the physician at work and the lack of family time due to work during "pajama time" are contributors to disrupting the work-life balance (WLB) and are an example of poor work-life integration (WLI) as explained in previous work (Bolger et al., 1989; Iyer, 2022, Paul et al., 2021; Yucel & Latshaw, 2020).

**Theme 5: Helplessness**

The fifth theme presented in this study was helplessness. The spouses frequently described themselves as "fixers," or that they wanted to help the physicians when they (the physician) were experiencing burnout. Despite wanting to help the physician, the spouses felt there was nothing they could do, which resulted in the spouses feeling helpless. The spouses wanted to help, but they couldn't "fix" the physician's burnout. One thing that the spouses could do was to censor what they said to the physician and when they shared information. The spouses often reported feeling like they were "walking on eggshells" based on the physician's mood when they got home from work. The delivery of information was carefully calculated based on his mood, and how she perceived he would react to whatever it was that she had to share. This experience was a way that the spouse could buffer the physician from experiencing any additional stress in their day. Instead, the spouse would often take on the decision-making if the physician

didn't need to provide input. Additionally, if the physician had a bad day at work, and the spouse was able to shield them from further stress, they (the spouse) perceived this as a way to preserve family time and the home environment. The spouse carefully curating the physician's behavior at home because of his experiences at work demonstrates another example of poor WLI, WLC, and how the physician's work stress is crossing over into their marital relationship (Bolger et al., 1989; Iyer, 2022, Paul et al., 2021; Yucel & Latshaw, 2020).

**Theme 6: Misunderstood**

Misconceptions or misunderstandings of what being a spouse in a medical marriage would entail were reported frequently by the spouses. Additionally, spouses often experienced feeling judged on their marriage by outsiders, leaving them to feel misunderstood at times, which is Theme 6 of this study. The theme of being misunderstood was consistent with previous literature by Sotile and Sotile (2000). Spouses shared their experiences of thinking that both their and the physician's stress and burnout would be reduced or eliminated when certain milestones were met. For example, one common thought is once residency is finished and the physician finally starts his medical practice, he will make a good salary and life will be great. Or, once they have children, they will have the "perfect life." This perception by the spouse correlates with Gabbard and Menninger's (1989) explanation of postponement. Further, the spouses didn't realize that medicine and their husbands' jobs would consume so much of their lives. The overwhelming presence of the husband's medical profession described by the spouses contributes to work-family conflict (WFC), disrupted WLB, and poor WLI as

described in previous research (Bolger et al., 1989; Iyer, 2022, Paul et al., 2021; Yucel & Latshaw, 2020).

The spouses described many instances where they felt judgment of their marriage by outsiders or even family members. The most common experience of judgment that the spouses shared was that outsiders would assume that their marriages were perfect simply because their husband was a physician. Additionally, it was the spouses' perception that outsiders assumed they had significant wealth because their husband was a physician, but they (outsiders) never thought of the financial commitment that medical school was and the financial burden the couple was now facing, which is also consistent with the work of Sotile and Sotile (2000).

**Theme 7: Health Challenges**

Health challenges emerged as the seventh theme in this study. The health challenges experienced by the spouses were both mental and physical. Spouses described experiencing anxiety, depression, low self-worth, suicidal ideations, breast cancer, insomnia, mental strain, stomach issues, weight gain, high stress, low cortisol, and vitamin deficiency. All the spouses perceived these health challenges to be a manifestation of how the physician's work-related burnout directly affected their physical and mental health. Previous research associated burnout with adverse health consequences for the physician (American Medical Association, 2023b; UCSF Department of Medicine, 2023). Messias and Flynn (2018) noted that depression may be amplified when a person is experiencing burnout. Bolger's (1989) crossover theory may

support the spouse's feelings that some of their health issues were a result of the stress they experienced through the crossover effect.

