OCCUPATIONAL ROLE STRESS IN DUAL-DOCTOR MARRIAGES - A COMPARISON OF ORGANIZATIONAL ROLE STRESS IN DOCTOR-DOCTOR MARRIAGES & DOCTOR- NON-DOCTOR MARRIAGES

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ABSTRACT

Stress in doctors has major and far reaching effects for the doctors themselves, their family and patients. In dual-doctor marriages, stress may or may not be aggravated. Previous studies have shown that dual doctor marriages can either lead to an aggravation of stress in doctors, or diminish the cumulative stress levels in medical doctors. This study compared the various variables of organizational role stress among doctors who are married to doctors, and those married to non-doctors. A sample of 245 doctors, all married, and all working in the Public Health sector in Goa completed a self-report questionnaire. Role Stress was significantly higher in doctors who were married to doctors than in those married to non-doctors. This significant difference was also reflected in the variables of Role Stagnation, Role Expectation Conflict, Role Overload, Role Isolation, Self Role Distance and Resource Inadequacy. These findings have implications both for the well-being of doctors and their families, and for patient care.

KEYWORDS: Dual Doctors, Doctors, Occupational Role Stress

INTRODUCTION

Review of Literature

Dual-career marriages, where both partners are working in occupations requiring a high degree of involvement, accuracy and responsibility may be seen as sources of compounded or reduced stress. On the one hand, spouses who share similar work patterns and the inherent difficulties at work may lead to greater empathy and mutual support between them (Marshall & Bamett, 1993). In some situations, however, involvement in multiple roles may lead to excessive role stress (Sekaran, 1983; Steffy & Ashbaugh, 1986; Lewis & Cooper, 1988; Barnett, 1993), and ultimately affect mental and physical health (Cleary & Mechanic, 1983; Lewis & Cooper, 1987). Hall and Hall (1980) suggested that stress may be lessened where couples phased career stages, did not have children, or worked in related fields of medicine.

Spillover' or transmission of stress between couples also prevails (Fletcher, 1988; Bolger, DeLongis, Kessler & Wethington, 1989; Jones & Fletcher, 1993; Morrison & Clements, 1997) although it has proved difficult to separate the effects of occupational variables from individual personalities which might affect stress or well-being within such marriages.

In the workplace, males have traditionally given work precedence over family demands, and it is likely to be the female partner who adapts her career pattern to fit in with family demands (Nadelson, Notman & Lowenstein, 1979; Hiller & Philliber, 1982; Yandoli, 1989). In a study of 39 dual-career partnerships with young children, Karambayya and Reilly (1992) found that most couples divided domestic work on traditional gender lines even where both partners worked full-time.

Studying dual-career doctors specifically, Izraeli (1994) divided marriages based on the ratio of the husband's to wife's income, into 'conventionals', where men contributed more income and women invested more time in family, 'moderns' where both partners contributed equally, and 'innovatives', where the women contributed more income than her partner. The 'innovatives' made up the smallest proportion (less than 10%) of the sample. Similarly, Tesch, Osborne, Simpson, Murray and Spiro (1992) found that women physicians married to other physicians were more "traditional" in adapting their own career progress to accommodate their partner's careers than women physicians who were not married to doctors. This trend was less marked in younger physicians, suggesting a more egalitarian division of labour.

Studies have suggested that role demands of work and home are additive, with occupation of multiple roles leading to conflicts, stress and strain owing to 'overload' (e.g. Sekaran, 1983; Greenhaus & Parasuraman, 1986) and reduced physical and mental well-being.This may not always be manifest as a disadvantage; multiple role occupancy may lead to increased satisfaction and well-being in some situations (Thoits, 1983; Cooke & Rousseau, 1984; Verbrugge, 1986). However, since most studies have been cross-sectional it has often been difficult to determine the direction of causality, i.e. whether multiple roles lead to increased wellbeing, or whether individuals with more well-being are likely to successfully adopt more social roles. Alternatively, it may be the degree of complexity of roles, in terms of an individual's investment and involvement in that role, which is important, rather than purely the quantity of roles an individual occupies (Cooke & Rousseau, 1984).

