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All words and phrases in quotes in the text are the words and phrases of students, unless noted otherwise.

Abstract

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At the interpersonal level barriers to women's participation in the professions are mediated in part through language. Men's language cast women as inappropriate candidates for becoming a professional. This paper focuses on the language strategies of women entering medical school, who attempt to negotiate their acceptance as colleagues and to diffuse their threatening potential to the heroic image of the practicing physician. How successful the women are, and the implications for them of the strategies used are discussed.

LANGUAGE AS SOCIAL STRATEGY: THE NEGOTIATION OF SEX-LINKED BARRIERS FOR BECOMING A MEDICAL STUDENT[1]

INTRODUCTION

In this paper I shall take the position that the barriers to women's participation in the professions are largely structural and that these structures are mediated at the interpersonal level in part by the language used in the interactions between male members and women seeking collegial acceptance. I shall focus on the language strategies used by women in response to their male counterparts' reluctance to accept them as appropriate candidates for the profession. The negotiation of two of the sex-linked barriers is presented here: 1) collegial acceptance, and 2) the organization of work and men's attitudes about that organization and women's abilities to participate in it.

Though women accepted for training in male professions must have the requisite credentials, their sex contradicts the image and the myths that these professions have about what it takes to be a successful member. These images are also public images and provide support for the legitimacy of the mandate of the professions and for future recruitment. In the case of medicine the image has been persuasive. Physicians command power, respect, and monetary rewards, in part, because they have been able to withstand the rigors of learning the extensive body of exclusive medical knowledge and because their lives are devoted to the high calling of saving lives. It is an heroic image. The heroics--the dash, the verve, the charisma--that which is needed beyond intellect in the struggle with life and death--are threatened by the very nature of the newcomers.

But the image of physician-as-hero began tarnishing before the profession was compelled to admit women (and racial/ethnic minorities). From within and without the profession has been charged with becoming too heroic. The trend toward men entering high status specialty training and research has contributed to a maldistribution of services. Certain populations in this country have become underserved or even mal-treated. Women are among the new generation of young men and women recruited to remediate the problems the profession has created for itself.

Thus, women entering medicine in large numbers are faced with having to neutralize their threatening potential, while at the same time they represent the kind of nuturant and altruistic personality that the profession is seeking among new recruits. In the first months of medical school there are particular linguistic strategies that women use in order to gain recognition from their fellow classmates that they are capable and serious candidates. Though these verbal strategies are part of their strategic actions (Lofland 1976), I will focus on the verbalizations women use in response to their male coutnerparts' attempt to cast them as inappropriate candidates for the profession and, as abnormal women.

LANGUAGE STRATEGIES

How people use appropraite language or language strategies--and by users, here, I mean both speakers and hearers--in negotiating and/or maintaining a relationship has been the focus of a number of theoretical formulations regarding language use. Scott and Lyman (1968) discuss the use of the form "account" in repairing fractured relationships. Stokes and Hewett (1976) discuss "aligning actions" in which people in problematic situations attempt to aligh their actions with cultural norms or

agreed-upon-acceptability of the language in use. The notion of a vocabulary of motives (Mills 1940) or of accounts includes both the repeated action (misdemeanor or no) and the repeated language. The sutuation must be rather routine for a situated-regularized-agreed-upon language strategy to have developed.[2] For example, successful medical school applicants learn, as undergraduates, the appropriate deeds and the appropriate language with which they bargin for a relationship in which they may be medical students. The strategy used to get into school is to make the case that they are exceptional candidates for the profession of medicine. This includes, in the words of one student, "studying hard and getting good grades, and making sure you get to know your professors so you can get good recommendations, and getting some outside activities so you'll look well rounded. And writing a good essay." The strategic action includes both deeds and words. If the applicant is a woman, the student continued, the language strategy must also include, "making sure you know, as a woman, how you're gonna' conduct your life as a woman once you get into medical school."

In not-yet-regularized situations people must determine the appropriate actions (deeds and language)with which and through which they will maintain a relationship, preferably negotiating one that is satisfactory or agreeable to them. When the situation is not-yet-regularized for the people involved they may or may not want or be able to honor the cues given to them or respond to the questions asked of them. When the parties involved are establishing a new type of relationship, as between here-to-fore-excluded large numbers of women in a predominately male medical school and their male classmates, the parties must first negotiate what are the questions and answers important to them in that relationship. In other words, they must de-

termine what kind of relationship it will be and under what conditions they will maintain that relationship. People do this by casting other people into particular identities and confering upon them the necessity of honoring a particular kind of landuage strategy and assuming for themselves identities suitable to the language offered.[3]

