Group discussions with doctors' wives

J. N. SAVORY, MRCGP
General Practitioner, Boston, Lincolnshire

SUMMARY. Group discussions with the wives of general practitioners and vocational trainees have been held in the Boston vocational training scheme. Many problems such as being tied to the telephone and the registration of doctors' families with other general practitioners were discussed.

A consensus view emerged on several topics and I believe that further discussions with wives on subjects of this kind would be valuable.

Introduction

IN October 1978 an editorial in the *Journal of the Royal College of General Practitioners* stated that it was "virtually unheard of in the UK for trainees' wives to be offered any help in adjusting to their new roles, whereas in the University of South Carolina, Curry (1978) reports offering just such support as does Walpole (1978) in Australia". Such a seminar was also attempted four years ago in Boston, Lincolnshire, and was repeated recently. The following is an account of the second seminar.

Aims

The educational objectives of the group were:

1. That doctors should know the special stresses and strains their jobs impose on their wives and families, and should develop the skills necessary to cope with these problems.

2. That doctors' wives should know what problems they will have to face when dealing with their husband as a doctor, his practice, and his partners and his partners' families; and they should develop the skills necessary to cope with these problems.

Method

Seven weeks before the seminar a circular was sent to the trainees' wives inviting them to attend. Two weeks before the seminar, a further circular was sent to all who might attend stating briefly the educational objectives and listing some of the topics that were to be discussed.

Twenty-six people attended. They were divided into two groups, husbands and wives being separated. In my group there were five trainees, three trainees' wives, two trainers, and two wives of general practitioners.

Results

Because the group was new, a slightly nervous start was inevitable. However, confidence was soon established and the group dealt with several problems in some depth and with considerable sensitivity.

The following topics were discussed, though not necessarily in the order given:

1. *Choosing a practice.* Three or four partners was felt to be the ideal number, but if the wife wanted to work, the hours on call would need to be reduced as much as possible and therefore a larger practice would probably be better.

2. *Wife as a doctor.* There would be opportunities to do part-time sessions in general practice, to work in the school medical service, or to have an attachment to the local hospital.

3. *Doctors' hours.* There was a consensus that doctors' hours are not really too bad but are unpredictable and that an appointments system helps to make the day more predictable and helps solve such problems as who should take the children to school.

4. *Telephone.* There was a consensus that this was a great tie and one general practitioner's wife considered that it was even more of a problem when the children were grown up because freedom was so limited. In country practices it is hard to find a substitute for a wife manning the telephone out of hours unless there is a local hospital. Wives are probably the best answerers because they know some of the patients, and their husband's wishes. When the husband is on call, he can go out on visits or to meetings but his wife cannot, and their children are tied to the house and garden. One general practitioner's wife thought that this problem could be dealt with to some extent by adequately remunerating the wives (their pay should be rather more than the £975 wives' income tax allowance). Other ways of diminishing the problem are to have operator-controlled and subscriber-controlled telephone number re-routing arrangements. A rural doctor's wife was

asked what would happen if she was telephoned about a patient who had collapsed and who then died 20 minutes later, there being no doctor immediately available. Would she feel guilty because there was nothing she could do about it? Her answer was "no" because it would take the ambulance half an hour to get there and another half hour to get the patient to hospital. However, her husband did his best to let her know where he was so far as was possible.

5. *Wife's duties.* A rural doctor's wife said that she did a good deal of out-of-hours bandaging in addition to manning the telephone, because there was no local hospital and therefore no accident department.

6. *Confidentiality.* There was a consensus that the husband and wife are one unit; that is, the wife can be told all, even about close friends or relatives, and in fact this may well be in the friends' or relatives' best interest. If a general practitioner tells his wife a little she will naturally want to know more and if he tells her nothing she may well feel that he does not trust her discretion.

7. *A study.* There was a consensus that medical books and journals should be kept out of the living areas of the house.

8. *Medical fraternity.* There was a consensus that the medical fraternity as a whole has no thought at all for doctors' wives and families and puts much implicit pressure on doctors to go to postgraduate meetings, committee meetings, and lectures, which the wives often feel are a waste of time.

9. *Doctors' family doctors.* There was a consensus that where practical a doctor and his family should be registered with a 'non-partner' who is relatively young so he will not be retiring while the doctor's children are growing up. It was felt that several months should elapse before deciding which doctor should be chosen and that the doctor and his family should be treated like any other patient; that is, they should attend the surgery when this was appropriate.

10. *Doctors treating their own families.* The consensus was that doctors should treat short-lived non-serious illnesses only and that an outsider was needed for more serious or chronic illnesses.

11. *The new doctor's interview.* This should be expected to last all day. The doctor's wife should expect to be asked and if the couple were not invited for lunch this would be a black mark against the practice. However, if the new doctor accepted the invitation to the interview (and lunch) and then decided in advance he would turn the job down, he must still go to lunch! Partners' personalities cannot be assessed in one day; however, the freedom with which the new doctor feels he can ask questions is some guide to their personalities. This needs further assessment during the probationary few months.

12. *Holidays.* One senior partner was known who insisted on three weeks' holiday in August although two other partners had school-age children.

13. *Weekends.* One senior partner was known who insisted on never changing his weekends on call.

14. *The working wife.* The husband must understand his wife's needs and wants and plan accordingly. Partners' attitudes to wives working need to be established at the interview stage, since it can cause problems, particularly over manning the telephone.

15. *Practice experience for wives.* There was a consensus against the trainees' wives spending an afternoon or two in a trainer's practice but a consensus for trainees' wives having an informal chat with a general practitioner's wife, a trainer, and perhaps a receptionist one evening before the trainee's year in general practice. There was also a consensus for the new partner's wife spending an afternoon or two in the new practice reception area.

16. *Buying a house.* The temptation to do this in the probationary few months is strong but it is probably wiser to wait.

17. *The dynamics of medical marriages* were not discussed but this would be a useful additional topic based on Nelson's (1978) excellent paper.

Discussion

Most of the trainees had anticipated a boring, time-wasting afternoon but in fact enjoyed it and obtained some useful insights from it. The comments of trainees' wives were also enthusiastic. The average score was 3·7 out of 5, which for a non-factual subject is quite high for our training scheme. Absolute solutions to problems were not pursued. All group members were sensitive to the direction that the group as a whole wanted to take. The problems of the trainee year were largely avoided and there was no personal animosity. Both the doctors and their wives avoided taking authoritarian attitudes.

Unfortunately, the other group did not have an enjoyable afternoon, largely because of friction between members of the group.

Conclusion

There is no doubt that in spite of the success of one of the two groups, the seminar could be improved upon. It is recommended that such seminars should be held in the evening because this leads to a more relaxed atmosphere and avoids arranging a crêche; that they should be voluntary; and that they should be composed of members who can be relied upon to be sensitive to the general feeling of the group in order to avoid friction.

References

Curry, H. (1978). Statement at Eighth World Conference on Family Medicine, Montreux, Switzerland. Unpublished.

Journal of the Royal College of General Practitioners (1973). The family doctor's family. Editorial, **28**, 579.

Nelson, B. (1978). *Journal of the Royal College of General Practitioners,* **28**, 585-587.

Walpole, S. (1978). Paper read on "The Doctor's Wife". Eighth World Conference on Family Medicine, Montreux, Switzerland. Unpublished.