**Theme 8: Self-care**

The eighth theme presented in this study is self-care. The spouses described how they frequently put the needs of their children and the physician ahead of their own, causing them to disregard their self-care. Lack of self-care resulted in the negative health challenges described in Theme 7. To address their needs, the spouses used various coping strategies such as talk therapy, medication, Transcranial Magnetic Stimulation (TSM) treatment, networking in Alliances, making new friends, exercising, healthy eating, prayer, volunteering, coaching, meditation in person and on apps, and yoga. Many of the women noted their social support networks through various Alliances as one of the greatest tools they used. Similarly, earlier research discussed social relationships, social support, and connecting with others of similar professional backgrounds as ways physicians can support their well-being (Aalto et al., 2018; Song et al., 2021; Weissman et al., 2023). Further, professional support such as seeing a psychologist or licensed therapist to address mental health issues was recommended for physicians and was also referenced as a method used by the spouses (Bernard & Cohen, 2018).

**Theme 9: Pride in his service**

Despite the spouses describing the physician's long work hours, unpredictable schedule, and feeling like a single parent as a negative aspect of being in a medical marriage, Theme 9, pride in his service, was evident in each interview. All of the spouses shared experiences of being out with the physician and seeing a patient or someone who

knew the physician and that person saying what a good doctor he was, or how they (the physician) cared for them or a family member. When the spouses heard positive accolades toward the physician's capabilities it made them feel a sense of pride. The spouses perceived the positive comments as outweighing the negative experiences they have had. This study has discussed how Bolger's (1989) crossover theory applies to spouses of physicians who are experiencing work-related burnout. The data suggests that when the physician is experiencing the negative effects of burnout, it can also carry over to the spouse. The crossover theory also suggests that positive experiences can crossover as well (Brough et al., 2018; Bolger et al., 1989). This would suggest that when a physician receives a compliment, or when the spouse hears something in support of the physician, this positive experience can cross over to the spouse as well.

**Theme 10: Relationships**

Relationships, specifically marital and family relationships, emerged as Theme 10 in this study. The spouses who reported that the physician brought work home with them, or did work during "pajama time," perceived this additional work as detrimental to their one-on-one time as a couple and taking away time spent together as a family. The spouses perceived the lack of one-on-one time as contributing to their feelings of loneliness, isolation, and feeling disconnected from the physician. Further, the physician's burnout led to the spouse carefully monitoring their (the physician's) mood and demeanor if they needed to act as a buffer or "run interference" between the children and the physician if he had a bad day to not "trigger" him.

Previous literature identified the spouse as the physician's greatest tool to combat burnout; however, when the work is not compatible with the demands of the physician's home and family life, WFC can occur (Beltràn Ponce et al., 2023; Jovanovic & Wallace, 2013; Lee et al., 2021). In recent work, Trockel et al., (2022) recognize that the effects of work-related distress can influence one's personal relationships. This is also consistent with the crossover theory (Bolger et al., (1989)

## Limitations of the Study

This basic qualitative study sought to examine physician burnout and the marital relationship from the perspective of the spouse. In qualitative research, respondents may be hesitant to share personal and potentially negative information about themselves, their partners, or their relationships. All participants in this study shared their perspectives voluntarily. As the spouse of a physician, and a member of both the FMAA and AMAA, I have personal experience with the topic of physician burnout from the spouse perspective. My affiliation with the FMAA and AMAA may have given the participants the confidence to speak openly and honestly about their experiences, knowing that I could relate; however, it is also possible that my affiliation with these organizations may have caused participants to exercise restraint or pause in how they answered some of the questions out of concern that we may see each other at meetings or events in the future. Additionally, I had no previous personal relationship with any of the participants, which may have also contributed to them sharing freely. Further, I managed any potential personal bias by abiding by the strategies for trustworthiness as explained in Chapter 4.

During the interviews, I refrained from interjecting my own commentary, allowing the participant to answer fully and completely.