Thus, a woman medical student, when requested by a male medical student to explain to him, "Why would a girl want to go into medicine?" refuses to be cast as a "girl in medical school" and uses a language strategy in which she assumes the identity of "a medical student like every other medical student" and casts the classmate into the identity of student relating to student. If she wants to be a colleague, she will insist that he take on the identity of one and she will assume that identity for herself. "It's definitely a professional type of air, about them," Izzy said about this part of the women's strategy. "And that's definitely the kind of person that a doctor should be, you know? Very professional in everything. Everything! . . . You know, so that, as for as other men in the class are concerned, the [women treat them as] professional colleagues. I mean. . . . Anything else beyond that the [girls] turn off too. . . . I know of a few [men] who wish that the female medical students were more responsive to them as women. . . . But I don't know of any girls who wished the men would be more responsive as men . . . I think they just want to be treated as equals." In the classroom situation discussed in this paper the women gradually develop the power to cast their male counterparts as equals and be accepted as equals themselves. But both men and women forecast that this is a situation that will not last, once they enter clinical training.

SUBJECTS AND DATA

The data presented here were provided by medical students in their first year in a Northeastern state school. In this year (1974-75) women represented approximately 30 percent of the class. This is slightly above the national figure for the year (27%), which represents a 400 percent increase in women admitted to American medical schools since 1970.[4] The students were in the basic sciences curriculum in which all of them progressed through the same course sequence of lectures and laboratory work. Fourty-eight students from the 120 enrolled participated, 28 of the women and a random sample of the men.

Over 100 hours of interviews generated some 2000 pages of transcript. The interviews were structured topically only (e.g., How did you get into medicine?). They were otherwise open ended and the students introduced issues they were interested in discussing. The students, without exception, focused the interviews on their current situation in school. With few exceptions they were cooperative, willing participants and frequently thanked me for talking to them. In this sense they viewed me as a sympathetic listener. I, as much as each other student, became a part of the audience for language strategies, which served to support current and future actions. These stratigies gave private and personal support to each person's self image, as well as being the vehicles through which they sought to develop the more public identity of medical student.

The data presented here are coorborated by both sexes. That is, both men and women knew and described the situation in school, their own and the other sex's strategies for dealing with the other.

THE SITUATION IN SCHOOL

I pointed out earlier, all medical students must present appropriate characteristics (credential and skills), as well as appropriate explanations to become members-in-training. These language strategies also assist their gaining acceptance as peers in their class. Women must, however, also have appropriate language strategies for why as women their class mates should accept them as equals.

When women enter medical school they do not have equal status with their male counterparts, even though they have the background, skills, and motivation to gain admission (cf. Austin, et al., 1973; Campbell, 1973). Male students relate to the women on the basis of their sex first, not as peers in school, and create among the women resentment that they are "not being taken seriously," as medical students and potential physicians. This means that the women must negotiate a relationship with male students in which they become peers, rather than oddities. They must bargain for the status of "capable serious medical students," in which they are known and treated as good students, capable of being good physicians. And, they must also be able to negotiate acceptance as people who will be able to be good physicians. The women become aware that even though they may gain acceptance, while in the classroom of the basic sciences curriculum, that there is one important unresolvable difference between them and their male classmates. Women medical students' futures are perceived as different from men's. And their male classmates continually remind them of this by questioning their futures. They ask them how they will manage to combine career and marriage without "compromising," their careers or their family well being, and often assume that women will enter certain specialties. The

implication is that women's colleagues will judge not only their professional work but, also, their home work in admitting them to membership in the profession.

Encountering Collegial Disbelief

Male medical students often relate to the women entering school with them on the basis of their sex by not understanding that the women want to be physicians, and that not all of them want to go into fields traditionally "appropriate" for women. Male classmates question the women's seriousness; they think they will practice only part time. They often asked them to explain why a woman would want to become a physician.

"I think most of the men students in the class don't think women should go into medicine, "Judy A. said about this. "I've found very few . . . guys that were liberated. . . . They always . . . think, 'O.K., that's what you wnat to do, that's cool, but my wife will never be a professional.' You know? . . . I've met guys in college that . . . thought what I was doing was great. . . . And I thought that men in my class would be like that, but I haven't met anybody. . . . You're another medical student, but they . . . find it very hard to understand why any woman would want to be in medicine. . . . It bothers me that somebody would wonder why you want to be a doctor, if they want to be a doctor. I mean, like, couldn't you have the same motivations that they do? I had one friend that I got into a big argument with one night and he said, 'Why don't you just be a dentist? Like, you'll have more time to yourself.' And, I said, "Would you want to be a dentist?" And he'd go, 'No.' And then I said, 'Then why should I want to be a dentist? . . . I'm gonna' be a doctor!' They can't understand that, you know. . . . This guy had this theory . . .

if you're a woman, obviously you're gonna' be the one to bring up the kids. . . . You know, maternal instinct and all that? Like, you shouldn't spend all your time being a doctor. You can't do both. Well, that's what most of them think: you can't do both."