Perceived equity of domestic and occupational roles may be a more important factor in the level of organizational role stress than the actual workload contribution of each partner (Lewis & Cooper, 1987). Based on the premise that females have primary responsibility for home life, and males perceive work as primary because of their 'breadwinner' role, Pleck also suggested that work to home conflict would be greater for males, whereas the demands of home life were more likely to conflict with work demands for females. Studies of gender differences in the symmetry of the home/work relationship have generally failed to find such differences (Frone et al, 1992, 1997; Swanson et al, 1998), perhaps owing to recent changes in traditional male and female roles within the family and workplace, although one study found that 'overloads' and 'conflicts' at home had a greater impact on work for males than for females (Bolger et al., 1989), and it may be that male managers married to managerial or professional spouses were likely to experience greater role conflict related to the female partner's expectations of egalitarian relationships (Lewis & Cooper, 1988).

Characteristics of medical work may make doctors especially vulnerable to stress between work and home, particularly since a high proportion of doctors are married to other health professionals, or to other doctors. In Allen's (1988) medical school cohort study, 47% of the sample were in dual-doctor marriages. An earlier cohort study of female medical school graduates also identified over half (55%) as being married to doctors or dentists (Ward, 1982). Availability of partners, likelihood of mutual support, empathy and compatibility of areas of interest are offered as reasons for the high number of between-doctor marriages. However, the advantages of such compatibility may be balanced by negative aspects of careers in medicine. Factors such as heavy workloads, long working hours, emotional commitment and 'burnout', and the need for geographical mobility in pursuit of career goals may be compounded in dual-career marriages (Rout, 1996).

Conflict and unhappiness in medical marriages is a source for concern, although previous studies have tended to discuss problems faced by partners of male doctors without reference to the female partner's own occupational status (Bates, 1982). Female doctors may fare less well than their male colleagues in establishing and maintaining successful marriage, with approximately one-third of women doctors remaining single (Allen, 1988) and higher divorce rates being noted for female than male doctors (Myers, 1984). Although the most commonly cited cause of marital conflict for doctors relates to 'time-based' difficulties or long working hours, evidence that this is a causal factor in dysfunctional marital

relationships is not conclusive (Gabbard, Menninger & Coyne, 1987; Rout, 1996). Marital or family problems may also affect doctors' work performance (Gabbard et al, 1987; Kirwan & Armstrong, 1995) and increased occupational stress and reduced job satisfaction in doctors in general practice, in particular, have been shown to be related to quality of work performance, especially poor prescribing (Melville, 1980; Grol et al, 1985) and to doctors' and patients' satisfaction with consultations (Howie, Hopton, Heaney & Porter, 1992; Winefield, Murrell, Clifford & Farmer, 1995).

One aspect of medical work, out of hours time spent on call, has been identified as a major stressor for GPs (Hallam, 1994; Myerson, 1991). Since time on call is often spent at home, this has important implications for the stressfulness of the 'home work interface'.

Dual-doctor partnerships may be open to as many potential hazards as compensations for both male and female partners. Most previous studies have found home/work role confiicts to be a greater source of stress for female than for male doctors (Izraeli, 1998; Cooper et al, 1989; Sutherland & Cooper, 1993), although few have considered the issue of asymmetric permeability of work to home and home to work stress. Studies have also suggested that division of gender roles may be predominantly 'traditional' in medical professionals, since the majority of females generally work fewer hours, and have lower earnings than their male counterparts (Weisman & Teitelbaum, 1987; Grant, Simpson, Rong & Peters-Golden, 1990; Izraeli, 1994; Swanson, Power & Simpson, 1996), although female doctors have fewer career breaks and less time out for child rearing relative to women in other professions (Ward, 1982).

In a study on dual doctor careers, by Swanson and Power (1999), male doctors perceived their work as more stressful and less satisfying than females. Work stress had a greater impact on home life than vice versa, but there were no gender differences in levels of stress from work to home (WH) or home to work (HW). However, more males than females, particularly younger males, reported that work was a source of conflict with their partner. WH stress predicted marital conflict for both male and female doctors, whereas HW stress predicted marital conflict only for females. Time on call out of hours, the ethical commitment to medicine, and work encroaching into family time were identified as major sources of conflict.

Hypothesis

H1 There will be significant difference between the stress levels of doctors married to doctors, and doctors married to non-doctors.

Methodology

The survey research design was utilized for this study. The sample for this study consisted of 245 married doctors from Goa, consisting of public sector employees from Goa Medical College, Primary Health Centres and District Hospitals in Goa.. The questionnaire was divided into two parts; the first part was designed to capture the demographic responses. The second part was the ORSS (Organizational Role Stress Scale) questionnaire. Findings were analysed using the SPSS software and the t test.