The design of this study created several limitations as it only included a small sample of 10 female spouses of male physicians. The study excluded spouses of medical students, residents, fellows, and those spouses whose husbands had been practicing for less than five years. Additionally, this study excluded male spouses of female physicians, dual-physician couples, and LGBTQ+ couples. Eligibility requirements also limited inclusion to physicians practicing in the U.S. The findings in this study would be generalizable to a sample of similar participants; however, a study conducted with participants outside of the specified eligibility criteria cannot be generalized.

## Recommendations

There is a wealth of information on physician burnout and how it decreases job satisfaction, patient satisfaction, and productivity while it increases medical errors and costs for the organization (Aalto et al., 2018; American Medical Association, 2023; Berg, 2018; Doolittle, 2020; Patel et al., 2018; UCSF Department of Medicine, 2023; Weissman et al., 2023; West et al., 2018). Substantial research has also been conducted on other high-stress professions, such as military and first responders as well as how the stress and burnout of these professions affect their spouses (Beehr et al., 1995; Bolger et al., 1989, Buck & Neff, 2012; Jackson et al., Long & Voges, 1987; Morrison & Clemets, 1997; Pavett, 1986). Gabbard and Menninger (1988) and Sotile and Sotile (2004) have explored the spouse perspective regarding their medical marriages and in recent literature, Trockel et al., (2022) explored how a physician's work can adversely affect

relationships and patient complaints, but none of these works addressed the spouse's perspective on how their marital relationship was affected by the physician's burnout. In their crossover theory, Bolger et al. (1989) explained how the negative impact of work conflicts can carry over into the marital relationship. Yucel and Latshaw (2020) described how female spouses experience more adverse effects of their husband's burnout as a result of the crossover theory. At the time this study was conducted, only one published study conducted by Grimmer and Jacquin (2023) specifically addressed the issue of physician burnout and its impact on spouses and families. After the study was completed, a more recent article was published by Ungerleider et al., (2024) titled *Assessment of the well-being of significant others of cardiothoracic surgeons*. This article was specific to the specialty of cardiothoracic surgeons and included spouses and significant others (SO) without a specific focus on the gender of the spouse or physician. Their work recognized that a majority (60%) of the SOs felt the physician's work stress carried over into their family life while 63% noted that limited family time was an issue. Poor WLB and interaction they described as "not good-natured" were also present, though in lower concentrations of 27% and 23% respectively (Ungerleider et al., 2024).

The limited research on physician burnout and the marital relationship from the spouse's perspective coupled with the evidence that physician burnout carries over into the marital relationship and has a negative effect on the spouse and the family suggests that further research on this topic is justified. Recommendations for future research would be to interview a larger sample size to provide greater support for generalization. Additionally, research to explore specific periods of a physician's practice, such as

medical school, residency, fellowship, and early practice, would provide an alternative perspective of the needs of the medical families during those times. Each of these time frames carries different demands on the physician, and thus, their spouse. A final recommendation would be to conduct further research on specific demographics, such as female physicians with male spouses, dual-physician couples, and LGBTQ+ couples. These couples each carry unique and complex qualities that differ from that of the "traditional" male physician and female spouse and deserve adequate representation. Finally, the presence of loneliness as a common theme in this study and the limited amount of research on marriage and the effect of loneliness on younger couples, especially those in medical marriages, calls for further investigation.

## Implications

This basic qualitative study explored how male physicians' female spouses experience the physician's burnout in their marital relationship. The limited research in this area and demographics not yet explored suggest that additional opportunities exist to reduce physician burnout and address the needs of medical families. The causes of physician burnout have been researched extensively; however, many organizational factors still exist that are primary contributors to this issue (American Medical Association, 2023; UCSF Department of Medicine, 2023). Addressing physician burnout at each stage of a physician's career may play a crucial role in marital and family relationships, work-life balance (WLB), and job performance. For example, programs can be created to prepare medical students for what to expect during medical school, stress management techniques, teaching them the importance of self-care, and providing them

tools that support their mental and physical well-being. Additionally, offering counseling and therapy for individuals and couples to help them navigate this experience together.