The men also see the women going into "women's fields," such as family practice or pediatrics. "I'm not interested in just only being a pediatrician, which is the first thing that people ask me when they hear I'm a women in medicine," said Laura S., who is interested in opthalmology. Wanting "to be taken seriously," the women do not like it, when the men in their class do not accept them as potential doctors or can only see women as limited in their participation by family obligations or women's interests.

The men also treat them as "cute girls," and, again, do not accept them as serious students. "All these men--they say, 'Oh, she's a cute girl. . . . Isn't she nice," reported Meg. "And I can't stand it, I hate it." Meg, goes on to describe how the men first attempted to relate to the women, as girls, rather than serious medical students: "Oh, like, I think a lot of the men like the women and stuff and think they're gonna' make good dactors. . . . But I think a lot of them just sort of, like, with another man can sit down and do serious work. With a woman they can have a nice time and study. If you can sort of see the difference. Like, you know, I have guy friends that I study with. In fact, one of them is one of the top students. But, I think we just had a nice time together. He likes me because I'm charming and I can talk about other things besides medicine . . . But he, you know, wouldn't study with me because I had something to offer him. It's not like I can help him with physiology. And I think that's how it is with a lot of women."

Are the men reacting to the women as a threat? They do, certainly, try to relate to the women's status as females. The women, however, do not describe this as overt discrimination from male classmates--in fact they say there is none in this school from students or faculty. Yet, male students first relate to the women as cute girls, potential sexual partners, or superwomen, strong willed, or overly competitive. They in effect relate to the women as girls-in-medical school, or as girl-medical students. Though they are called "the guys," they are medical students, not guys-in-medical school. The men call the women "not normal," because they are "highly motivated," have "very professional attitudes," "put in lots of effort," and "want a career." At the same time, the men view the women as very normal or "traditional," because they also want marriage and families, and expect to take care of their own children. They comment on the fact that many women dress stylishly (almost too well), and even more are attractive. The language of the male students presents them as unable to understand how the women can be liberated enough for a high commitment career and be traditional enough to have a home and family life.

THE WOMEN'S LANGUAGE STRATEGIES

Women must have the appropriate acts and language strategy of medical students just as any other medical student does; they must also have appropriate language strategies for how as women they can be successful medical students and physicians. The language strategy the women use to gain acceptance as "capable serious medical students" may be outlined as follows:

I. They Have the Appropriate Language Strategies of Medical Students: Women are "No Different."

1. <u>They assert their credentials and their rights</u>. Women say they have the right to become a physician and they have the credentials (grades, MCAT scores, requisite courses, intelligence, job experiences), which qualify them for admission to medical school. They describe themselves to be as good as anyone else to the challenge of becoming a doctor. They do not have a "place" or "role" in medicine "as women."

2. <u>They assert their motivation and desire for a challenging career</u>. They, like any other medical student, have the motivation for the challenge of getting through the rigors of medical school. And, they "really want" to become physicians, as does anyone who will "make a good doctor."

II. They Have Acceptable Language Strategies of How They Will Do It, As Women.

1. <u>They assert that going into medicine and into certain male specialties is also a challenge for them, as women</u>. To enter a formerly male domain is a challenge. Many of them find it challenging to enter specialties which are "opening up to women." As ambitious, achievement oriented people, they say that medicine is for them an opportunity to use their skills and motivation.

2. <u>They point out women's special qualities, now needed in medicine, which they can contribute to health care</u>. They can contribute "understanding" and "empathy" to many patient-physician relationships, such as in practices with large proportions of women and children. They will take time with their patients.

3. <u>They agree that the issue of combining career and marriage is an important question. But medicine is the important part of their life now</u>. They either assert that they can combine wife-motherhood and

a career without deleterious results to either, or refuse to answer the question for the time being.

They Have the Appropriate Language Strategies of Medical Students: Women are "No Different"

Becoming a medical student is, indeed, an exclusive goal.[6] Students wishing to get into a class must have very good credentials and very good language strategies. When women talk about their motivation and desire to become a physician and present their credentials in the form of grades and scores and experiences, they and the men in their class are very much alike. There is little deviation in the credentials those accepted to medical school have presented (see Johnson and Dube, 1975), and in the language strategies they use, which include telling how they got interested in medicine, what they did to prepare themselves for admission, and the major reasons for wanting to become a doctor (cf. Cartwright, 1974; Hammond, 1977). When women talk about being "no different," and that standards were not lowered for their admission they have a strong case.