Tool

Organizational Role Stress (ORS) was measured with the help of an ORS-scale (Pareek, 1983). The scale comprises 50 items. The respondents rate each item as 0, 1, 2, 3 and 4 depending on the item's applicability to their organizational role (0 for rarely/not applicable and 4 for nearly always/very frequently applicable. The scale measures the following ten role stressors. The score for each role stressor (in the range 0-20) is obtained by adding the scores of five pre-assigned items.

1. **Inter-Role Distance (IRD):** is experienced when there is a conflict between organizational and non-organizational roles.

2. **Role Stagnation (RS):** is the feeling of being stuck in the same role for long due to lack of opportunities or development.

3. **Role Expectation Conflict (REC):** arises out of conflicting demands originating from superiors, subordinates or peers.

4. **Role Erosion (RE):** arises when a role occupant feels that others are performing certain functions, which should have been a part of his role.

5. **Role Overload (RO):** is the feeling that one is required to do too much.

6. **Role Isolation (RI):** arises when a person feels that his role is isolated from the mainstream of organizational life.

7. **Personal Inadequacy (PI):** is created by the lack of adequate skills and the resulting inability to meet the demands of ones role.

8. **Self-Role Distance (SRD):** arises from a gap between one's concept of self and the demands of his role.

9. **Role Ambiguity (RA):** is experienced when there is a lack of clarity about the demands of the role.

10. **Resource Inadequacy (RIN):** arises when human and material resources allocated are inadequate to meet the demands of the role.

OBSERVATIONS AND DISCUSSIONS

Table 1: Test of Significant Difference of Doctor and Non Doctor (Spouse) and Role Stress among Medical Doctors

Role Stressors	DOCTOR N= 138		NON DOCTOR N=107		
	Mean	S.D	Mean	S.D	t- ratio
IRD	10.90	3.034	8.21	3.350	8.232
RS	11.55	3.582	7.63	3.066	11.597**
REC	10.29	3.143	7.66	2.932	8.400**
RE	10.78	2.955	6.90	2.573	12.991
RO	9.46	1.972	7.13	2.371	9.799**
RI	10.57	2.251	9.22	2.817	4.824**
PI	12.54	3.301	8.74	3.664	10.642
SRD	10.62	2.443	7.26	2.032	14.854**
RA	8.49	2.988	6.48	3.169	6.324
RIN	9.76	2.735	7.86	3.322	5.686**
TRS	104.96	15.990	77.01	19.967	14.078**

*p<0.05, **p <0.01

Role Stress was significantly higher in doctors who were married to doctors than in those married to non-doctors. (t=14.078, p <0.01). This significant difference was also reflected in the variables of Role Stagnation, Role Expectation Conflict, Role Overload, Role Isolation, Self Role Distance and Resource Inadequacy. This study is in conformity with earlier studies which showed that being married to a doctor increases occupational role stress. (Sekaran, 1983; Greenhaus & Parasuraman, 1986; Rout, 1996; Swanson and Power, 1999).

From this finding, one can infer that being married to a doctor is associated with aggravated stress levels, rather than being married to a non-doctor. This can be attributed to the fact that a non-doctor can be more supportive, than a doctor spouse who will have a tendency to be judgemental. The non-doctor spouse would be more sympathetic to the doctors stress, as against a doctor spouse who may himself/herself be in a stressful work environment, hence compounding an already stressful situation.

CONCLUSIONS

Doctors are central figures in the communities in which they work. They deal with people on a daily basis and their public and private lives have a high level of 'visibility' within the community. Moreso than for other professionals, the well-being of doctors is important for the health of the wider community in which they work. Stresses and strains in medical professionals are likely to affect their work performance, including the quality of patient consultations and prescribing, as well as impact on their own personal and family life. Nevertheless, in many respects medical practitioners are in a position of privilege regarding their careers. Medical work is generally stimulating, intellectually and financially rewarding and offers high levels of role autonomy and status compared with many occupations. For female doctors, it is possible to combine a medical career with child rearing, via the availability of childcare leave and the ability to afford high-quality childcare. Despite this, there is substantial evidence that medical careers are highly stressful for both male and female doctors (Cooper *et al.,* 1989; Sutherland & Cooper, 1993; Swanson *et al.,* 1996), and demands of medical work have an adverse impact on marital relationships and family life (Gabbard *et al.,* 1987).