Many of the participants in this study were not married during medical school but were married and had children during the residency stage of the physician's career. These spouses described this time as the most demanding. Continuing to implement burnout reduction programs to support the physician is vital; however, incorporating support systems for the spouse and families can help to improve the spouse's well-being. Providing marriage counseling or couples therapy to help guide the couple through this stage would be helpful so that each party can understand what the other is experiencing. The physician may have had an idea of the demands of medical school or residency but may not have completely understood the demands they would be placing upon their spouse.

Once a physician completes training and ventures into their first "real job" as an attending, the demands and expectations placed upon them change. They are now fully responsible for the medical decisions they make and do not have instructors or program directors to rely on (Lai et al., 2020). This new responsibility can elevate the stress level for both the physician and their spouse. At this stage, hospitals and organizations that employ physicians must recognize that physicians are an asset that must be valued. The UCSF Department of Medicine (2023) stated that 80% of physician burnout can be attributed to organizational factors. Providing programs to reduce burnout and suggesting tools for self-care fall under the 20% of factors that the physician can control. Organizations must recognize the role they play in physician burnout and focus on

preserving their assets (i.e., physicians). When physician burnout is reduced, their health improves, job satisfaction increases, medical errors decrease, patient satisfaction increases, physician turnover decreases, and costs of replacing a physician decrease, resulting in overall revenue for the organization increasing (Aalto et al., 2018; American Medical Association, 2023b; Beltràn Ponce et al., 2023; Berg, 2018; Messias & Flynn, 2018; Parikh & Cavanaugh, 2023; UCSF Department of Medicine, 2023; Weissman et al., 2023). These companies can continue providing support services such as counselors and support groups to both the physician and their spouse. Offering networking opportunities outside of the workplace can help boost camaraderie and morale for the physician, help the spouse feel included, and potentially reduce feelings of loneliness and isolation. Listening to the physicians when they have complaints or concerns about how they are being treated and addressing their concerns allows them to feel heard and valued (Maslach & Leiter, 2022). Further, reducing the amount of time the physicians spend completing electronic health records (EHR) and other administrative burdens previously completed by nurses, medical assistants, and receptionists can increase the time they can spend with patients and provide a more personal versus transactional experience (American Medical Association, 2023; U.S. Department of Health and Human Services, 2022).

Another way organizations can support their clinicians is by creating and incorporating a position of a Chief Wellness Officer to act as a liaison between the physicians and the organization who can help bridge the gap between the two parties. This position can help the organization emphasize the “quadruple aim” of improving

patient care, promoting better health outcomes, supporting physician well-being, and lowering costs (American Medical Association, 2020). Additionally, providing wellness coaching for physicians can also help manage burnout, foster a growth mindset, reduce imposter syndrome, and provide a smoother transition from training into practice (Boet et al., 2023; Fainstd and Mann, 2023). Most of the previously mentioned recommendations do center on the physician; however, as Bolger's (1989) crossover theory grounds this study, this framework suggests that if the physician's burnout is addressed, reduced, or prevented from happening in the first place, the negative impact their spouse experiences can also be affected accordingly.

## Conclusions

In conclusion, this basic qualitative study investigated how male physician's female spouses experienced the physician's work-related burnout in their marital relationship. The participants in this study all believed their husbands (the physicians) had experienced burnout due to their profession of being a physician and shared their perspectives on the causes, implications, and how their (the physician's) burnout affected them (the participants). This study illuminated 10 themes including sacrifice/loss, loneliness, solo parenting, anger, helplessness, misunderstood, health challenges, self-care, pride in his service, and relationships.