Credentials and rights. The women first insist that they have the right to become a physician, and in any area and specialty they wish. They do not want to be "restricted" to certain areas or denied access to others. Women students do not see themselves as having "a place" in medicine or a "limited role" because they are female, though they know that they may have trouble with some patients, and are aware that they will face discrimination from clinicians (particularly in certain specialties), as an expression, many of them feel, of the "prejudice against women who will practice less."

In claiming their right to become doctors women state they are

"equal to men" and that their interests and competencies will "determine" what they do. "I've never really thought of myself as a woman applying. . . . And I don't think of my role as a woman in medicine. I think women can do very well as physicians," said Judy M., who wants to go into family practice. "There is not a 'role' for me," stated Lynn, who hopes to go into administration, do research, and teach surgery. Irrespective of the kind of doctors they want to be, they do not see themselves as "a woman in medicine." As Joyce, an aspiring cardiologist, put it, "I can't say that I think women have any special difference [from] . . . men." The difference to which they refer is that they will be less of a medical student or a physician because of their sex.

To negotiate an equal status with their male classmates their claim to the right to be a doctor puts them on an equal footing with the men. Morally it is hard to deny the claim. It is as passé among college educated students to deny women's rights as it is to call blacks "nigras" or "niggers." But the right can only be claimed if it is supported by the requisite academic and experiential credentials. And, these were challenged at the beginning of the school year. "The women were resented," Meg's comments are typical, "because the guys felt . . . there's sort of a reverse descrimination being practiced. That they're taking more women just because they're women. Guys hate that! You know, a lot of guys have said to me, 'I have a lot of friends who didn't get in with the same credentials [as you]. They took you 'cause you're a woman.' I was really pissed off. . . . There are so many factors that go into it, you know? I went to [a prestigeous university]. I just didn't go to Podunk U., you know!?"

Not only is one's public image important for success as a medical student, but also one's personal image. To be able to have the right combination of skills and abilities, work experiences, courses, grades, board scores, and interests which make one "well-rounded," is part of the expected and accepted medical student. When men relate to women on the basis of their sex first, their legitimate acceptance to school, their purposes and their goals are all doubted.

Motivation and Desire. The second part of anyone's strategy for acceptance as "capable serious medical student" is to demonstrate the right kind of motivation. Students say they "worked hard" (or "it just came natural") and got high grades; their part time jobs in college were in a medical related setting, where they found out how satisfying and rewarding it was to work with people.

Students present themselves as highly motivated to be a doctor and motivated for the right reasons, which means they will be good doctors. Anyone who wants to be accepted as a capable serious medical student wants to be one for the right reasons, that is, they want to "help people" or like "working with people." They, often, want "to help the whole person." In addition they want work that is "challenging" and "demanding," "not boring" but "full of variety," which provides "immediate rewards," and "immediate gratification." For them, the medical student who will become the good physician combines a liking for science with a liking for people. And, he or she, alone, made the decision to enter medicine; parents "didn't push."

Male or female they say that they want the skills and knowledge of the physician--and the authority. They say their personalities are not suited to being subordinates; but they are humanistic and altruistic:

They want to become physicians because it is "at the top" in service to others, personal rewards, and in autonomy.

If, becoming a physician is an opportunity to have a "challenging career," the process of training, as well, is viewed as challenging. And, medical students must indicate the strength of their motivation by being willing to undergo the "sacrifices" necessary to get into the school and be successful students. Howard makes this clear in the following comments, "I thought I worked hard as an undergraduate. . . . At times I probably did work as hard, but not as often. . . . I recently spoke with a fellow that's applying and I told him that I never would want to discourage him, but he'll have to experience how much he will sacrifice. Actually there's no telling anybody to the point where they really understand the amount of work in the next few years. . . . That's appalling. . . ." The sacrifices now are ones people are willing to make for their future gain, as Laura G. makes clear, ". . . you know, I'm normal. I'd love to go out. I'd love to go to the movies all of the time. You just can't do that. And, if you sacrifice, you might as well be sacrificing for something you really like. Otherwise, you know why waste your youth? Why waste four years. . . . And that's why you're sacrificing. . . . There's just so much work you have to get done for an exam. . . . And I love what I'm doing. I mean: it's a love hate relationship for sure. But in the end I love what I'm doing, so it makes it all worth it."