One explanation for this may lie in the emotional content of medical work and the strong ethical commitment of the medical profession, whereby the needs or demands of the patient take precedence over the needs of the doctor, and his or her family. For some of those doctors who reported work as being a source of confiict with their partner, the 'patient comes first' ethic was frequently mentioned as a reason for conflict between work and time for self or partner. This is less likely to occur in other professions, wherein a patient who is essentially a human being in need of assistance, is the source of conflict. Work demands during 'home' or family time was a major source of confiict for dual-career doctors, mentioned more frequently by males than by females. In this sense 'spillover' of work role or being "on-call" was perceived as a source of stress which may be compounded where both partners have heavy work role demands, as in the medical profession.(Swanson & Power,1999).

Limitations of this Study

The study did not take into consideration whether the individuals were parents or non –parents. Further the personality and dispositional aspects were not studied.

In particular, a disposition to see life in a negative light (negative affectivity, e.g. Watson & Clark, 1984) has been shown to be a major confounding factor in studies of occupational stress. Individual values and levels of commitment or investment in both occupational and domestic roles are important sources of variance which could also be assessed in future.

REFERENCES

1. Allen, I. (1988). Doctors and their careers. London: Policy Studies Institute.

2. Barnett, R.C. (1993). Multiple roles, gender and psychological distress. In L. Goldberger & S Breznitz.(Eds), Handbook of stress: Theoretical and clinical aspects. New York: Free Press.

3. Bates, E. (1982). Doctors and their spouses speak: Stress in medical practice. Sociology of Health and Illness, 4, 25-39.

4. Bolger, N., Delongis, A., Kessler, R.C. & Wethington, E. (1989). The contagion of stress across multiple roles. Journal of Marriage and the Family, 51, 176-182.

5. Cleary, P.D. & Mechanic, D . (1983). Sex differences in psychological distress among married people. Journal of Health and Social Behaviour, 24, 111-121.

6. Cooke, R.A. & Rousseau, D.M. (1984). Stress and strain from family roles and work-role expectations. Journal of Applied Psychology, 69(2), 252-260.

7. Cooper, C.L., Rout, U. & Faragher, B. (1989). Mental health, job satisfaction and job stress among general practitioners. British Medical Journal, 298, 366-370.

8. Fletcher, B.(C.) (1988). The epidemiology of occupational stress. In C.L. Cooper & R. Payne (Eds), Causes, coping and consequences of stress at work. Chichester: Wiley.

9. Frone, M.R., Russell, M. & Cooper M.L. (1992). Prevalence of work-family conflict: Are the boundaries asymmetrically permeable? Journal of Organizational Behaviour, 13, 723-729.

10. Frone, M.R., Russell, M. & Cooper, M.L. (1997). Relation of work-family conflict to health outcomes: A four year longitudinal study of employed parents. Journal of Occupational and Organizational Psychology, 70, 325-335.

11. Gabbard, G.O., Menninger, R.W. & Coyne, L. (1987). Sources of conflict in the medical marriage. American Journal of Psychiatry, 144(5), 567-572.

12. Grant, L., Simpson, L.A., Rong, X.L. & Peters-Golden, H. (1990). Gender, parenthood and work hours of physicians. Journal of Marriage and the Family, 52, 39-49.

13. Greenhaus, J.H. & Parasuraman, S. (1986). A work-non-work interactive perspective of stress and its consequences. Journal of Organisational Behaviour and Management, 8, 37-60.

14. Grol, R., Mokkonk, H., Smits, A., Van Eijk, J., Beek, M., Mesker, P. & Neisten, J. (1985).

15. Work satisfaction of general practitioners and the quality of patient care. Family Practice, 2, 128-135.

16. Hall, D . T . & Hall, F.S. (1980). Stress and the two-career couple. In C.L. Cooper & R. Payne (Eds), Current concerns in occupational stress. Chichester: Wiley.

17. Hallam, L. (1994). Primary medical care outside normal working hours: Review of published work. British Medical Journal, 308, 249-253.

18. Hiller, D.V. & Philliber, W.W. (1982). Predicting marital and career success among dual career couples. Journal of Marriage and the Family, 44, 53-62.

19. Howie, J.G.R., Hopton, J.L., Heaney, D.J. & Porter, A.M.D. (1992). Attitudes to medical care. The organisation of work and stress among general practitioners. British Journal of General Practice, 42, 181-185.

20. Izraeli, D.N. (1994). Spousal incomes and family/work relations among physician couples in Israel. Sociological Quarterly, 35(1), 69-84.