The findings of this study demonstrated the effect that physician burnout has on the marital relationship from the spouses' perspectives. Despite the negative experiences the spouses described their pride in what their husbands do, and their altruistic nature were highlighted. The findings suggest the need for the hospitals and organizations that

employ physicians to become aware of, and accountable for, their role in physician burnout and recognize their ability to reduce or eliminate it. Additionally, the need for programs and support services for the physician and their spouse to be implemented at all levels of the physician's career is evident. For example, support groups, family support services, and networking opportunities outside of work allow spouses and families to feel "plugged in," engaged, and included to reduce feelings of loneliness and isolation. Jovanovic and Wallace (2013) described the marital relationship and spouse support as a crucial element in physician's achieving their professional goals. When spouses feel supported, they are better able to support the physician. When physicians feel supported, their overall productivity, job satisfaction, health, and patient experience can improve, while medical errors, absenteeism, physician turnover, and costs to the organization decrease. Supporting physician's spouses and families is a fundamental component of creating a successful healthcare system.

The knowledge acquired from this study provides the scholarly communities and organizations that employ physicians with how their work-related burnout can cross over into their marital relationship, and impact their spouses and families, creating a bidirectional effect on their work performance, productivity, patient care, organizational bottom line, and medical errors. Further, knowing how physician burnout is experienced by the spouse allows for additional support services to be created and implemented. Inevitably, every person in our society will have an interaction or experience with a physician or healthcare system and seek a positive experience. When physician burnout is

reduced, so is its effect on the spouse and the marital relationship. As a result, overall patient care is improved, which can foster positive social change.

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## Appendix A: E-Mail Request to Organizations for Participation

The following message will be sent to Facebook administrators of groups that cater to physicians or their spouses:

Dear Admin of [insert Facebook Group name]

My name is Lisa Muehlenbein. I am a doctoral student at Walden University pursuing my Ph.D. in Health Psychology. Additionally, I am also the wife of a physician. I am contacting you today asking for assistance in recruiting participants for my study on physician burnout and the marital relationship. My study specifically seeks to understand this issue from the spouse's perspective. This study is significant in that it will help improve the understanding of how physician burnout affects a medical marriage from the experience of the physician's spouse. The results of this study should inform the scholarly communities that have direct relationships with physicians on how the burnout they experience due to the stress and strain of their profession can carry over into the marital relationship and their families, effect on their work performance, patient care, and contribute to medical errors.

My goal is to interview at least 10 physician's spouses via phone, in person, or via Zoom. I have attached a flyer and would be grateful if you would consider allowing me to post it in the Facebook Group. On the flyer, I am requesting potential participants to contact me directly to determine their eligibility for participation in the study. Upon completing the study, I would happily share my final published dissertation with you and the group. I thank you for your support and assistance in completing my study and my goal of improving the lives of our physicians and their families.

Sincerely-

Lisa A. Muehlenbein

Ph.D. Candidate, Walden University

The following version of the above e-mail will be sent to the Presidents of the AMAA and FMAA whom I have already had personal contact with:

Dear [Ellie (FMAA)/Rachael (AMAA)],

I hope this e-mail finds you well. As you know from our previous conversations at our Alliance events, I am currently a graduate student at Walden University pursuing my Ph.D. in Health Psychology. I appreciate our earlier conversations about the study I am working on as partial completion of my dissertation on physician burnout and the marital relationship. My study specifically seeks to understand this issue from the spouse's perspective. This study is significant in that it will help improve the understanding of how physician burnout affects a medical marriage from the experience of the physician's spouse. The results of this study should inform the scholarly communities that have direct relationships with physicians on how the burnout they experience due to the stress and strain of their profession can carry over into the marital relationship and their families, effect on their work performance, patient care, and contribute to medical errors.

During our previous discussions, you had expressed a willingness to help me in my dissertation process; thus, I am reaching out to you today to ask for assistance in recruiting participants for my study. My goal is to interview at least 10 physician's spouses via phone, in person, or via Zoom. I have attached a flyer and would be grateful if you would consider e-mailing it to the general membership database on my behalf. On the flyer, I am requesting potential participants to contact me directly to determine their eligibility for participation in the study. Upon completing the study, I would happily

share my final published dissertation with you and the Alliance. I thank you for your support and assistance in completing my study and my goal of improving the lives of our physicians and their families.