That they are motivated enough to make the sacrifices to meet the challenge--and to even like what they are doing--is also a part of being a "capable serious medical student." Such a student is one about which there is no question that he or she will eventually become a good physician.

They Have Acceptable Language Strategies of How They Will Do It, As Women

A Challenge as women. Going into medicine is also a challenge as a woman. Even though the women see their potential and skills and motivation as no different from their male classmates', to become a physician is also a challenge for them as women. Maria, who wants to be a pediatrician, said, "I feel there's got to be determination and courage . . . I think it's more of a fight for women to be appreciated as doctors . . . you know, 'If you're not going to spend more than sixty hours a week, you shouldn't be in medicine. . . .' I probably won't be able to become a neurologist. . . . Pediatrics and OB/GYN are safer for women."

Part of this challenge to women is that, now that medicine is "opening up" to women, they are taking on the challenge to enter a "formerly male domain." Cheryl's comments are representative of her classmates who want to enter what they term "high powered" specialty areas, where women have formerly been denied admission: "I feel that there are many more women in medical school now . . . it's just going to open up. Not like a knock on the door and they will let you in. But it will be a knock two or three times to get in. Which is why I really wanted to get into something very highly specialized, because there really haven't been very many women there before."

Brenda, who wants to contribute to women's health care needs, is also challenged by the prospect of entering a male field. And, she clearly, sees the opportunity to contribute her special understanding of women patients an appealing one in a higher status specialty, "I wanted something in--you know--a male dominated field [that] was also sort of challenging, which is another reason why I may get involved in

obstetrics instead of becoming something less time-consuming. [Instead of] something lower down in the field." Apparently entering high powered--translated high status--fields is as appealing to some women as it has been to men.

For women to enter medicine is an opportunity to use the ambition and achievement orientation that girls in high school and college develop, but for which they often have found no outlet, when their schooling is over. As Kay tells it, the women's movement provided her with the confidence to try, "I started to read the books . . . and I just devoured them. I was a senior in high school and I was getting tired of high school, and I didn't know where I was going, and I was ambitious but didn't know how to channel it into anything. And then I read them, and I just--Oh! I was completely sold! And especially . . . if you really want a career and family, you can go ahead and do it. And women should be able to do whatever they want to."

The challenge is one for which women have had the capabilities but not the supports and opportunities necessary for their continued achievement. Men students recognize this, also. As Ed put it, "I have to admire them for going up against what I see as the odds against them . . . I admire them for their perseverance and everything . . . I'll say this. I'm glad I'm a man . . . I think women--they're starting from a weaker position, as for as achieving. . . . Whenever I wanted to do something, I could do it. I've gone out with girls, who wanted to do things and couldn't do it. They got flack . . . and I think that's an injustice on their part . . . They have to be an extraordinary person in order to buck that sort of . . . 'Don't do anything unusual . . .' just keep along the same vein as your parents have done--or your mother and . . . I would not want to handle that."

Women's special qualities. I have tried to make clear that medical students, who are women, want to be accepted as medical students and potential physicians, not some category of women-medical students or physicians. But this does not mean that they do not recognize the contributions that women can make in the quality of care they give. Women talk about the contributions that they can make in terms of understanding and time. The women's touch is needed, they feel, today in medicine in the doctor-patient relationship. Laura S.'s comments are representative of those that women make about a "woman's point of view," "I think medicine would--number one-- become less glorified. . . . Just because the whole idea of the white coat and the black bag and the whole thing from way back seem so stereotyped. . . . It's like somebody proclaiming: 'Here we all are and, look, we're all male and we're all doctors.' And, it's like they're calling the shots and everybody's got to follow them. I think there's a lot to be understood from the women's point of view. About treating, like, the families of patients. . . . But people tend to forget that. And I hope that by the time I'm done with this training routine or whatever--this militia that they pump you through, I won't have lost that kind of attitude."

Those who feel that women can make a special contribution talk about it, also, in terms of women's ability to empathize with and understand certain types of patients. These are the women and children who make up the majority of patients in obstetrics, gynecology, pediatrics, and family practice. There are a number of women entering medicine who do have a particular interest in women's health care needs and in educating women about their own bodies, birth control, and childbearing. "I thought it would be particularly good to do this," Judy B. reported, "in a field like gynecology. That could be just very important in terms

of supplying the kind of health care that's not there now. And supplying other needs than those specifically medical. I mean a woman gynecologist could do [more than a man] . . . just like the psychiatric aspects maybe, and empathy aspects."