21. Izraeli, D.N. (1998). Burning out in Medicine: A comparison of Husbands and wives in dual-career couples. In E. GOLDSMITH (ed). Work and family: Theory Research and Applications. Journal of Social Behaviour and Personality (Special Edition) 3, 329-346.

22. Jones, F . & Fletcher. B.(C.). (1993). An empirical study of occupational stress transmission in working couples. Human Relations, 46(7), 881-883.

23. Karambhayya, R. & Reilly, A.H. (1992). Dual earner couples: attitudes and actions in restructuring work for family. Journal of Organizational Behaviour, 13, 585-601.

24. Kirwan, M. & Armstrong, D . (1995). Investigation of burnout in a sample of British general practitioners. British Journal of General Practice, 45, 259-260.

25. Lewis, S.N.C. & Cooper, C.L. (1987). Stress in uvo earner couples and stage in the life cycle. Journal of Occupational Psychology, 60, 289-303.

26. Lewis, S.N.C. & Cooper, C.L. (1988). Stress in dual earner families. In B.A. Gutek,,

27. A.H. Stromberg & L. Larwood(Eds.), Women and work: An annual review (Vol. 3). Sage. Newbury Park, California, USA.

28. Marshall, N.L. & Barnett, R.C. (1993). Work-family strains and gains among two-earner couples. Journal of Community Psychology, 21(V), 64-78.

29. Melville, A. (1980). Job satisfaction in general practice: Implications for prescribing. Social Science and Medicine, 14A, 495-499.

30. Morrison, D.L. & Clements, R. (1997). The effect of one partner's job characteristics on the other partner's distress: A serendipitous, but naturalistic experiment. Journal of Occupational and Organizational Psychology, 70, 307-324.

31. Myers, M.F. (1984). Overview: The female physician and her marriage. American Journal of Psychiatry, 141(11), 1386-1390.

32. Myerson. S. (1991). Doctors' methods of dealing with ongoing stress in general practice. Medical Science Research, 19, 267-269.

33. Nadelson, C.C. , Notman , M . T . & Lowenstein, P. (1979). The practice patterns, life styles, and stresses of women and men entering medicine: A follow-up study of Harvard Medical School Graduates from 1967 to 1977. Journal of American Women's Association, 34(\\), 400-405.

34. Rout, U . (1996). Stress among general practitioners and their spouses: A qualitative study. British Journal of General Practice, 46, 157-160.

35. Sekaran, U . (1983). Factors influencing the quality of life in dual career families. Journal of Occupational Psychology, 56, 161-174.

36. Steffy, B.D. & Ashbaug, D . (1986). Dual career planning, marital satisfaction and job stress among women in dual career marriages. Journal of Business and Psychology, 1(2), 114-123.

37. Sutherland, V.J. & Cooper, C.L. (1993). Identifying distress among general practitioners: Predictors of psychological ill-health and job dissatisfaction. Social Science and Medidne, 37(5), 757-581.

38. Swanson, V., Power, K.G. & Simpson, R.J. (1996). A comparison of occupational stress and job satisfaction in female and male GPs and consultants. Stress Medicine, 12, 17-26.

39. Swanson, V., Power, K.G. & Simpson, R.J. (1998). Occupational stress and family life: A comparison of male and female doctors. Journal of Occupational and Organisational Psychology,71, 237-260.

40. Swanson, V. & Power, K.G.(1999). Stress, satisfaction and role conflict in dual doctor partnerships. Community, Work & Family, 2 (1), 67-88.

41. Tesch, B.J., Osborne, J., Simpson, D., Murray, S.F. & Spiro, J. (1992). Women physicians in dual-physician relationships compared with those in other dual-career relationships. Academic Medicine, 67, 542-544.

42. Thoits, P. (1983). Multiple identities and psychological wellbeing: A reformulation and test of the social isolation hypothesis. American Sociological Review, 48, 174-187.

43. Verbrugge ,L.M. (1986). Role burdens and physical health in women and men. Women and Health,11, 47-77.

44. Ward, A.W.M. (1982). Careers of medical women. British Medical Journal, 284, 31-33.

45. Weisman, C.S. & Teitelbaum, M.A. (1987). The work-family role system and physician productivity. Journal of Health and Social Behaviour, 28, 247-257.

46. Winefield , H.R., Murrell, T.G.C., Clifford , J.V. & Farmer, E.A. (1995). The usefulness of distinguishing different types of general practice consultation, or are needed skills always the same? Family Practice, 12, 402-407.

47. Yandoli, A.H. (1989). Stress and medical marriages. Stress Medicine, 5, 213-219.