Sincerely-

Lisa A. Muehlenbein

Ph.D. Candidate, Walden University

Appendix B: Flyer Invitation to Participate

# Study Volunteers Needed

*Physician Burnout and the Marital Relationship: Spousal Perspective*

**Attention: Spouses of Physicians**

*My name is Lisa Muehlenbein. I am a doctoral student at Walden University pursuing my Ph.D. in Health Psychology. Additionally, I am the wife of a physician. I am currently seeking other female spouses of male physicians to complete a 45-60 minute interview with me for my dissertation study (in-person, by phone, or via Zoom). My study focuses on physician burnout and the marital relationship specifically from the perspective of the spouse. I want to hear about your experience!*

## Eligibility Requirements:

- Heterosexual marriages
- Over 18 years of age
- Be fluent in English
- Identify as female
- Be the spouse of a male physician (M.D. or D.O.) who has been practicing full-time for the last 5 years
- Must not be a physician yourself
- You believe your physician spouse has experienced work-related burnout

***If you believe you meet the eligibility requirements above, and would like to participate in this study, please send an email with your name and preferred contact method to:***

**[email address removed]**

Walden University IRB approval # 12-08-23-1155451
Approval expiration date: 12/7/2024

# Appendix C: Eligibility Screening Questionnaire

## Physician Burnout and the Marital Relationship: Spousal Perspective Eligibility Questionnaire

This questionnaire was designed to confirm eligibility for participation in the study being conducted by Lisa Muehlenbein as a Ph.D. candidate at Walden University.

IRB# _____

1. Are you over the age of 18? Yes/No
2. Are you fluent in English (reading and speaking)? Yes/No
3. Do you identify as female? Yes/No
4. Are you married to a male physician (M.D. or D.O.) who is currently practicing in the United States and has been practicing for more than five years? Yes/No
5. Are you also a physician? Yes/No
6. Do you believe your spouse has experienced burnout related to their profession as a physician? Yes/No
7. Please share your e-mail so that you may be contacted to schedule your interview once eligibility has been confirmed (your e-mail will remain confidential and used for this study only). _____

# Appendix D: Demographic Questions

Researcher: Lisa A. Muehlenbein, MPhil

IRB #:

Participant ID:

Date of interview:_____

1. What state do you live in?_____
2. How long have you been married to your husband?_____
3. What is your age?
    a. 18-25
    b. 26-34
    c. 35-44
    d. 45-54
    e. 55-64
    f. 65+
4. How would you describe your ethnicity/race?
    a. Caucasian
    b. Latino or Hispanic
    c. African-American
    d. Asian
    e. Native American
    f. Native Hawaiian or Pacific Islander
    g. Prefer not to answer

5. What is your highest level of education?
    a. Some High School
    b. High School
    c. Some College
    d. Bachelor's Degree
    e. Master's Degree
    f. Ph.D. or higher
    g. Trade School
    h. Prefer not to answer
6. What is your employment status?
    a. Employed Full-Time
    b. Employed Part-Time
    c. Not Employed
    d. Student
    e. Retired
    f. Prefer not to answer
7. What is your husband's age?
    a. 18-25
    b. 26-34
    c. 35-44
    d. 45-54
    e. 55-64

f. 65+

8. How would you describe your husband's ethnicity/race?
    a. Caucasian
    b. Latino or Hispanic
    c. African American
    d. Asian
    e. Native American
    f. Native Hawaiian or Pacific Islander
    g. Prefer not to answer
9. Do you have children? Yes/No
    a. If yes, how many?_____
        i. Prefer not to answer
    b. If yes, what are the ages of your children?
        i. >3
        ii. 4-6
        iii. 7-9
        iv. 10-12
        v. 13-15
        vi. 16-18
        vii. 18+
        viii. Prefer not to answer
10. What is your husband's medical specialty?_____