Besides being more understanding of and sensitive to women's needs, women entering medicine are likely to be well accepted by children and their parents. Sarah's comments are representative of the perspective of women, who are interested in pediatrics, ". . . I think, as a woman pediatrician, I would be very well accepted by patients. By their mothers, their children."

In other words "women have a lot to offer. I think I have a lot to offer," as Meg put it. "A lot of women can be more empathetic, more understanding, make things more personal, rather than 'business-like.' Although I think for a long time a lot of the women, who were in medicine, were very business-like, because those . . . types of women, who could survive the competition, were really 'manly' sorts of women, if I must use that term. Now they're taking ordinary women, you know? Women. Normal women. Women that can be feminine and that can also succeed . . . I don't think you have to sacrifice femininity or being gentle or understanding in favor of being educated and a physician. . . . It seemed to me that there, for awhile you had to sacrifice one or the other." Women, these students feel, have a lot to offer a profession, which wants humane and altruistic candidates. Not only do women have particular needed qualities, but, as Meg points out, they feel they do not have to become the stereotype of the manly women.

Eight of the women in this study (29%) do not refer to the special contributions of women. Five of these are going into surgical specialties or specialties where such qualities are devalued by members of the

specialty, and which, students feel, often require that one does not "get too emotionally involved with patients."

It's an important question; but medicine is more important, now. Women, who enter medical school face the question from the men in their class, of how they will combine career and marriage. The atmosphere at this school is one in which there is much pressure put on the women to practice. "A practicing physician, is the best type of physician is the policy around here," according to Cheryl and her classmates. "It really is. They hate to see someone getting out of the practice, just to have kids . . . and so you can tell that there's a little bit of the pressure on you. Some of the people would . . . rather not see you get married at all and just continue practicing just like a male, but . . . you can't compromise your own beliefs and the way you feel. . . ."

Most of the women accept that they will likely marry, which is "no problem." The issue, of course, is children. The women's explanations must support their being different women--women who will postpone marrying and having children until after their training and who will not waste their training. "I could never think about getting married, while I was in med school." "It probably would not be until after my residency," are typical ways they talk about it. The basic tactic is to agree that it's an important question for women because being a physician is a major responsibility and being a mother is a major responsibility.

1. Those who will not have children. Joyce represents the view that it is such a major responsibility that she may not have children. "I decided, well, you can't do two things and do them really well. You know motherhood is a really big responsibility. And, therefore, since I want to do medicine and that's gonna' be a really big responsibility, then I don't want to be a mother too. I don't want two major responsibilities in life. . . . If I'm gonna' decide to have children, I want to make sure that I'm gonna' really be responsible about it. . . . Or else forget it."

2. The equivicators. Some women admit the responsibility, but, instead of saying they will not have children, they take the position that they cannot answer the question very well until they are faced with it. "I'll cross that bridge, when I come to it," said Cheryl. "But . . . I'm definitely . . . not leaving anything out of my mind. I'm not saying that I'm not going to get married. And I'm not saying that I'm not going to have children, . . . I have given [it] a lot of thought, too. Although it's very bleak . . . I would have to avoid having children until life was more settled. . . . During the internship years, it's just so hard that it would be impossible. If I ever did get pregnant, then I would have to discontinue the internship."

These women are equivocators. They realize the responsibility, can agree that there are and list a multitude of problems, but say they will not do anything but be a medical student for the next few years. They agree that the question is important, but put it off, because it "depends on the kind of circumstances" and "I will just have to play it by ear" for the time being because "I don't know whether I'll marry or have children or not." In the end they admit, "I would like to have children."

3. I'll do both. Another group is not so equivocal. Motherhood is still a big responsibility. They admit "it's a problem," and a few say "it's no problem." They will do both. "I would want to be a good mother and that also involves putting [in] time," typically stated Betsy, when talking about combining career and motherhood. "I

don't think of it so much, now, as a conflict. I used to. I was wondering whether or not it's possible. And I'm becoming more and more of the opinion, the more . . . women doctors I see, that it is possible to be both a good mother and a good doctor, too. But I think it's going to take a lot of work in doing."

They are not sure how they will do it, as Laura G., also points out, but they will. "I definitely want a family. It's not right now . . . to tell the truth . . . I really am not sure how I'm gonna' do it, but--somehow, some way." Sandy, also "feel[s] strongly positive about it . . . I would really like two [children]. I'm not real sure, at this point, how I would carry out raising my children . . . I can't see completely cutting myself off from my career."

Only one women, among those interviewed, refuses to agree that the question is a legitimate one she must answer. <u>She</u> will "call the shots" in <u>her</u> personal life: "They're still thinking of doctors as some kind of glorious profession. And I tend to think of it as a job, but a job of choice. And one that you . . . spent a long time getting to. And once you're there, I think that you should call the shots and

not feel pressured into putting in 60 hours. Everybody else works 35 or 40 . . . What's wrong with that? Motherhood is a big responsibility. Right now medicine is what I want."