11. How long has your husband been practicing (i.e., years practicing post-residency or fellowship training)?_____

12. Did your husband complete a fellowship?_____

    a. If so, in what specialty?_____

13. Please describe your living situation:

    a. Own a single-family home

    b. Own a condo, apartment, or townhome

    c. Renting a single-family home

    d. Renting a condo, apartment, or townhome

    e. Other

    f. Prefer not to answer

14. What is your household income?

    a. > $150,000

    b. $150,000-$250,000

    c. $250,000-$350,000

    d. $350,000-$450,000

    e. $450,000-$550,000

    f. $550,000 +

    g. Prefer not to answer

# Appendix E: Interview Questions

Based on the recommendations of Patton (2015) and guided by the MBI-HSS (Maslach & Leiter, 2018), the following open-ended questions will be asked during the interview process. Following each question, listening attentively, and reflecting on what has been said is important so that participants know they have been heard. Additional probing questions will be asked to allow more profound insight to be gained. Responding with empathy and remaining present throughout the interviewing process is paramount to retaining trust and engagement with the participant (Patton, 2015).

- *Tell me how you met your spouse.*
    - *At what stage of their career did you get married?*

- *How would you describe your spouse's job?*
- *Thinking about your husband's job, please describe your spouse's stress level.*
- *One qualifier for this study was that you believe your husband has experienced burnout due to his profession as a physician. Tell me more about his experience with burnout.*
    - *Please describe a situation in which you believe your spouse's experience with burnout has impacted their experience working in medicine.*
    - *When thinking about your husband's profession as a physician, please describe what you perceive to be the most significant contributing factor to your spouse's burnout.*

- *In your own words, please explain how your spouse's burnout has impacted their mental health.*
    - *Please describe any interventions/coping strategies your spouse has used to manage/cope with their burnout.*
    - *Please share what you perceive as the most beneficial intervention your spouse has used to cope with/manage their burnout.*
    - *Please share what you perceive as the least beneficial intervention your spouse has used to cope with/manage their burnout.*
    - *Please describe any intervention you believe would be helpful that your spouse has not tried yet.*

- *Tell me about your experiences as the spouse of someone who has experienced burnout in their work.*

    - *Thinking about your average day, how much one-on-one time would you say you and your spouse spend together?*
    - *In your own words, please describe how you believe you personally have been affected by your husband's burnout.*
    - *Describe how your spouse's experience with burnout has impacted your marriage.*
    - *Regarding the household duties, describe the role your husband takes.*
    - *Explain how your spouse's experience with burnout has impacted your family.*

    - *Regarding parenting responsibilities, describe the role your husband takes.*
    - *How much time does your spouse spend on work after working a full day/coming home?*
- *Tell me, if there was one thing you could change about your spouse's profession that you believe would reduce their level of stress and burnout, what would it be?*

Upon completion of the designed interview questions, the participants would be asked a final open-ended question:

- *What else would you like for me to know? (If participant has not addressed the COVID-19 pandemic, I will add: For example, tell me how COVID-19 affected your husband's burnout and your marital relationship.)*

And lastly:

- *Do you have any questions for me?*

# Appendix F: Brief Explanation for Participant Recruitment

Request for Interview Study Participants with Lisa A. Muehlenbein, AMAA Member

As physician spouses, we often have a unique marriage experience very different from those families who are not involved in the practice of medicine. As a Ph.D. candidate in Psychology with a specialization in Health Psychology, I have chosen to dedicate my dissertation to addressing this issue familiar to all of us. The attached flyer describes my study titled *Physician Burnout and the Marital Relationship: Spouse Perspective*. This independent study for my dissertation seeks to interview female spouses of male physicians and learn their perspective and experience. In my request for participants, I feel it is important to recognize that additional demographics indeed deserve studied; however, for the purposes of this dissertation, the focus is on the largest demographic present according to existing data. I hope to explore additional types of relationships upon completion of my education and continue to expand important work on this topic. I welcome you to review the flyer for the study and reach out directly to me at [email address removed] if you are interested in participation. I look forward to sharing the data with our organization upon completion. Thank you!