Part of the women's strategy at this school is to agree that being a parent involves major responsibilities. Some women say they will not have children. Other women's language strategies are long and complex accounts of the problems involved in attempting to combine parenthood and a career. They do not like to say whether or not they want families, but appear to lean towards putting a career first. Other women have motive stories in which they are not sure how they will "do both," but they will, even though it "may be hard." A minority will or may not marry.

In reports of medical women, past and present (cf., Walsh, 1977; Weichert, 1977), women's language strategies have had to support their being both a parent and a physician to be acceptable members of the profession. But at this school there seems to be a difference. Part of their language strategy, as Judy A. stated, is to say that they "see themselves as getting married and having a family . . . I don't know any of them that tell you <u>how</u> they're gonna' do it." Yet they say, "it has been done," by the women who they are meeting as they go through their first year of school. Their strategy may not include telling male members of the profession how they will manage both career and a family, but it does consist of agreeing that this is a legitimate, important, and difficult question to answer, but that right now their primary interest is medicine.

SUMMARY AND CONCLUSIONS

In this paper I have argued that the barriers to women's participation in male professions are largely structural. As more women enter male occupations, they become aware of the sex-linked barriers to their full participation and seek acceptable strategies for negotiating these barriers. In negotiating occupational barriers, women engage in a power struggle with the men whose sex has always made them acceptable candidates for membership.

Into what is perceived as a demanding, taxing, and rigorous training program, women (and ehtnic/racial minorities) are now being admitted. The very initiation strategy of the medical profession is threatened. That doctors are the best because of high entrance standards; and that though, demanding, time consuming training makes them the best is an image threatened. An important element of the image of the physician--an image that has assisted in the assumption of autonomy and power by the profession--is being threatened by women's admission in large numbers. Yet, by mid-year most men in the class do not question anymore the women's credibility as medical students. And, by this time the women say, as does Mimi, "I find no differences . . . I find that we're colleagues." Yet, the students suggest that women may not be accepted when they enter clinical training.

The women's acceptance by male colleagues is assisted by 1) the women's use of acceptable strategies and by 2) the impact on their negotiation of their relatively large numbers. Men require acceptable language strategies to validate what they perceive as unusual, unacceptable, or threatening actions from women. The women's language strategies present them as no different, as medical students; yet bringing women's

special qualities and interests to their practices. Such strategies are necessary for women to overcome their threatening potential to the charismatic male image of the physician and to men's control of the profession. By using the strategy that "women are no different than any other medical student," the women do not, at least, derogate by their presence the image of the medical student as one who relys on skills and a high level of motivation to enter and successfully endure the rigors of medical school. To use the language strategy, which emphasizes the special qualities women can contribute to patient care, diffuses their threatening potential to the image of the physician. The heroics, the dash, the verve, the charisma--those qualities which are needed beyond intellect in the rigors of a demanding practice or research position--are left to the men.

The difference in the way the women and men talk about their careers points up this important distinction between the sexes. Women emphasize patient care more often than men (versus combining care with teaching, research, and/or administration) and they focus on the qualities they can contribute to patient care in certain types of specialties. Women, thus, tend to reinforce the already existing sexual stratification in the medical profession (cf. Sullivan, 1974; Quadango, 1976), where, though they contribute more than their proportionate share of patient care, they are overrepresented in less prestigious specialties and locals where men have often been less willing to go.

In the situation presented in this paper there is great pressure from not only class mates, but faculty, as well, on the women to adapt to the system as it is; practice full-time; and, if they can't find husbands, who will be wives, omit children from their lives. Rarely,

in the language strategies of beginning medical students is there support for changes in the profession and the organizations in which it functions, which would assist parents. Such language strategies would reduce the importance of the challenge, the drama, and the power to which the students are drawn in the first place.

Though both male and female medical students may point out that many of the problems of combining career and family commitments for a physician are common to men as well as to women, only women must publically agree that they should be able to answer the question of how they will manage to combine career and family, as a condition of professional acceptance.[6]

If, indeed, the profession is selecting "normal women," fewer of them may be able to have families than when the profession selected only very outstanding women, unless they can find "exceptional husbands" who are "willing to work it out" in a situation of scarce resources.

In this class there are enough women to refute old stereotypes men may bring with them to school--verbally and by their work as good students, as well as by the fact that the men also are used to being in school with capable women students. Token women or very small proportions would not have enough contact with the members of their class to assist men in overcoming preconceptions or misconceptions about women who enter organizations organized for males (Kanter, 1977). It's better to be more equal [in numbers]," said Darleen of this. "I think the fewer women there are, the more they're isolated. And I just think that, if it were more even, then the relationships would be better . . . . There would be less likely to be distinctions made on the basis of sex." In the past women have had to overcome the prejudices against females by accepting marginal roles and/or by being exceptionally well

qualified and/or by putting more effort into their work than the men.

Male dominated occupations and professions have myths about why women are unable to be acceptable members. The myths associated with the structural barriers to women's participation are male language strategies which reinforce women's nonparticipation. In this day and age the only language strategy the men can use against women's entrance is to argue that combining career and familial roles is a tremendous task for women who are physicians. Women ought not, therefore, when the country needs doctors and goes to great expense to train them, take the place of a man who will be able to practice full time and use his education. The myth that women do not make use of their practice potential requires a response. But the circumstances of history do not permit women, yet, in medicine, law, or the military to say "bug off." "You're saying I won't be a good worker because I'll have a family is a bunch of baloney," is not acceptable as a strategy to women (or men) in competitive professional settings. But, by agreeing that males have the right to inquire about their personal lives, the women perpetuate the double standard for men and women's professional membership.

There is more involved in the organization of training and work than the inflexible scheduling of work for physicians and the amount of time they have to put into work and in mobilizing resources for childcare and other familial responsibilities. Organizational barriers include people's perceptions of the situation and people's attitudes and feelings about women and about proper work. Here is where male collegial acceptance and the organization of work by men for men are intermeshed. Male attitudes and feelings about appropriate

work organization and their attitudes and feelings about problems of combining work and family are underscored by the fact that they do or will do their work in the context of a familial support system and that women in medicine have done and do their work without having a wife at home. That men, who derive status, in part, from claims about the rigors of their training and work are threatened by women who in the past have assumed both work and familial responsibilities is understandable.

To argue for their acceptance into a profession because of the special qualities women can contribute presents the dilemma in which the very qualities which have been used to keep women out of medicine are being used to negotiate for their admission. The catch may be that after classroom work is over women will be admitted to clinical work--and hence to future practices--as women-students are treated as women-physicians, who somehow have a place in the profession different from men's.

FOOTNOTES

1. This is a revised expanded version of a paper to be presented at the American Sociological Association Meetings, San Francisco, September, 1978. Lawrence Radine provided invaluable stimuli to my thinking in developing the argument. I thank him, and Barrie Thorne for her criticism and encouragements, and Mayer Zald and Toni Antinucci for their comments.

2. Or there must be agreement that a particular language strategy may be generalized to a wide variety of action, as when all sorts of actions are explained, supported, or justified by a Freudian vocabulary or a Born-Again Christian vocabulary.

3. This is called altercasting by Weinstein and Deutschberger in Eugene A. Weinstein and Paul Deutschberger, "Tasks, bargains, and identities in social interaction." Social Forces 42(May, 1964): 451-452.

4. Since 1959 this increase in entering women has been almost 700 percent (Walsh, 1974: 268). The United States has one of the lowest proportions (8%) of practicing women physicians in the world. Women make up, for example, 20 percent of physicians in The Netherlands, 30 percent in Germany, 13 percent in Brazil, 35 percent in India, and 75 percent in Russia (Bowers, 1966). However, in 1910, American women made up 18 percent of physicians in Boston, 14.9 percent in Los Angeles, and 19.3 percent in Minneapolis. Walsh argues that women's decreased participation in medicine was not due to the more rigid credentialing requirements following the Flexner report of 1910 and documents a conscious effort on the part of the medical establishment to minimize the number of women physicians.

5. Women physicians work about ten hours per week less than men (Weichert, 1977. See also Campbell, 1974; Williams, 1971), and yet are overrepresented in full time salaried positions (requiring fewer hours work), and less frequently report "on call hours" (Woodsine, 1975). They also deliver more than their share of direct patient care (Center for Women in Medicine, 1974). Since the average life expectancy of women is seven years longer than men and greater proportion of male physicians (84.6%) are known to be retired after age 60 than women physicians (50%) who are retired (Walsh, 1977: 256). The perspective that women's practice potential is less than men's is questioned (Mathews, 1970; Weichert, 1977; Woodsine, 1975).

6. The male students in this class feel they, too, face the dilemma of combining career and family responsibilities, when physicians are known to spend so much time at their work than home-life, wives, and children are neglected (Hammond, 1977). But as men, they do not have an acceptable public explanation as a condition of membership in the profession.

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